Patient Registration **(PLEASE PRINT CLEARLY!)**

Patient's Name:_____ SS #: _____
First Name MI Last Name

Date of Birth:_____ ☐Male ☐Female Marital Status _____ Race _____

Home ph# _____ Cell# _____ Work# _____

Mailing Address:_____

City/State/Zip Code:_____ Email address: _____

Patient's Employer:_____ Work Phone w/Area Code:_____

Spouse's Name:_____ Date of Birth:_____ SSN#: _____

Spouse's Employer:_____ Spouse's Work Phone #:_____

Responsible Party:_____ Relationship:☐Self ☐Spouse ☐Parent ☐Other:_____

If patient is a Minor, are parents☐Married ☐Divorced Custodial Parent:_____

Custodial Parent's Home Phone w/Area Code:_____ Work Phone w/Area Code:_____

Custodial Parent's SS #:_____ Date of Birth:_____

In case of emergency, contact (not living with you):_____

Phone Number w/Area Code:_____ Relationship to Patient:_____

Is this work-related? __Yes __No If yes, date of injury?_____ Claim #:_____

How did this injury happen?_____

Referring Physician's and/or Primary Care Physician Name & Phone Number:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ Phone Number:_____

>>Primary Insured's Name:_____ >>Date of Birth:_____

Policy #:_____ Group #:_____ Relationship:_____

Insurance Company # 2:_____ Phone Number:_____

>>Primary Insured's Name:_____ >>Date of Birth:_____

Policy #:_____ Group #:_____ Relationship:_____

If you do not have insurance, have you applied for Medicaid?☐Yes ☐No If yes, what is the name and phone number of the social worker with whom you are working?_____

I hereby authorize the office of CMH Surgical Services, LLC to release my medical information during the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, co-payment, deductible and non-covered services. If I have Medicare, I also request that payment of authorized Medicare benefits be made either to me or on my behalf to CMH Surgical Services, LLC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

>>_____ _____
>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

I authorize CMH Surgical Services, LLC to treat me and use my personal health information for healthcare operations.

>>_____ _____
>>*Patient's Signature* (OR Parent if patient is a Minor) Date

PATIENT ACKNOWLEDGEMENT

I have been given a copy of Community Memorial Healthcenter's Notice of Privacy Practice that describes how my health information is used and disclosed.

_____ _____ _____
Patients/Guardian Signature Printed Name Date

**If signed by legal representative/guardian, list relationship to patient

_____

Patient Health Information **(PLEASE PRINT CLEARLY)**

Patient Name: _____ Age: _____ Height: _____ Weight: _____

Reason for today's visit: _____

How long has this been present: _____

Please check all that apply to you:

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ COPD
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Anemia
- ☐ Cancer
  - Type: _____
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Thyroid
- ☐ Kidney Failure
- ☐ Bowel Obstruction
- ☐ Cirrhosis of Liver
- ☐ MRSA Infection
- ☐ Crohn's Disease
- ☐ Genital/Anal Warts
- ☐ Depression
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ GERD
- ☐ Arthritis
- ☐ Emphysema

Other _____

Past Surgical History – Check any/all that apply to you:

- ☐ Hysterectomy
- ☐ Gallbladder Removal
- ☐ Appendix Removal
- ☐ Hernia Repair
- ☐ Colon Surgery
- ☐ Broken Bones
- ☐ Spleen Removal
- ☐ Hemorrhoidectomy
- ☐ Dialysis Shunt Insertion
- ☐ Varicose Vein Removal
- ☐ Tonsils Removed
- ☐ Mastectomy (Lt or Rt)
- ☐ Brain Surgery
- ☐ Gastric Bypass
- ☐ Thyroid Removal
- ☐ Open-Heart Surgery
- ☐ Portacath Insertion
- ☐ C-Section

Other: _____

Health Habits: Alcohol ☐ Caffeine ☐

Tobacco ☐ Drugs ☐

Gynecological History:

When did you first begin menstruating: _____

When did you stop menstruating: _____

First day of last period: _____

Pregnancies: ____ Complications: _____

Date of last mammogram: _____

Family History

Relation	**Age**	**State of Health**	**Age of Death**	**Cause**
Mother:				
Father:				
Brothers:				
Sisters:				

Family History of Breast Cancer: ☐ Yes ☐ No

416 Durant Street
South Hill VA 23970
Phone: 434-774-2581 **** Fax: 434-447-4704**

Please Fill This Form out. This Form is very important if we ever need to send your records to another Doctors office or if you request your records. We have to have your Signature on this Form.

MEDICAL RECORDS RELEASE

I hereby request that any information and or medical records be released from:

Dr. Desi Rimon Cecelia Braun, PAC
Address: 416 Durant Street
South Hill VA 23970

Please circle one:

All Records

Other (Please Specify) _____

_____	_____	_____
Patient Signature	**Social Security Number**	**Date**
_____	_____	
Printed Name	**Date of Birth**	

A Service of Community Memorial Healthcenter
416 Durant Street, P.O. Box 756 – South Hill, VA 23970
434-774-2581

Financial Policy

- As with any other business, it is necessary for us to receive payment for the services we provide to ensure we can continue providing these services for you at reasonable prices.
- **Your copayment (copay) is due at check-in**
  The copayment is a fixed fee defined in your insurance policy that is paid each time a medical service is accessed. Most copayment amounts should be listed on your insurance card. Please be prepared to pay the co-payment at check in to avoid your appointment being rescheduled.
- If you do not have insurance, and if you are unable to pay the entire amount, you will be required to sign a payment plan before being seen.
- Please note that any procedures, labwork, etc that you have done outside of this office or that is sent for interpretation, is not included in your office visit(s). You will receive a separate invoice for these charges directly from the facility providing the service.
- In addition, if you have an outstanding balance with us and you have not arranged a payment plan, then you will be required to make a payment on the balance and sign a payment plan for a monthly amount. This includes accounts that have been sent to a collections agency.
- Payment plans are available for patients needing to make special arrangements to pay-off their bills. These arrangements should be made in advance of receiving services.
- Please feel free to ask questions and discuss financial matters with our financial staff in the business office.
- For your convenience, we accept Visa, Mastercard, bank debit cards (which is run as a credit), cash, personal check or money orders.
- If you do not show for a scheduled appointment, you will be charged a $50 no-show fee, which must be paid before the next visit.
- A $25 return check fee will be charged for all returned checks. Insurance does not cover this charge.
- We charge $5 to complete forms and copy medical records. This payment is due **PRIOR** to completion. Insurance does not cover this charge.
- We participate with many insurance companies; however, we do file claims to most insurance companies on your behalf. If your insurance company is one in which we do not participate, you are responsible for payment of account. You should always contact your insurance company with questions you may have prior to arranging an appointment to be seen.
- Parents and Guardians of minor children will be held fully responsible for the account, unless notified with appropriate documentation.
- You the patient, hereby authorize the payment of medical benefits to CMH/Surgical Services for services rendered. You are financially responsible for services not covered by insurance carrier. Furthermore you agree to pay all collection costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts outstanding.
- You the patient, hereby authorize CMH/Surgical Services to release any medical information necessary to complete and process my insurance claims.

_____ _____ _____
Printed Name of Patient Relationship to Patient Date

_____ _____
Signature Printed Name if different from Patient