HealthWorks FOR NORTHERN VIRGINIA

Patient Registration Form

PATIENT INFORMATION (PLEASE PRINT)

Last Name: **First Name:** **Middle Name:**

Home Phone Number: ( )

Street Address:

Mobile Phone Number: ( )

City: **State:** **Zip Code:**

Date of Birth: / /

Sex at Birth: ❑ M ❑ F

Marital Status
- ❑ Single, Widowed, Divorced
- ❑ Married
- ❑ Partner
- ❑ Separated

E-Mail Address ❑ Yes ❑ No

_____@_____

Are you Homeless? ❑ Yes ❑ No

Advance Directive? ❑ Yes ❑ No

If Under the Age of 18, Parent or Guardian's Name:

Date of Birth: / /

Parent or Guardian Phone #: ( )

Parent or Guardian's Street Address (if different from patient address):

Parent or Guardian City:

Parent or Guardian State: **Parent or Guardian Zip Code:**

Do you consent to receiving healthcare-related information through the following methods of communication? Please mark. Yes or No

Cell Phone	❑ Yes	❑No
Text Message	❑ Yes	❑No
Home Phone	❑ Yes	❑No
E-Mail/Patient Portal	❑ Yes	❑No
Voice Message	❑ Yes	❑No

PATIENT DEMOGRAPHICS (PLEASE ANSWER ALL QUESTIONS)

Race: ❑ Black/African American ❑ Caucasian (White) ❑ Asian Indian ❑ Hawaiian ❑Chinese ❑Filipino ❑Japanese ❑Korean ❑ American Indian/Alaska Native ❑Vietnamese ❑Other Asian ❑Other Pacific Islander ❑ Guamanian or Chamorro ❑Samoan ❑ Declined to Specify

Preferred Language: ❑ English ❑ Spanish ❑ French ❑ Urdu ❑ Arabic ❑ Hindi ❑ Farsi ❑ Chinese ❑ Japanese ❑Slavic Languages❑ Vietnamese ❑ Other African ❑ Italian ❑ Other

Ethnicity:
- ❑ Mexican American/Chicano
- ❑ Puerto Rican
- ❑ Cuban
- ❑ Another Hispanic/Latina (o) or a Spanish Origin
- ❑ Non-Hispanic/Latina (o) or a Spanish Origin
- ❑ Choose not to disclose

Are you a seasonal worker ❑ Yes ❑No

Are you a migrant worker? ❑Yes ❑No

Do you need an interpreter? ❑ Yes ❑No

Are you in the military? ❑ Yes ❑ No

Are you a veteran? ❑ Yes ❑ No

Are you employed? ❑ Yes ❑ No

Are you employed? ❑ Full-time ❑ Part-time

Are you self-employed? ❑ Yes ❑ No

Are you a student? ❑ Yes ❑ No

How did you hear about us:
- ❑ Physician's Office
- ❑ Community Organization/School Referral
- ❑ Family/Friend
- ❑ HealthWorks Brochure
- ❑ Social Media
- ❑ HealthWorks Staff Member
- ❑ Google/Website
- ❑ Insurance
- ❑ Social Worker/Behavioral Health Referral
- ❑ Outreach/Events
- ❑ Other: _____

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EMERGENCY CONTACT (PERSON WE MAY CONTACT IN CASE OF EMERGENCY - OVER AGE 18)		
FULL NAME:	**RELATIONSHIP TO PATIENT:**	**CONTACT PHONE NUMBER:** ( )

HEALTH INSURANCE INFORMATION ❑ Yes ❑ No Health Insurance		
Subscriber Name:	Subscriber Number:	Subscriber Date of Birth: / /
Insurance Company:		
If Guarantor is different from the Guardian, Guarantor Name:		
If Guarantor is different from the Guardian, Guarantor Address:		

Insurance & Billing Release

I hereby authorize my insurance benefits to be paid directly to HealthWorks for Northern Virginia. I understand that I am personally responsible for all non-covered services, including services that my insurance company may deem unnecessary. I understand that I will receive an invoice for these charges and that unpaid invoices may be turned over to a collection agency.

Patient's Initials Here: _____

✓ **The above information is true to the best of my knowledge.**

_____

Printed Name of Patient/Parent/Legal Guardian

_____ _____

Signature of Patient/Parent/Legal Guardian **Date**

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HealthWorks for Northern Virginia Policies and Consent

All patients are requested to read, initial, and comply with HealthWorks for Northern Virginia policies below. If you have any questions about our policies, please ask to speak with one of our Site Office Managers.

- **Appointment Check In**

Please check in 10 minutes before your appointment time. If you arrive after your appointment time, you may have to wait for the next available appointment.

Patient's Initials Here: _____

- **Cancellation Policy**

We will confirm your appointment by telephone, e mail, or text based on your preferred method of communication. If you need to cancel or reschedule an appointment, please call HealthWorks. In order to make space available for other patients who may need appointments, please cancel or reschedule as far in advance as possible.

Patient's Initials Here: _____

- **Consent for Treatment**

I authorize HealthWorks providers to perform and hereby consent to such treatment and examinations, including diagnostic procedures or evaluations and treatment, as may, in the opinion of the patient's provider, be necessary. This consent remains in effect as long as I receive care at HealthWorks or until I withdraw my consent.

Patient's Initials Here: _____

- **No Show Policy:**

In a course of one calendar year, if the patient missed two appointments without providing prior notification within the designated 24-hour period and no valid reason is identified, the patients will be unable to schedule appointments and is required to make future appointments in person to be seen the same day if the space is available. Some exceptions may be considered at the discretion of the Center's supervisors or based on the provider's medical recommendation.

Patient's Initials Here: _____

- **Consent of Communication**

I authorize HealthWorks to send text, emails, or voice messages regarding my healthcare. This communication will include appointments reminders, test results, medication notification and patient satisfaction surveys, unless I decide to withdraw my consent.

Patient's Initials Here: _____

- **HIV, Hepatitis B & C Testing**

In the event that staff of HealthWorks comes in contact with my or my children's body fluids, I consent to be tested for HIV, Hepatitis B and C and Sexually Transmitted Infections.

Patient's Initials Here: _____

- **Ambient Scribe Technology**

Ambient scribe technology listens to and transcribes the conversation between you and your healthcare provider during your consultation. Your Healthcare provider reviews the information for accuracy before it is documented in your record. The ambient scribe technology adheres to all applicable laws and regulations regarding patient confidentiality and data protection, including the Health Insurance Portability and Accountability Act (HIPAA).

☐ I consent to the use of ambient scribe technology during my medical consultations.
☐ I do not consent to the use of ambient scribe technology during my medical consultations.

Patient's Initials Here: _____