

## **ROCKBRIDGE FAMILY MEDICINE**

**Welcome to Rockbridge Family Medicine. Please complete the forms you printed out and please make sure these forms arrive in our office 24 hours prior to your scheduled appointment. We will have all of this information documented and entered prior to your visit.**

**Please bring your current insurance card, photo ID and your co-pay.**

**Thank you so much for your cooperation, we look forward to your visit.**





## Rockbridge Family Medicine

**Patient Name:**

Last	First	Middle Initial
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**Address:**

Street & Apt #	City	State	Zip Code
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Date of Birth:	PHARM/ACY # _____	SS#: _____	Sex F M Marital Status S M W D
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Employer: _____	Race: _____
Occupation: _____	Ethnicity: _____

<b>*****PHONE INFORMATION*****</b>					
Home Phone:		Work#:		Cell#:	
Please circle the # to leave appointment reminders			Please circle the # to leave personal & private info		
HOME	WORK	CELL	HOME	WORK	CELL

<b>*****EMAIL INFORMATION*****</b>	
Please provide your email address to communicate lab results:	

**Emergency Contact:**

name and relationship	phone #
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<b>If you wish for your spouse, parent, etc. to receive results or information on your behalf you MUST complete this section:</b>	
I give permission for (name) _____	(relationship to patient)
(dob) _____	(phone #) ( ) _____
<b>to receive results or information on my behalf.</b>	

Person responsible for this account **if other than self or if the patient is a minor.**

Name: _____	Relationship: _____
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Address: \_\_\_\_\_

Home Phone: _____	Wk Phone: _____	Cell Phone: _____
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Employer : _____	Occupation: _____
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<b>Insurance Information</b>	
Primary Insurance Company: _____	ID#: _____
Name of Policy Holder: _____	(person whose work insurance is through)
SS#: _____	DOB: _____ Relationship: _____

If you have secondary insurance please provide the card to the front desk.

It is the policy of this office that payment is the responsibility of the patient and payment be made at the time services are rendered. However, we will file your claim if we are a participant on your insurance. I give my permission for all providers with Rockbridge Family Medicine to treat the patient above. The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my provider or any member of his/her staff responsible for errors or omissions that I may have made in the completion of this form. I authorize any holder of medical or other information about me to release to my insurance company or to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to my physician. Regulations pertaining to medical assignment of benefits apply. I understand that I am financially responsible to the physician for charges not covered by this agreement or that which is above the usual and customary determined by my insurance company.

**I UNDERSTAND THAT ROCKBRIDGE FAMILY MEDICINE IS HIPAA COMPLIANT. I HAVE BEEN GIVEN THE OPPORTUNITY TO REVIEW THE HIPAA PRIVACY POLICIES.**

Signed: _____	Date: _____
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