Sapphire Family Practice
1921 Medical Ave.
Harrisonburg VA, 22801
Phone #: (540) 217-4455
Fax #: (540) 217-5169

SAPPHIRE
FAMILY PRACTICE

New Patient
Established Patient

Insurance
Self-Pay

Patient Information

Last Name: _____ First Name: _____ Middle name: _____
Date of Birth: (mm/dd/yyyy) ___/___/_____ Age: _____
Sex: F M Other : _____ Race: _____
Ethnicity: _____ Preferred Language: _____
Social Security #: _____ - _____ - _____

Address:

Street: _____ Apt #: _____ City: _____
State: _____ Zip: _____

Contact Information:

Home phone: (_____) _____ Cell Phone: (_____) _____
Work Phone: (_____) _____ Preferred: Cell Home Work
Email: _____

Parent/Guardian/Guarantor Information

Last Name: _____ First Name: _____ Middle name: _____
Date of Birth: (dd/mm/yyyy) ___/___/_____ Age: _____
Sex: F M Other : _____ Race: _____
Ethnicity: _____ Preferred Language: _____
Social Security #: _____ - _____ - _____

Address:

Street: _____ Apt #: _____ City: _____
State: _____ Zip: _____

Contact Information:

Home phone: (_____) _____ Cell Phone: (_____) _____
Work Phone: (_____) _____ Preferred: Cell Home Work
Email: _____

Relationship to patient:

Parent Guardian Spouse Employer

Valley Urgent Care
1921 Medical Ave.
Harrisonburg VA, 22801
Phone #: (540) 434-5709
Fax #: (540) 434-5710

By signing this consent form, I acknowledge that I have read, understood, voluntarily consent to, and authorized the following: Authorization to treatment: The administration and cost of all medical and surgical procedures, x-ray, and medication for myself and for my dependents.

Guarantee of Payment:

_____ **Self-Pay:** I elect to pay for all services rendered in full today. I understand that my insurance will NOT be
initial billed by Sapphire Family Practice.

_____ **Insurance:** Assignment of Benefits: I authorize payment directly to Sapphire Family Practice (SFP) for all
initial benefits otherwise payable to me. I also acknowledge that SFP will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my balance today based on the best available information of my current policy and SFPs current contract with my insurance carrier. I understand this is only an estimate, and my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While SFP makes every effort to verify my correct insurance information prior to leaving, I understand SFP cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred. I also acknowledge I am responsible for any and all attorney fees, court costs, and any other costs associated with collection of unpaid balance.

Release of Medical Records:
I authorize Valley Urgent Care to release verbally, electronically, and/or in writing confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employment), immediate family member(s), and/or other healthcare provider(s) for purpose of treatment, payment of charges, quality assurance and utilization review, transfer, and follow-up procedures. I understand that should I choose not to release my medical record to a specific entity/person(s), I must specifically state so in writing to be kept in my medical record.

Receipt of Privacy Practices: By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices of Valley Urgent Care is available to me upon request. I understand that a copy of this consent form may be used with the same effectiveness as the original.

Consent for Text/Voice Appointment Notifications: By signing this consent form I acknowledge that Valley Urgent Care and its EHR system Experity will text or call me of upcoming. Message & data rates may apply and I acknowledge I may opt out at any time.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

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HIPAA Disclosure Form

Today's Date: _____

Patient Name: _____ DOB: _____

How do you want to be contacted (please circle all forms of contact): Phone/Email/Text

Can we leave a voicemail: Yes/No

I, the Patient, hereby authorize any staff with Sapphire Family Practice to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Signature: _____ Date: _____

Updated 01/31/2022
Update once yearly

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Patient Name: _____ Date of Birth: _____

Social Security #: _____ Date: _____

Financial Policy

At Sapphire Family Practice, we are committed to providing you with the best possible care. Please help us to serve you by allowing us to focus on patient care and reducing the number of bills we must send to you.

Payment Is Expected at The Time of Service

You will be asked to pay your copay, deductible, and any outstanding invoice balances at the time of your appointment. Please arrive prepared to take care of these financial matters. Sapphire Family Practice accepts cash, personal checks, VISA, and MasterCard.

Self-Pay/Out of Network

We realize that there are many insurance choices, and that Sapphire Family Practice may not participate with your particular plan. We are happy to see you and to courtesy file your insurance claim. However, self-pay and out of network patients are expected to pay their bill at the time of service. While we try to obtain all the medical charges prior to check out, there may be corrections to your statement when the medical notes are finalized by the provider. If there is an outstanding balance after your date of service payment, you will be billed for this amount. If you overpaid, you will be refunded accordingly. You will be asked prior to service how you will be paying for your visit.

Insurance

Please check with your insurance carrier prior to making your appointment so you are familiar with your benefits and your responsibilities.
Your insurance plan is a contract **between you and the insurance provider.** We are happy to file your claims if we participate with your insurance, but please understand that every plan is different, and we will not know everything about your unique coverage from your insurance card or verification of insurance.

_____ **initials** Please note that **insurance coverage is not a guarantee of payment.** The patient, guardian, guarantors are ultimately responsible for payment of service(s) rendered.

There are many reasons why your insurance may not pay for a claim:

- You have not met your annual deductible
- You have not received the proper referral or preauthorization for this visit or procedure
- Some services may not be covered by your insurance plan
- We may not be "participating providers" with your insurance

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1.) We will submit your bill to our participating insurance companies as a courtesy to you. **It is your responsibility to make sure we have accurate insurance carrier information and billing information. If a claim is unsuccessful because of flawed insurance or billing information, you will be responsible for the balance.** Please be sure that we are aware of any restrictions your policy has on ancillary services (such as requiring a specific lab).

If we are unable to verify your insurance at the time of your visit, or you do not have your insurance card with you, full payment is due prior to service.

2.) **If your insurance has a co-payment policy, the co-payment is due at the time of service.** If you have a deductible, you may be responsible for all charges until the deductible is met. You are also responsible for any and all remaining balances after your insurance has paid its portion.
3.) If we have not received payment from your insurance company within 60 days of the date of service, you may be expected to pay the balance in full. We will bill secondary insurance companies, as a courtesy to you, if you have provided that information AT THE TIME OF YOUR VISIT. Please note that primary insurance co-payments CANNOT be billed to the secondary insurance carriers.
4.) When you receive a statement, you will have **30 days** to remit any additional balances due, unless a payment arrangement has been extended to you. Any balances not paid within 30 days are subject to 18% APR. Outstanding balances not paid in full within 60 days of the original invoice may be turned over to collections. If so, the patient/guarantor is responsible for all outstanding charges, applicable interest, and/or any collections/Attorney's fees. We understand that temporary financial problems may affect timely payment of your balance. Please contact us immediately in order to avoid potential collections fees and scheduling difficulties.
5.) It is your responsibility to make sure we have a way to contact you with billing or scheduling issues. Should we receive return mail we will try the phone number listed in your file. If we are unable to contact you, your account may be sent to collections.

Communications With You -TCPA

_____
initials

1.) You agree, in order for us to service our account or to collect any amounts you may owe, we, our agents, assignees, third parties, or servicing agent(s) may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You agree that we, our agents, assignees, third parties, or servicing agent(s) may, for training purposes or to evaluate the quality of service, may listen to and record phone conversations you have with us and/or our agents, assignees, third parties or servicing agent(s).
2.) Collection Fees – If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees. I understand that all accounts with a balance over 30 days will be assessed with a 1.5% late charge per month on the unpaid monthly balance.

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Returned Checks/Refunds

1.) Sapphire Family Practice charges a $50 fee **IN ADDITION TO OUR BANK FEES** for any returned checks.
2.) Patient/guarantor credits in amounts of less than $5.00 will be retained on the account to be credited toward future balances unless a written request for refund is received. Amounts of $5.00 and greater will automatically be refunded to the patient/guarantor.

Missed Appointments/Late Cancellations

1.) We understand that urgent problems happen on occasion and that you are not able to keep your scheduled appointment. Please understand that broken appointments also represent a cost to us, and to others who are waiting to be seen by the provider. Unless there is an emergency, cancellations should be made ONE FULL BUSINESS DAY (24 HOURS) prior to the appointment (for example, Monday appointments must be canceled no later than Thursday afternoon). We reserve the right to bill you for missed appointments or late cancellations (not received by clos of business one full business day prior to your appointment) as follows:
   - Medical - $50.00
   - Cosmetic/Surgical - $100.00
2.) Missed appointment charges must be paid in full prior to rescheduling. A credit card guarantee may be required for subsequent appointments.

Forms For Other Forms of Insurance/Disability Claims, Etc.

Sapphire Family Practice charges a $20 fee for each supplemental form that you request we fill out for you. This includes but is not limited to supplemental insurance (such as life insurance, AFLAC, etc.), short/long term disability claim forms, FMLA forms, physician's statements, and medical leave forms. While we regret that we must do this, completion of these forms requires time and materials from our office that is not reimbursed by your insurance. This fee must be paid at the time the forms are dropped off. Forms cannot be completed until the fee is paid in full. Also, please be aware that we legally have 14 days to complete forms/paperwork.

Signature: _____

Printed Name: _____

Date: _____

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Authorization To Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____

Social Security #: _____

I request _____ to release healthcare information of the patient named above to:

Name: **Sapphire Family Practice**

Address: **1921 Medical Ave., Suite B, Harrisonburg, VA 22801**
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☐ All healthcare information

☐ Healthcare information relating to the following treatment, conditions, or dates: _____

_____

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus (HPV), genital wart(s), condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and gonorrhea.

☐ Yes, I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ No, I do not authorize

Drug, Alcohol or Mental Health Treatment

☐ Yes, I authorize the release of my records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ No, I do not authorize.

Signature: _____ Date: _____

Updated 01/31/2022
Update once yearly

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Today's date: _____

New Patient Clinical Questionnaire

*We ask that you please limit your health concerns to 3 or less for your first visit as we want to ensure that we have adequate time to establish a good patient to provider relationship and provide you with the care that you need. We can always schedule another appt. for any additional concerns that you may have.
We thank you for your cooperation and are we are happy that you chose Sapphire Family Practice as your PCP

Name: _____ DOB : _____

Phone #(s): Please include area code.

Cell: _____

Home: _____

Work: _____

Email address (for invite to patient portal): _____

Preferred Pharmacy (and location): _____

Previous provider (PCP) and clinic/location: _____

Current Health Conditions or diagnoses: _____

_____

Reason for today's visit (questions, health concerns, etc.):

_____

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Name: _____ **DOB :** _____

Medications

(please include all prescriptions, over the counter medications and vitamins/supplements, even if they are only as needed)

Medication Name and Dose (mg, mcg, mL, unit, etc.)	**How many?** (# of tablets, capsules, etc.)	**Frequency** How many times a day do you take this?

Allergies

(Medications, foods, & environmental)

Allergan	Reaction

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Name: _____ **DOB :** _____

Social History

Please circle your answer below.

Marital Status	Single	Married	Separated	Divorced	Widowed
Children	**Yes**		**No**		
	If yes, how many? _____				
Employment Status	Employed	Unemployed	Disabled	Retired	
	Employer: _____				
	Job Title: _____				

Care Team

Please list all other providers that you see (specialists, dentist, eye doctor, etc)

Providers Name	Specialty

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Name: _____ **DOB :** _____

Family History

Family Member	Living?	Medical conditions/health issues
Mother		
Father		
Sibling(s)		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Other		

Surgical History

Procedure/Surgery	Provider/Facility	Date

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Name: _____ **DOB :** _____

Alcohol, Tobacco, Nicotine & Drug Use Questionnaire

Do you smoke cigarettes/cigars? **Yes** **No**

If yes, how many cigarettes per day? _____

Former smoker? _____

Vape or electronic cigarette? _____

Do you use smokeless tobacco? **Yes** **No**
(Snuff or chewing tobacco)

If yes, how much per day? _____

Any other drug use? **Yes** **No**
(Marijuana, cocaine, heroin, opioids, etc.)

If yes, what and how often?

_____

Do you drink alcohol? **Yes** **No**

How often?

_____ Never
_____ Monthly or less
_____ 2-4 times a month
_____ 2-3 times a week
_____ 4 or more times a week

How many drinks do you have in one day?

_____ 0
_____ 1 or 2
_____ 3 or 4
_____ 5 or 6
_____ 7 or 9
_____ 10 or more

How often do you have 6 or more drinks in 1 occasion?

_____ Never
_____ Less than monthly
_____ Monthly or less
_____ Weekly
_____ Daily or almost daily

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Name: _____ DOB : _____

↓ THIS PAGE IS FOR NURSING STAFF ONLY ↓

Vitals

Height	Weight	BP	Pulse	O2	Resp	Temp	Pain (if applicable)

Provider @ Sapphire Family Practice: _____

Nursing notes: _____

_____

_____

_____

_____

Nurse initials & credentials: _____