1921 Medical Ave., Suite B
Harrisonburg, VA 22801
P: 540-217-4455 F: 540-217-5169

SAPPHIRE
FAMILY PRACTICE

New Patient
Established Patient

Insurance
Self-Pay

Patient Information

Last Name: _____ First Name: _____ M.I: _____

DOB (mm/dd/yyyy): _____ Age: _____ Sex: ☐F ☐M ☐Other: _____ Marital Status: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

SSN: _____ Email: _____

Address: _____ APT #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Preferred: ☐ Home ☐ Mobile ☐ Email

Referred by: _____

Parent / Guardian Information

Last Name: _____ First Name: _____ M.I: _____

DOB (mm/dd/yyyy): _____ Age: _____ Sex: ☐F ☐M ☐Other: _____ Marital Status: _____

Preferred Language: _____ Relationship to patient: _____

SSN: _____ Email: _____

Address: _____ APT #: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Preferred: ☐ Home ☐ Mobile ☐ Email

Consent for Treatment and Payment

I give my consent to Sapphire Family Practice ("SFP") to provide clinical services that are necessary for my care. I understand that SFP will explain any treatments and procedures before they are performed. I further understand that this consent remains in effect until it is formally retracted in writing to SFP.

Guarantee of Payment (initial one):

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

_____ Insurance: I authorize Sapphire Family Practice to submit claims directly to my insurance for any medical benefits available to me. I understand that if my insurance does not cover the full cost of services rendered, I will be responsible for paying the remaining balance. Should my account be sent to a collection agency, I agree to pay the outstanding balance, along with a 40% collection fee, interest at an annual rate of 18%, court costs, and attorney fees.

Signature: _____ Date: _____

If signed by someone other than the patient, please specify relationship to the patient: _____

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Financial Responsibility

At Sapphire Family Practice, we are committed to providing you with the best possible care. To help us focus on your health needs and minimize the number of billing issues, we ask that you be prepared to address financial matters at the time of service.

Payment is expected at the time of service: Payment for co-pays, deductibles, and any outstanding balances is expected at the time of your appointment. Please arrive prepared to take care of these financial matters. Sapphire Family Practice ("SFP") accepts cash, personal check, VISA, MasterCard, AMEX, Discover.

Out-of-Network/Self-Pay: We may not participate with all insurance plans, as there are many options available. We will courtesy file your insurance claim and charge a $50 out-of-network fee at the time of visit. However, self-pay patients are expected to pay their bill at the time of service. Please note that while we strive to provide an accurate estimate of charges before checkout, there may be adjustments to your statement if the doctor's medical notes require updates. If there is an outstanding balance after payment, we will bill you for the remaining amount. In case of an overpayment, we will issue a refund.

Insurance: We strongly encourage you to verify your benefits and responsibilities with your insurance carrier before your appointment. Please note that insurance coverage is not a guarantee of payment. The patient or guarantor is ultimately responsible for payment of services rendered.

We will submit your bill to participating insurance companies as a courtesy. It is your responsibility to ensure we have accurate insurance and billing information. If a claim is denied due to incorrect information, you will be responsible for the balance. Please also inform us of any policy restrictions, such as the need to use specific labs, so we can ensure your claim is processed smoothly. If you have secondary insurance, we will bill it only if you provide the necessary information AT THE TIME OF YOUR VISIT.

If we are unable to verify your insurance at that time, or if you do not have your insurance details with you, full payment will be required before services are provided.

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 responsible for any and all remaining balances after your insurance has paid its portion.

If we do not receive payment from your insurance within 60 days of the date of service, you may be expected to pay the balance in full. You will have 30 days to pay any outstanding balance after receiving a statement, unless a payment arrangement has been made. Outstanding balances not paid in full within 60 days of the original invoice may be turned over to collections. If your account becomes assigned to a collection agency, you agree to pay a 40% collection fee, interest in the amount of 18% APR, court costs, and attorney fees. Please contact us immediately to avoid potential collections.

It is your responsibility to ensure that we have up-to-date contact information for billing and scheduling purposes. If we receive return mail and are unable to reach you by phone, your account may be sent to collections.

Communications with you – TCPA: You agree that in order for us to service our account or to collect any amount you may owe, we, our agents, assignees, and third party(s) or servicing agent(s) may contact you by phone 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, automatic dialing devices and/or text messages, as applicable. You agree that we, our agent, assignees, third party(s) or servicing agent(s) may, for training purposes or to evaluate the quality of service, listen to a record phone conversation you have with us and/or our agents, assignees, third party(s) or servicing agent(s)

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Returned checks/refunds: SFP charges a $50 fee, IN ADDITION WITH OUR BANK FEES, for any returned checks.

Patient/guarantor credits in amounts less than $5.00 will be retained on the account to be credited toward future balances unless written request for refund is received. Amounts of $5.00 and greater will automatically be refunded to the patient/guarantor.

Forms for other forms of insurance/disability claims, etc.: We charge a $25 fee for each supplemental form you request us to complete. This includes, but is not limited to, forms for supplemental insurance (e.g., life insurance, AFLAC), disability claims (short-term or long-term), FMLA forms, physician's statements, and medical leave forms. The fee is due at the time you submit the forms. Please note that the forms cannot be completed until the fee is paid in full.

Missed appointments/late cancellations: We understand that emergencies happen, but missed appointments still incur a cost to our clinic and prevent other patients from being seen. Unless it is an emergency, please cancel your appointment at least **ONE FULL BUSINESS DAY** in advance. For example, if your appointment is on Monday, you must cancel by Thursday afternoon. If you miss an appointment or cancel late, you may be charged a $50 fee for each missed appointment. These charges must be paid in full before you can reschedule.

☐ I decline to receive text messages from SFP.

Print Name: _____

Signature: _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Date: _____

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HIPAA Disclosure Form

Receipt of Privacy Practices: By signing this consent form, I acknowledge that a copy of the Notice of Privacy Practices of Sapphire Family Practice 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.

In accordance with HIPAA regulations, I authorize any staff with Sapphire Family Practice to disclose my protected health information ("PHI") to the party or parties below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

☐ I decline to release my information.

Patient Signature: _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Date: _____

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Authorization to Release Healthcare Information

Patient Name: _____

DOB: _____ Phone Number: _____

Release Information FROM:

☐Sapphire Family Practice

☐Other, specify organization:

_____

Street: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Fax: _____

Release/Send Information TO:

☐Sapphire Family Practice

Attn:

_____

Fax: 540-217-5169

☐Other, specify organization:

_____

Street: _____

City: _____

State: _____ Zip Code: _____

Phone: _____

Fax: _____

Records or Reports to be Released

☐All healthcare information

☐Health 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.

Patient / Representative Signature: _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Date: _____

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New Patient Clinical Questionnaire

Preferred Pharmacy (Name and Location): _____

_____

Previous PCP (clinic, location, and provider): _____

_____

Allergies (please include all allergies such as medications, foods, environment, etc.: _____

_____

Medications

(list ALL medications that you are CURRENTLY taking. Include all vitamins/supplements, over the counter, prescriptions, etc.)

Name and Dose (mg, mcg, mL, units, ect.)	**How many? (# of tablets/capsules)**	**Frequency (How many times a day?)**
**If medications go beyond the space provided, please attach a separate sheet.		

Surgical History

Procedure/Surgery	Provider/Facility	Date

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Care Team

(List all other providers you see such as specialist, dentists, eye doctor, etc.)

Provider's Name	Specialty

Social History

(Please circle your answer below)

Marital Status	Single	Married	Separated	Divorced	Widowed
Children	Yes How many if yes: _____		No		
Employment Status	Employed	Unemployed	Disabled	Retired	
	Employer: _____				
	Job Title: _____				

Family History

Family Member	Living?	Medical Conditions/Health Issues
Mother		
Father		
Sibling(s)		
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		
Other		

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Alcohol, Tobacco, Nicotine & Drug Use Questionnaire

Do you smoke cigarettes/cigars?	Yes No If yes, how many cigarettes per day? _____ Vape or electronic cigarette? _____ Former Smoker? _____
Do you use smokeless tobacco (snuff or chewing tobacco)?	Yes No If yes, what and how often? _____
Any other drug use? (marijuana, cocaine, heroin, opioids, etc.)	Yes No 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 – 2 _____ 3 – 4 _____ 5 – 6 _____ 7 – 9 _____ 10 or more How often do you have 6 or more drinks on 1 occasion? _____ Never _____ Less than monthly _____ Monthly or less _____ Weekly _____ Daily or almost daily