



Greater Prince William Community Health Center

AN AFFILIATE OF THE GREATER PRINCE WILLIAM COMMUNITY HEALTH CENTER, INC

4379 Ridgewood Ctr. Dr #102, Woodbridge, VA 22192
Phone: 703.680.7950 Fax: 703.680.7953

9444 Taney Road, Manassas, VA 20110
Phone: 571.722.4590 Fax: 703.361.9198

REGISTRATION FORM

Today's date:				Social Security no.:			
PATIENT INFORMATION							
Patient's last name:		First:		Middle:		Marital status (circle one)	
						Single / Mar / Div / Sep / Wid	
Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other				Birth date:		Age:	Sex:
Street address:				/ /		<input type="checkbox"/> M	<input type="checkbox"/> F
City:		State:		ZIP Code:		Home phone no.:	
						()	
Is the patient employed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the patient a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		Native language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Urdu <input type="checkbox"/> Arabic <input type="checkbox"/> Hindi <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Slavic Languages <input type="checkbox"/> Farsi <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other			
If under 18, Parent/Guardian's Name:		Employer:				Employer phone no.:	
						()	
INSURANCE INFORMATION							
Person responsible for bill:							
		Birth date:		Address (if different):		Home phone no.:	
Occupation:		/ /				()	
Subscriber's name:		Employer:		Employer address:		Employer phone no.:	
						()	
		Subscriber's S.S. no.:		Birth date:	Group no.:	Policy no.:	Co- payment:
Patient's relationship to subscriber:				/ /			\$
IN CASE OF EMERGENCY		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of local friend or relative (not living at same address):							
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Greater Prince William Community Health Center or insurance company to release any information required to process my claims.				Relationship to patient:		Home phone no.:	Work phone no.:
						()	()
Patient/Guardian signature: _____				Date: _____			



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Consent for General Primary Care

Patient: _____
Name

DOB: _____

I authorize the physicians, nurse practitioners, nurses and other health care providers of the Greater Prince William Community Health Center to examine and/or treat me or my dependents as named above. This consent remains in effect as long as I receive care in this facility or until I withdraw my consent.

I authorize to be tested for HIV, Hepatitis B and Hepatitis C in case of any exposure to me or anyone in contact with my body fluids.

Signature of Patient or Guardian: _____

Date: _____

Relationship to Patient: _____

Notice of Privacy Practice

I understand that, as a patient of the Greater Prince William Community Health Center, all information obtained will be kept confidential under HIPAA law. I acknowledge that I have received the Notice of Privacy Practices from the Greater Prince William Community Health Center.

Signature of Patient or Guardian: _____

Date: _____

Relationship to Patient: _____



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Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the Greater Prince William Community Health Center (GPWCHC).

I understand that I am financially responsible for non-covered services, including services that my insurance company or Medicare may deem unnecessary.

I also authorize the GPWCHC to release any and all information required in the processing of this claim.

I authorize the providers of the GPWCHC to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary.

To provide continuity of care, I authorize the release of medical information to specialty physicians who may be consulted for my care.

Furthermore, if I am not eligible for insurance, I understand that I am responsible for full payment for services rendered by the Greater Prince William Community Health Center providers.

Patient Name

Signature of Patient or Guardian

Date

LATE ARRIVAL AND LATE FEE NOTICE:

Please be aware that Patient's that arrive later than 15 minutes will NOT BE SEEN. We will gladly re-schedule the appointment for another day. If you still would like to be seen and have arrived late, we will charge an additional fee of \$10.00 to Work the Patient in for the same day.

Signature of Patient or Guardian

Date



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Cancellation Policy

If you need to cancel or change your appointment, please call 703.680.7950. All cancellations require a 24 hours advanced notice, unless it is an emergency. If the clinic is closed or you cannot reach an attendant, please leave a detailed message, and leave your phone number and name. Failure to cancel an appointment will result in your being billed a "NO SHOW" fee and you will be billed \$25 dollars.

I have read and understand the cancellation policy.

Signature: _____

Date: _____

Permission to release & Exchange Information

Every year must obtain written consent to release your confidential medical information to any medical providers or other practitioners that may need your healthcare information for referrals or other medically necessary procedures. In addition, your may want us to release your information to other family members/ other adults that may assist in your care.

In addition, if you have minor children, we need your permission to release results of school physicals to their respective schools, and we require your written consent to release their information.

Name of Patient: _____ Patient Date of Birth: _____

I authorize the exchange of information between Greater Prince William Community Health Center and the following person or entity:

The reason for such release of information is:

Parent/Guardian Signature

Date

Our Mission:

The mission of Greater Prince William Community Health Center is to increase access to high quality, comprehensive and preventative health care that is culturally sensitive in order to improve the health status of the underserved and vulnerable residents of Prince William County and the cities of Manassas and Manassas Park.