INOVA™
Join the future of health.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

LAST NAME: _____ FIRST: _____ MI: ____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME#: _____ CELL#: _____

EMAIL ADDRESS: _____

S.S.N. #: ____-____-_____ SEX: M / F DATE OF BIRTH: ____/____/____ AGE: _____

RACE: _____ ETHNICITY: _____ MARITAL STATUS: _____

EMPLOYMENT STATUS: FULL TIME / PART TIME / RETIRED / NOT WORKING

EMERGENCY CONTACT

NAME: _____ LEGAL GUARDIAN: Y / N RELATION: _____

HOME#: (____) _____ CELL#: (____) _____ WORK#: _____

GUARANTOR

NAME: _____ RELATION TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME#: (____) _____ WORK#: (____) _____

SEX: M / F DATE OF BIRTH: ____/____/____ AGE: _____

EMPLOYMENT STATUS: FULL TIME / PART TIME / RETIRED / NOT WORKING

INSURANCE INFORMATION

ARE YOU THE SUBCRIBER? YES / NO RELATION TO PATIENT: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

INSURANCE ID NUMBER: _____

SECONDARY INSURANCE (IF APPLICABLE)

PLAN NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DOB: _____

INSURANCE ID NUMBER: _____

INOVA
Join the future of health.

Authorization for Claims Payment and Reviews

1. Assignment and Coordination of Insurance Benefits - I agree to provide information regarding all group hospitalization, health maintenance organization, Workers' Compensation, automobile, and other health care benefits ("Insurance Plan(s)") to which I may be entitled. I hereby assign payment(s), if any, from my Insurance Plan(s) to Inova Health System (or its affiliate) and each of the independent contractor physicians and/or professional corporations for services rendered to me. The direct payment hereby assigned and authorized includes any Insurance Plan(s) benefits to which I am otherwise entitled, including any major medical benefits otherwise payable to me under the terms of my policy, but is not to exceed the balance due to the Inova Health System (or its affiliate), the independent contractor physicians and/or professional corporations for services rendered to me during the applicable periods of medical care.

2. Unauthorized, Non-Covered, or Out of Plan Services - I understand if my Insurance Plan(s) does not consider this admission or any service rendered during this admission a covered service or has not authorized this service, they will not pay for this admission or the service rendered during this admission or outpatient visit. I agree to be fully responsible for payment to Inova Health System for this admission or any service if determined by my Insurance Plan(s) to be a non-covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, co-insurance or other charge In the event my Insurance Plan(s) does not reimburse these services provided to me, I acknowledge I will be responsible for any remaining balance.

3. For Medicare Recipients Only - I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to the Hospital and/or independent contractors for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for the related services. In the case of Medicare Part B benefits, I request payment either to myself or to the party who accepts assignment.

4. Residents, Interns or Medical Students- I understand residents, interns, medical students and other health care professional students may participate, under the supervision of an attending physician or other health care professional, in my care as part of the Inova Health System's education programs.

By signing below, I certify I have read and understand the foregoing, have had the opportunity to ask questions and have them answered and accept the above conditions and terms and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova Health System. *I understand and agree this document will remain in effect for all future outpatient or physician office visits to Inova Health System, unless specifically rescinded in writing by me.*

Patient Signature: _____ Date: _____

Relationship to Patient: _____

I certify that I have been made aware of Inova Health System's **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova Health System's health care operations. The Notice also describes my rights and Inova Health System's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova Health System's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342.**

Inova Health System reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices.** I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova Health System's web site listed above to view the most current version.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CAT #84498 / R032103
PKGS OF 100

MR 32-06

INOVA
Join the future of health.

Inova Urgent Care Center
Brief Health History

Personal Information Date: _____

Patient Name: _____ Birth Date: ____ / ____ / _____ Age: _____

Name of Primary Care Physician: _____

Preferred Pharmacy and Location: _____

Date of last Tetanus shot: _____

Medical Information

Please list any **MEDICATIONS** you are currently taking, prescribed or over the counter (use the back of the page if needed and indicate so):

Medication	Dosage	Route	Frequency

Any **ALLERGIES** to medication or food (list reactions): ☐ None Known

ALLERGY	REACTION

For Females: Date of last menstrual period: _____ / _____ / _____ Are you pregnant? Yes No

If **YOU** have any of the following, please circle: ☐ None Known

Asthma	Type 1 or 2 Diabetes	Kidney Disease	Stroke
Anxiety/Depression	High Blood Pressure	Liver Disease	Seizure Disease
Blood Clots	High Cholesterol	Neurological Disease	Thyroid Disease
Cancer, Type(s): _____	Heart Attack	Respiratory Disease	Other: _____

Please list any **SURGERIES** you have had: ☐ None Known _____

_____

If anyone in your **FAMILY** has the following please circle:

	Heart Disease	Lung Disease	Diabetes	Stroke	High Blood Pressure	Cancer	Other
Mother							
Father							
Sibling							

TOBACCO: Usage: _____ Current _____ Former _____ Never

Type: _____ Cigarettes _____ Pipe _____ Snuff _____ Chew

If you are a smoker how many cigarettes/cigars per day? _____ Number of years using tobacco products: _____

Have you ever used tobacco products in the past but have quit? _____ Date quit: _____ / _____ / _____

ALCOHOL: Do you drink alcohol? Yes No

If yes, what type? _____ # of drinks per week? _____

INOVA™

3HEAR

Inova Staff: A list of disability and special need supports and instructions can be found on the back of this form. At the first opportunity, please complete this form with the patient or companion and have it scanned into the patient's electronic medical record. **Complete one form per person requesting accommodation.**

Patient or Companion: If you or any companion assisting in your care have a special need, please indicate below:

☐ Patient's medical condition does not allow completion at this time.

	Patient	Companion/Legal Guardian
Are you deaf or do you have serious difficulty hearing?	☐ Yes ☐ No	☐ Yes ☐ No
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	☐ Yes ☐ No	☐ Yes ☐ No
Do you have serious difficulty walking or climbing stairs? (5 years old or older)	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any other special needs or disability that require services or accommodations during your visit today?	☐ Yes ☐ No	☐ Yes ☐ No
If you have indicated a need above, do you or your companion need services or accommodations related to your identified need(s)?	☐ Yes ☐ No	☐ Yes ☐ No

Please describe type of accommodation requested:

_____

_____

Do you have any special instructions for care providers? If so, please describe below:

_____

_____

Staff Notes regarding accommodations given: (**Inova Staff:** Please document in detail accommodation(s) requested and services given. Resource suggestions on the back.)

_____

_____

By my signature below, I hereby certify that: (i) I have been given the opportunity to communicate whether I and/or my companion have a disability or special need requiring accommodation; (ii) I have had the opportunity to communicate my needs to staff as reflected above and that the above selections are true, accurate and complete; (iii) I understand that Inova Health System will use its best efforts to accommodate my requests and that any accommodations provided will be given free of charge; (iv) I have been offered/given a copy of the patient rights brochure which contains information for filing a complaint if I am unsatisfied with my requested accommodations during my visit today.

_____ _____

Signature of Patient/Patient Representative/Companion Date Time

Print: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Family Member ☐ Friend ☐ Other _____

_____ _____

Signature of Employee Witness Date Time

Print: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

Inova Health System

Americans with Disabilities Act (ADA)/ Special Needs Assessment

CAT # 20328DT/R051714 • PKGS OF 100

Inova Staff: Please discuss available services, aids or accommodations with the patient and/or companion. Complete one form for each person requesting accommodation. Note that not all items are available at each location. For a complete list of equipment available at your facility, check InovaNet.

Vision Services/Aids

	Date & Time Requested	Date & Time Provided
☐ Documents in large print		
☐ Documents read aloud		
☐ Screen magnifier		
☐ Magnifying sheet		
☐ Request escort		
☐ Special lighting		
☐ Braille phone		
☐ Modified call bell		
☐ Other (comment) ☐ _____ _____ _____		

Mobility Services/Aids

	Date & Time Requested	Date & Time Provided
☐ Walking escort		
☐ Wheelchair escort		
☐ Extra-wide wheelchair escort		
☐ Transfer assistance		
☐ Assistance positioning		
☐ Accessible exam table		
☐ Accessible weight scale		
☐ Modified call bell		
☐ Walker in room		
☐ Other (comment) ☐ _____ _____ _____		

Hearing Services/Aids

	Date & Time Requested	Date & Time Provided
☐ Assistive listening device (Pocketalker)		
☐ Disposable amplifier		
☐ Interpreter services		
☐ Point to speak cards		
☐ Notepad		
☐ TTY (if admitted)		
☐ Closed caption TV decoder (if admitted)		
☐ Amplified phone with flasher (if admitted)		
☐ Other (comment required) _____ _____ _____		

Other Special Needs

	Date & Time Requested	Date & Time Provided
☐ Cognitive impairment		
☐ Requires additional time		
☐ Sound sensitivity		
☐ Speech impairment		
☐ Uses point to speak cards		
☐ Uses service animal		
☐ Other (comment required) _____ _____ _____		

Special Instructions

☐ Uses hearing aides	☐ Uses notepad
☐ Speak loudly	☐ Knock before entering
☐ Speak slowly	☐ Announce your presence
☐ Make eye contact	☐ Read white board
☐ Reads lips	☐ Orient to changed surroundings
☐ Speak in right ear	☐ Uses service animal
☐ Speak in left ear	☐ Uses walker
☐ Uses point to speak cards	☐ Uses cane
☐ Wait for interpreter before communicating	☐ Other (comment required) _____ _____ _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name _____

DOB: _____ MR#_____

Inova Health System

Americans with Disabilities Act (ADA)/ Special Needs Assessment

CAT # 20328DT/ R051714 • PKGS OF 100