

Red Hook Family Practice PC

Red Hook Family Practice
6500 Red Hook Plaza, Suite 205
St. Thomas, VI 00802 • 340.775.2303

Yacht Haven Family Practice
5302 Yacht Haven Grande, Ste. 124
St. Thomas, VI 00802 • 340.776.1511

Cruz Bay Family Practice
The Marketplace, 3rd Floor, Suite 104
St. John, VI 00830 • 340.776.6789

www.redhookfamilypractice.com

Registration Form (please print clearly)

Section One:

Patient Information

Legal Name: _____ Preferred: ☐ Mr. ☐ Ms. ☐ Miss ☐ Dr.
Date of Birth: _____ / _____ / _____ Gender: ☐ Male ☐ Female Social Security Number: _____
Month day year
Email: _____ U.S. Veteran: ☐ Yes ☐ No
Physical Address: _____
City State Zip
Mailing Address: _____
City State Zip
Race: ☐ Black ☐ White ☐ Other Ethnicity: _____ Language preference: _____
Home Phone: _____ Cell: _____ Work: _____ x: _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed Students: ☐ Full-Time ☐ Part-Time
Spouse's Name: _____ Contact number: _____
Emergency Contact: _____ Contact #: _____ Relation to Patient: _____
Primary Care Physician: _____ Date of last physical exam: _____ / _____ / _____
Month day year

Section Two:

Person Responsible for Account Payment

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____
Name: _____ Date of Birth: _____ / _____ / _____ Gender ☐ Male ☐ Female
month day year
Address: _____ SSN: _____ Marital Status: _____
Phone: Home _____ Cell _____ Work _____ Email _____
Parent: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female SS# _____
Parent: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female SS# _____

Section Three:

Insurance Information

Name of Primary Insurance Co: _____ Policy ID#: _____
Group No: _____ Co-Pay Amount: _____
Policy Holder's Name: _____ Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Holder's SSN: _____ Policy Holder's Date of Birth: _____ / _____ / _____
Month day year
Policy Holder's Occupation _____ ☐ Part-Time ☐ Full-Time
Policy Holder's Employer: _____ Employer's address: _____

Is there additional Insurance for the patient? **Y** or **N** If Yes, please complete the back section of this form.

By signing below, I agree that the above information is true / accurate to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____



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PATIENT HIPAA AWARENESS

With my permission, Red Hook Family Practice PC (RHFP), which consists of Red Hook Family Practice, Yacht Haven Family Practice, and Cruz Bay Family Practice, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Red Hook Family Practice PC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have reviewed the Notice of Privacy Practices prior to signing this consent. Red Hook Family Practice PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, Red Hook Family Practice PC may call my home or other designated location that was provided on the registration form and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. If any contact information changes, it is my responsibility to complete a new registration form.

With my permission, the office of Red Hook Family Practice PC may mail to my home or other designated location that was provided on the registration form any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Red Hook Family Practice PC may e-mail to my email address that was provided during registration any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request in writing that Red Hook Family Practice PC restrict how it uses or discloses my PHI to carry out TPO.

By signing this, I am allowing Red Hook Family Practice PC to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If any change in demographics or insurance information is made, it is my responsibility to inform RHFP and complete a new registration form.

Signature of Patient or Legal Guardian

Print Patient's Name

Patient's Date of Birth

Print Name of Legal Guardian

Date

As an adult, guardian, or minor, I give RHFP authorization to release medical information pertaining to drug screen testing to:

Name: _____

Relationship: _____

Phone: _____



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Patient Name: _____ Patient Date of Birth: ____/____/____
Month / date / year

CONSENT FOR TREATMENT

I hereby consent to the performance of medical treatment and/or diagnostic procedures as deemed necessary or advisable by my physician(s) at Red Hook Family Practice PC. I also understand I have the right to be informed about all treatments given to me and the right to decline any specific treatment should I choose. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my Physician. Further, I understand that should any medical personnel, physician, or other person(s) be exposed, or report an exposure to, my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis B and C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Red Hook Family Practice PC.

PAYMENTS

We want to give you the best and most reasonable service possible. We ask that our patients pay for services at the time they are rendered. We accept cash, traveler's checks, debit cards, AMEX, Discover, MasterCard, and Visa. We appreciate your cooperation regarding this payment policy. In the event of billing error, the difference will be either refunded or billed to the appropriate party.

RED HOOK FAMILY PRACTICE PC INSURANCE POLICY:

We submit claims to only Insurance Companies that are part of the VI Equicare Network. As a service to you, our office has agreed to bill your insurance company for payment of your office visits. The patient is responsible for all co-payment and deductibles specified by the insurance company at the time of the visit. Insurance companies do not always cover immunizations, laboratory testing, surgical supplies and trays. We may request payment for additional services to be paid when services are rendered. Most insurance companies DO NOT COVER the charge for the Sterile Instrument tray. If one is required for your procedure, the charge is \$60 and is due upon services being rendered. Our physicians find it medically necessary to use these Sterile Instrument Trays to reduce the chance of infection.

Non-Participating Insurance: If your insurance company is not in the VI Equicare Network, payment is due in full at the time of service, and we will gladly supply you with a claim form so that you may submit directly to your insurance company for reimbursement.

It is my responsibility to provide RHFP with a current, valid insurance card at each visit.

By signing below, I understand and agree to the stated policies above.

Signature of patient or person acting on behalf of patient

Date



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No Show/Late Arrival Policy

Thank you for trusting your medical care to Red Hook Family Practice. When you schedule an appointment with Red Hook Family Practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Late Arrival Policy:

- Patients are asked to arrive to their appointments before their scheduled appointment time. **Established patients** are to arrive at least **10 minutes before** their scheduled appointment time. **New patients** are to arrive **20 minutes before** their scheduled appointment time to allow enough time for the registration process to be completed.
- A grace period of **15 minutes** will be permitted for unforeseen delays a patient may encounter while travelling to the clinic location for their appointment. If a patient arrives **more than 15 minutes late** for an appointment, the appointment may need to be rescheduled to a later time on the same day if the schedule permits, or rescheduled for a later date. This is to ensure patients that do arrive on time are seen in a timely manner.

No Show/Cancellation Policy:

- A "No Show" is a patient who fails to appear or cancel/reschedules a scheduled appointment **without providing a 24 hour cancellation notice**.
- There is a **\$50 charge** for all No Show visits.
- All patients will have **no more than three (3)** no show appointments and/or cancelled appointments.
- All patients who have three (3) no show appointments and/or cancellations will no longer be permitted to schedule appointments with Red Hook Family Practice and will only be seen on a walk-in basis.
- The No Show fee is charged to the patient, not the insurance company and is due at the time of the patient's next office visit.

To assist patients in keeping appointments, Red Hook Family Practice sends out appointment reminder text messages/calls before the patient's scheduled appointment. The patient is responsible for confirming or cancelling/rescheduling the appointment no less than 24 hours before the scheduled appointment. If you do not receive a reminder text message/call, the above Policy will remain in effect. Please ensure your contact details are up to date.

To cancel or reschedule an appointment please call Red Hook Family Practice at 340 775 2303. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

I have read and understand the No Show/Late Policy and agree to its terms.

Print Name (Patient)

Signature Patient/Legal Guardian

Relationship to Patient

Date



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PATIENT FINANCIAL RESPONSIBILITY FORM

Due to frequent changes in insurance policies, it is no longer easy to stay current with every plan's requirements. While we do our best to stay informed, we strongly encourage you to contact your insurance company directly to understand your coverage—including whether you need a referral or prior authorization for your visit or procedures. This is your responsibility. Failure to comply could result in you, the patient, being responsible for all costs incurred.

To help verify your coverage, the insurance company has a customer support number on the back of your insurance card. Some insurance plans require a referral to see a specialist from your primary care provider or primary care manager. If your plan requires a referral or prior authorization, you are responsible for obtaining it and providing it to our office before your appointment. Failure to do so may result in needing to reschedule your appointment or accepting full responsibility for payment. In addition, some insurance plans require you to see physicians or facilities within their participating network. It is also your responsibility to confirm that we are an in-network provider with your insurance plan.

If you cancel your appointment with less than 24 hours' notice or fail to show up, a \$50 no-show fee will be charged. After three (3) no-call/no-show appointments, you will not be able to reschedule.

Please note that your copayment at the time of service is not the total cost of the visit. After your visit, we submit a claim to your insurance provider. Once your insurance processes the claim, they may assign additional costs to you such as deductibles, coinsurance, or non-covered services. These additional charges are not known at the time of your visit and may be billed to you afterward.

We understand this may be confusing and encourage you to reach out with any questions after receiving a bill. Our billing staff is here to assist you.

You will receive your balance statements as follows:

1. One initial billing statement by mail
2. One final demand notice by mail
3. Courtesy collections communication 20 days after the final demand if payment is not received

All past-due balances must be paid at the time of service unless you have arranged a payment plan with our office. Should your account become delinquent, it may be referred to a licensed third-party collection agency in accordance with applicable laws. If this occurs, you will be responsible for the full amount due, as well as any collection agency fees and legal costs (up to 33⅓% as allowed by law).

Please note, Red Hook Family Practice collects copayments and other time-of-service payments as permitted by your insurance and required for self-pay patients. If additional services are rendered that are not known or billed at the time of the visit, any remaining balance will be billed to you after insurance processing.

Patient Signature

Date



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AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____

I hereby authorize _____ to release my medical records, including but not limited to office notes, test results, imaging, and any other pertinent health information, to the **Red Hook Family Practice** for the purpose of continuing my medical care. This authorization includes the release of any records protected under federal or state law. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

Please send the following information:

- ☐ Lab Reports
- ☐ Pathology Reports
- ☐ Radiology
- ☐ Consultation
- ☐ Other:

Patient Signature: _____ **Date:** _____

Please fax to: 855-279-4420