Atlas Medical Services, LLC

James Stiltner, FNP-BC
33573 Main Street, Jonesville VA 24263
Phone: 276-346-5039; Fax: 276-383-8011
atlasmedicalservice@outlook.com

Name: _____

Gender: Male, Female *(Circle)*

SS#: _____**DOB:** _____

Insurance Provider: _____

Mailing Address: _____

_____

_____

Phone number: _____**Email:** _____

Allergies: _____

Past medical history: _____

_____

Surgeries: _____

_____

Pharmacy: _____

Current medications and dosages: _____

_____

Current Provider: _____

Emergency Contact Information

Primary Contact Name: _____

Relationship: _____

Phone number: _____

Enter as patients, leave as family!

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Release of Information

By signing below, you authorize ***Atlas Medical Services, LLC,*** to use and/or disclose your health information to the following:

Name: **Relationship:**

_____

_____

_____

The release of information will remain in effect until terminated by me in writing.

***Signature*: _____*Date*: _____**

Virginia Prescription Drug Monitoring Program

This program allows the provider to perform an online search for prescriptions of patients as it is extremely important the provider knows what medications you are taking. By signing your name, it allows the provider to utilize this program. If you choose not to sign below, ***Atlas Medical Services, LLC,*** may decline to provide treatment to the patient.

***Signature*: _____*Date:* _____**

Enter as patients, leave as family!

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Import Medication Consent

By signing your name, this allows the provider to import your medications from your pharmacy. If you choose not to sign below, ***Atlas Medical Services, LLC,*** may decline to provide treatment to the patient.

Signature: _____***Date:*** _____

I give permission to ***Atlas Medical Services, LLC,*** to use and disclose health information to carry out treatment, payment, and healthcare operations. ***Atlas Medical Services, LLC,*** has the right to revise their Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by a written request to ***Atlas Medical Services, LLC.*** If you choose not to sign below, ***Atlas Medical Services, LLC,*** may decline to provide treatment to the patient.

Signature: _____***Date:*** _____

Acknowledgement Form

I have received the notice of privacy practices from *Atlas Medical Services, LLC,* and I have been provided with the opportunity to review it.

Signature: _____***Date***: _____

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Agreement of Financial Responsibility

Thank you for allowing Atlas Medical Service, LLC, to provide you with healthcare. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance policy.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit.

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I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature of Responsible Party: _____

Date: _____

Relationship to Patient: _____

Enter as patients, leave as family!