Village Primary Care Providers

New Patient Intake Form

Patient Registration Information

First, Middle, Last Name

Date of Birth: MM/DD/YYYY
_____ / _____ / _____

Contact number:
( ) -

Email Address:

Social Security Number:
_____ - _____ - _____

Race:
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Decline to provide
- ☐ Asian
- ☐ White
- ☐ Other

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to provide

Preferred language (if not specified, English will be chosen as your preferred language):

Other names: (Maiden, name change, etc)

Home Address:
Street:
City: State:
Zip:

Billing Address:
☐ Same address

Reason for visit / diagnosis:

Primary Care Provider:

Referring Provider:

Pharmacy:
Name: Address:

Guarantor / Responsible Party

Name: Date of Birth:

Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ APOA ☐ Other _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Home Address:

Mailing Address (if different)

Home Phone: Mobile Phone: Work Phone:

Emergency Contact(s)

Name: Phone:

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____

Home address: City: State: Zip:

Name: Phone:

Relationship to patient: ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____

Home address: City: State: Zip:

Insurance

PRIMARY INSURANCE Name:	**SECONDARY INSURANCE** Name:
Subscriber/Member ID #:	Subscriber/Member ID #:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Address:	Address:
Employer:	Employer:
Date of Birth:	Date of Birth:
Relationship to patient:	Relationship to patient:

Required Documents Checklist

Please ensure documents are attached at the time of submission.
ALL required documents are needed prior to establishing care with Village Primary Care Providers.

Please return the completed form and required documents:

Village Primary Care Providers
1111 Delafield Street Suite 327
Waukesha, WI 53188
Phone: 262-875-4892 **Text**: 262-239-4209
Fax: 866-817-3838

REQUIRED DOCUMENTS

DOCUMENT	ATTACHED	MISSING	N/A
Facesheet	☐	☐	☐
Photo ID (photocopy)	☐	☐	☐
Primary insurance card (photo of front and back)	☐	☐	☐
Secondary insurance card (photo of front and back)	☐	☐	☐
Tertiary insurance card (photo of front and back)	☐	☐	☐
Problem list	☐	☐	☐
Medication list	☐	☐	☐
Last provider visit note	☐	☐	☐

IF APPLICABLE DOCUMENTS

DOCUMENT	ATTACHED	MISSING	N/A
Designation of Power of Attorney form *(Please attached all pages)*	☐	☐	☐
Activation Power of Attorney form *(1 page document with 2 provider signatures)*	☐	☐	☐
Guardianship form	☐	☐	☐
DNR (DO NOT RESUSCIATE) form	☐	☐	☐

Urgent needs: ☐ Meds ☐ Referral ☐ DME ☐ Wound ☐ Hospital Discharge

Comments:

_____

_____

Sent/referred by: _____ Date sent: _____

Village Primary Care Providers Consent Form

By seeking medical care at Village Primary Care Providers (VPCP) you consent to receive necessary medical treatment, including examinations, diagnostic tests, medications, advanced care planning, chronic care management, and procedures deemed appropriate by our providers. We will always strive to provide you with the highest standard of care.

Assignment of Benefits: I hereby assign and authorize VPCP to receive direct payment from my health insurance for any covered services rendered to me. This assignment includes all benefits payable under my insurance policy for the services provided by Village Primary Care Providers. I authorize VPCP to release any necessary medical information to my health insurance for the purpose of processing claims and determining benefits.

Financial Responsibility: You acknowledge and agree to be financially responsible for all services rendered to you by our medical practice. This includes any deductibles, co-pays, co-insurance or non-covered services as determined by your insurance plan or self-pay arrangements. We will provide you with an itemized statement of charges and work with you to facilitate payment.

Release of Medical Information: To ensure continuity of care, you authorize VPCP to request, and release your medical records, test results, and other relevant information to other healthcare providers involved in your treatment. This may include specialists, hospitals, laboratories, and insurance companies, as necessary for your healthcare management.

Communication Consent: You consent to receive communication from VPCP regarding appointment reminders, test results, billing statements, and other healthcare-related information via phone calls, text messages, emails, or postal mail.

Photography and Video Consent: On occasion, we may request your consent to capture photographs or videos for medical documentation, educational purposes, or promotional materials. Your identity will be protected, and your consent will be sought separately for each specific instance.

Recording consent, you consent to the recording of certain interactions, including, but not limited to phone calls, in person, consultations, and telehealth sessions for documentation, quality assurance, and training purposes. These recordings will only be accessible to authorized personnel involved in your care.

Revocation of consent, you have the right to revoke this consent at any time by notifying our office in writing. Revoking your consent may impact on our ability to provide certain services or may require alternative arrangements to be made.

I understand that my consent is voluntary and may be revoked at any time by notifying the office in writing.

Signature_____ Date_____

Village Primary Care Providers
HIM Department, Release of Information
1111 Delafield St., Ste 327
Waukesha, WI 53188
262-875-4892 Fax: 866-817-3838 Email: villagepeople@villagepcp.org

REQUEST FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (Print) _____ Full Address _____

Date of Birth _____ XXX-XX-_____ Social Security Number Daytime Telephone Number _____

INFORMATION TO BE RELEASED/RECEIVED FROM:

Provider Name/Organization:_____

Address:_____

Phone #: _____ Fax #:_____

SEND INFORMATION TO :

☐ **Myself at the address above unless noted below**

Provider Name/ Organization:_____
Address:_____
Phone Number:_____ **Fax:**_____

FORMAT OF INFORMATION TO BE DISCLOSED:

☐ Paper ☐ Electronically (Email) _____

By signing below you acknowledge that the security of transmission is not guaranteed.

INFORMATION TO BE DISCLOSED:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

☐ Disclose my complete health record except for the following information; _____

☐ Mental health records ☐ Communicable diseases including, but not limited to, HIV and AIDS ☐ Alcohol/drug abuse treatment

CHANGING STATUS: I understand the manner in which my clinical data is shared via the VPCP HIE participation, and I wish to change my status as denoted below: (Medicare statistic reporting)
Please initial one: _____ Opt-Out; - OR - _____ Opt-In (if currently in an Opt-Out Status)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Furthermore, I understand that this information has been disclosed from records protected by federal law (42 C.F.R. Part 2). These records are prohibited from further disclosure without written patient consent unless otherwise mandated by law. Only such records and/or information believed necessary for the purpose expressed above shall be released. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this request, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this request. This request will expire on_____ If I fail to specify an expiration date or event, this authorization will expire one year from the date it was signed and is only valid for information preceding this date. I understand that I may receive a copy of this form after I sign it and inspect and copy information to be used or disclosed. **I also understand there may be a charge for this information.**
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure treatment.

_____ _____ Yes

Date Signature of Patient or Representative Relationship to Patient*

*If signed by a guardian or activated power of attorney, correlating documentation is required