IN ORDER FOR US TO PROVIDE YOU WITH COMPREHENSIVE, FAMILY ORIENTED HEALTH CARE, PLEASE SUPPLY THE FOLLOWING INFORMATION.

PATIENT INFORMATION

PHARMACY NAME ADDRESS CITY STATE FOR Your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards. PERMARY INSURANCE SELF PAY PLEASE PROVIDE OUR OFFICE WITH ADVANCE NOTICE IF YOU SHOULD NEED TO CANCEL YOUR APPOINTMENT. FAILURE TO SHOW FOR YOUR SCHEDULED APPOINTMENT MAY RESULT IN A FEE TO THE RESPONSIBLE PARTY THAT IS NOT COVERED BY YOUR INSURANCE PLAN. I WAS REFERRED TO THIS PRACTICE BY: Under Virginia law, if any employee or agent of the practice is exposed to your blood or other body, fluids in a manner which may transmit human immunodeficiency virus (HIV) or hepatitis B or C viruses, you shall be deemed to have consented to the testing for infectious with HIV or hepatitis B or C viruses, you shall be deemed to have consented to the testing for infectious with HIV or hepatitis B or C viruses, you shall be deemed to have consented to the release of such test results to the person who was exposed. HIPAA Acknowledgement: All patients must initial one of the following: I hereby acknowledge that I have been provided with a copy of the AIM Notice of Privacy Policies. I hereby acknowledge that I have been provided with a copy of the AIM Notice of Privacy Policies. I have authorized treatment to patient by any AIM provider and/or any affiliated medical safe member(s). I further authorize release of any and all medical and/or billing information as is necessary for third party reimbursement from my insurance carrier, Tricare or Medicare. I authorize direct payment from said insure(s) to this practice. I accept responsibility for payment of all treatment of a medical information necessary to the Department of a treatment of a medical informati		LAST NAME	AST NAME FIRST NAME MIDDLE INITIAL SOCIAL SECURITY NO.												
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