



Pediatric Healthcare

Patient Registration Information – PLEASE SIGN FRONT & BACK

*Have any of your children ever been seen by this practice before? _____

MOTHER/GUARDIAN _____ Birth date ___ / ___ / ___ SS# _____

Address _____

City/State/Zip _____ Home Phone _____

Employer _____ Occupation _____

Work Phone _____ Cell Phone _____

FATHER/GUARDIAN _____ Birth date ___ / ___ / ___ SS# _____

Address _____

City/State/Zip _____ Home Phone _____

Employer _____ Occupation _____

Work Phone _____ Cell Phone _____

CHILD _____ Sex: M ___ / F ___ Birth date _____ Allergies _____

CHILD _____ Sex: M ___ / F ___ Birth date _____ Allergies _____

CHILD _____ Sex: M ___ / F ___ Birth date _____ Allergies _____

CHILD _____ Sex: M ___ / F ___ Birth date _____ Allergies _____

CHILDREN LIVE WITH: Mother ___ Father ___ Legal Guardian ___ Other-Specify Relationship _____

EMERGENCY CONTACT PERSON: _____

Phone Number _____ Relation to Patient (s): _____

How did you hear of us? Internet ___ Phonebook ___ Newspaper ___ Insurance Plan ___ Friend ___ Physician ___ Other _____

INSURANCE INFORMATION: Insurance Co. Name & Phone # _____

Insurance Co. ID# _____ Insurance Co. Group# _____

Name of Policyholder _____ Relationship to Patient _____

Insured's Employer Name & Phone # _____

I authorize Pediatric Healthcare to call and leave messages at the following phone number concerning appointments, test results, medical advice and account information: _____

It is your responsibility to keep this information updated and you may rescind this authorization at any time by written notice.

BY SIGNING BELOW I AM STATING THAT I AM LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND THAT I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE CONDITIONS LISTED ON THE BACK OF THIS FORM. I ATTEST THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature **Today's Date**

Printed Name **Relationship to Patient** **PLEASE CONTINUE TO BACK OF PAGE**

*****I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION BELOW:**

*****SIGNATURE REQUIRED HERE: _____ DATE _____**

Significant Exposure-Section 32.1-45.1 (A) and (B), Code of Virginia (1950, as amended) provides that in the event of frank exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV) is considered to have been given by the patient and/or healthcare worker thereby granting this office the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of this office.

Consent to Treatment-I agree that by virtue of presenting the patient to the office that I consent to the patient being examined and treated as medically advised.

Authorization & Assignment of Benefits- I authorize the release of medical and insurance information to any of my medical providers or insurance companies necessary for the completion of insurance forms or to coordinate patient care. I hereby authorize payment directly to Pediatric Healthcare, P.C. for all medical benefits otherwise payable to me under the terms of my insurance. I authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for services provided.

Financial Responsibility-I understand and personally guarantee, in consideration of services and materials provided, to be financially responsible for any and all deductibles, co-insurance, co-payments or any charges not paid by my insurance. Not all services provided by this office may be a covered benefit with my insurance plan. I accept that it is my responsibility to know what services are or are not covered by my specific insurance plan and agree to pay accordingly. Co-payments and non-covered services are due in full at time of service. There is an administrative fee for any co-payment not made at time of service.

I understand it is my responsibility to cancel an appointment with at least 24 hours advance notice otherwise a fee will be assessed. This fee is not covered by insurance.

If this office does not participate with my insurance plan or I do not have insurance, I will be responsible for payment in full at the time of service. In the event that my insurance coverage changes or terminates I will notify this office immediately.

If I present to an appointment without appropriate insurance information I will be required to pay in full at the time of service.

I am aware that whomever brings the patient to an appointment is responsible for making any co-payments at time of service. I am aware that all children under the age of 18 years old must be accompanied to their appointment by a parent or legal guardian. In the event a parent or legal guardian cannot be present, written and signed authorization must be presented to the office identifying the adult who may legally bring the patient to appointments, have access to medical and other information and consent to treatment. The signed authorization must also specify a phone number at which the parent/legal guardian can be reached.

I am aware that there is a fee for the completion of physical or similar forms required for daycare, school, sports, etc... that are not presented at the time of their routine physical appointment. This fee is not covered by insurance.

Billing-Payment is due at the time of service. There is a fee if co-payments are not made at time of service. Patient bills are mailed once a month. Payment in full is due within 30 days. Late fees and finance charges may apply to balances not paid within 30 days. I agree to pay all cancelled appointment fees, returned check fees, finance charges, court fees, collection fees and attorney fees that are accrued in the collection of any debt. Accounts placed in collections will be required to choose a new medical practice to provide medical services.

Referrals—I agree that it is my responsibility to know and understand my insurance policy and benefits. It is the policyholder's responsibility to make sure specific laboratory, radiology or specialist consultation/services accepts your insurance.

If your insurance requires you make a primary care physician (PCP) selection, our facility or one of our providers must be designated as the PCP. I understand that I will be financially responsible for charges incurred at time of service if Pediatric Healthcare or one of its providers is not listed with my insurance company as PCP.

If your insurance requires a written referral or preauthorization number to see a specialist this referral must be initiated by the PCP. Once a doctor/nurse practitioner advises you to see a specialist or to have a procedure requiring preauthorization, you must notify our office of the specialist/facility name and appointment date and allow 3 business days notice to process your request. Original referral forms must be picked up from our office and hand carried to your specialist appointment. This office does not fax, mail or backdate referrals.

Medical Records-Medical records may take up to 15 days to be copied and is subject to fees as allowed by Virginia's Health Records Privacy statute 32.1-127.1:03 J. The request must be made in writing. Medical records of a minor child shall be maintained until the child reaches the age of 18 or for six years after the last patient encounter regardless of age, whichever is longer. I authorize this office to share immunization and child locator information with other health care providers.

I agree that a photocopy of this authorization shall be considered as effective and valid as the original.