Pediatric Partners of Virginia 18+ Registration Form

Patient Information:					
Legal Last Name	Legal First Name	Middle Name	Nickname	Date of Birth	Sex
					□ M □ F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

I prefer to be reminded of future appointments by: □ Home Phone □ Cell Phone □ Text Message

Preferred Pharmacy Location: _____ Phone: _____

Primary Email: _____

Who is responsible for charges not covered by insurance? □ Self □ Other: _____

If other please complete the following:

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Alternate/Emergency Contact (Parent or Other): _____
Alternate Contact Phone: _____ Relationship to patient(s): _____

INSURANCE INFORMATION – YOU MUST HAVE YOUR INSURANCE CARD FOR OUR RECEPTIONIST

Primary Insurance: _____ Policy ID: _____ Group Number: _____
Policy Holder/Subscriber: _____ Date of Birth: _____

Secondary Insurance: _____ Policy ID: _____ Group Number: _____
Policy Holder/Subscriber: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

I understand that I am financially responsible for all professional charges that my children may incur. All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.

I hereby authorize payment of medical benefits direct to Pediatric Partners of Virginia. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations. Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for Pediatric Partners of Virginia.

_____ _____ _____
Patient Signature (Patient Signature if 18 or older) Printed Name Date

Pediatric Partners of Virginia Financial Policy

Pediatric Partners of Virginia is dedicated to providing excellent care and understanding overall service to every patient at every visit. In the interest of avoiding misunderstandings that may arise due to any financial matters, please take note of our financial policy and sign below if you are agreeing to be bound by these terms:

Our office participates in most major health plans, but please remember:

- It is your responsibility to verify that the pediatrician is a participating health care provider in your health plan. This should be done prior to making an appointment.
- Identification and the patient's insurance card must be brought to each visit so that we can ensure that we are billing the most current insurance plan.
- The insurance policy holder's/grantor's date of birth and social security number are required for account verification.
- It is your responsibility to know your benefits and to understand that if services rendered are applied to your deductible or considered non-covered services, you will be responsible for payment.
- Co-pays are due at the time of service.
- Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of an insurance claim. You are responsible for communication with your carrier regarding denied claims.
- Self-Pay patients are required to pay for the service in full at the time of visit.
- A $10.00 fee will be charged for the completion of each form that is not requested during the preventative check.
- A medical records fee may apply for records requests and will be priced at allowed state rates.
- Courtesy Appointment reminder calls are made to confirm appointments. It is your responsibility to keep account information up to date. A 24-hour notice is required if you need to cancel an appointment. If sufficient notice is not provided, you could be considered a "no show" and a $50.00 "No Show Fee" or a $25.00 "Rescheduling Fee" will be applied.
- All balances are due within 30-days of the first statement. **Please contact our Billing Office at 804-323-9100** if you have any concerns regarding your bill so we can assist you. If a payment is not received in full within 60 days a $10.00 late fee will be charged.
- Delinquent accounts more than 90 days past due, with no payments and/or broken payment arrangements are subject to collection activity. You will be notified by phone or in writing prior to collections.
- In the unfortunate event that we need to assign an account to a collection agency, an additional fee of 40% will be added to the delinquent balance on the account. Any discounts will be added back to the balance and the amount sent to the collection agency will be the full fee.
- Existing patients with delinquent accounts, accounts turned to a collection agency, active bankruptcy claims or have balances written off to bad debt may not be seen at a Pediatric Partners of Virginia office until such debt is satisfied or a payment arrangement is in place.
- Returned checks will be assessed a $50.00 returned check fee and we retain the right to refuse payment by check for future appointments.
- Repeat violators of these policies could be dismissed from our practice.

Should you receive a bill from us, and you find yourself in a financial bind, PLEASE call us to discuss setting up a payment plan. If more charges are added to the balance, new payment arrangements will need to be made. We are happy to help and are here to assist you.

By signing this form, I acknowledge that I have read, understood and agree to pay for all services rendered in accordance with the terms set forth in the financial policy of Pediatric Partners of Virginia.

_____	_____	_____
Signature of Guarantor	Printed Name	Date

Pediatric Partners of Virginia Consent for Treatment

I understand, that the laws of Virginia require that if my physician or any person employed by my physician(s) is directly exposed to my bodily fluids that may transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses according to the current guidelines for the Center of Disease Control (CDC), that I consent to be tested for infection with HIV or Hepatitis B or C viruses. I further understand that by law I consent to the release of these test results to the person(s) who are exposed to my bodily fluids.

_____	_____	_____
Signature of Patient	Printed Name	Date

OPTIONAL: DISCLOSURES TO FAMILY / FRIENDS (not including daycare, schools, camps)

Please list all persons (Parent, Grandparent, Friend, etc.) who may receive my (18+) health information regarding but not limited to scheduling, medical advice, treatment, prescriptions, medical forms, medical records and billing information. These individuals may be asked to present identification. If someone other than those you list below contacts us regarding your medical care, we will contact you for permission to advise or treat. In the event of an emergency, we will treat and make every possible attempt to contact you.

NAME	RELATIONSHIP	PHONE Number	Restrictions (if any)
_____			
_____			

This authorization will remain in effect until further written notice by patient/legal representative to discontinue. I understand that once information is released the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

_____	_____	_____
Signature of Patient	Printed Name	Date

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.