Pediatric Partners of Virginia Family Registration Form

CHILDREN'S INFORMATION - PLEASE LIST ALL CHILDREN TO BE REGISTERED UNDER THIS ACCOUNT					
Legal Last Name	Legal First Name	Middle Name	Nickname	Date of Birth	Sex
1.					□ M □ F
2.					□ M □ F
3.					□ M □ F
4.					□ M □ F

Address where children reside: _____
City: _____ State: _____ Zip: _____
Preferred Pharmacy Location: _____ Phone: _____

Primary Family Email: _____ Primary Family Phone: _____

Parent/Guardian Name: _____ **Date of Birth:** _____
Mobile Number: _____ **Work Phone:** _____
Home Address (if different from child): _____
□ Father □ Mother □ Other: _____ City: _____ State: _____ Zip: _____
Employer: _____ **List as account guarantor? □ Yes □ No**

Parent/Guardian Name: _____ **Date of Birth:** _____
Mobile Number: _____ **Work Phone**: _____
Home Address (if different from child): _____
□ Father □ Mother □ Other: _____ City: _____ State: _____ Zip: _____
Employer: _____ **List as account guarantor? □ Yes □ No**

Alternate/Emergency Contact (Other than Parent): _____
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 the time of service. All costs not paid by insurance are due upon receipt of the statement.

I hereby authorize the payment of medical benefits directly 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.
Permission to Treat Minor (under age 18): In the event of an emergency and I cannot be contacted, I give my permission to treat my child in their office as required by the events of an emergency.
Acknowledgment 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.

_____ _____ _____
Parent/Guardian Signature (Patient Signature if 18 or older) 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 child's 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 have my child 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 child's bodily fluids.

I further give my permission for Pediatric Partners of Virginia, LLC to treat my child(ren), _____ _____, according to the standards of care defined by the American Association of Pediatrics (AAP) and the realm of medical necessity as deemed appropriate by the treating Provider.

_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date

OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD (i.e. Nanny, Grandparent, Stepparent, and/or teen by themselves)

I,_____, do hereby consent to Pediatric Partners of Virginia and its Providers and Staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments. I give the Providers and Staff permission to treat my child in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for verbal consent if the treatment plan includes vaccines, and the best number to reach me for this is _____.

_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date

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

Please list all persons (Grandparent, babysitter, friend, etc.) who may receive health information regarding my child(ren), such as 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 listed below contacts us regarding your child, 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 the patient/legal representative to discontinue. I understand that once information is released, it may be subject to redisclosure by the party receiving it and may no longer be protected by federal or state law.

_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date

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

Revised 12/2023