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 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. 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.

______________________________ ______________________ ___________

Patient 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 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 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 Patient | Printed Name | Date

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