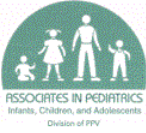


Pediatric Partners of Virginia — Family Registration Form

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 at Birth
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: _______________
Preferred Pharmacy: ______________________________ Pharmacy Phone: ________________

Biological Parent/Legal 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**

Biological Parent/Legal 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**

Please provide all legal guardianship or custody documents at the time of service.
Please list step-parents under the "Disclosures" section if you wish to include them in your child's care.

Alternate/Emergency Contact (Other than Parent): ______________________________
Alternate Contact Phone: _________________ Relationship to patient(s): _______________
Please list under "Disclosures" section if we have permission to speak with them in regards to your child's care.

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

Primary Insurance: ___________________ Policy ID: ______________ Group Number: _________
Policy Holder/Subscriber: ___________________________ Date of Birth: ____________

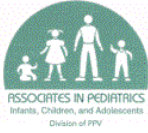
Secondary Insurance: ___________________ Policy ID: ______________ Group Number: _________
Policy Holder/Subscriber: ___________________________ Date of Birth: ____________

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)

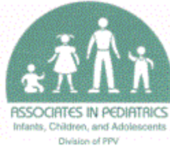
This authorization will remain in effect until further written notice by the patient/legal representative to discontinue. I understand that once information is released, it may be subject to redisclosure by the party receiving it and may no longer be protected by federal or state law.

__________________________________ __________________________________ ______________

Signature of Parent/Guardian Printed Name Date

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

Revised 04/2024



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 review our financial policy and sign below if you agree 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 healthcare provider in your health plan. This should be done before 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 before assignment to a collections agency.
- 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 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 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.

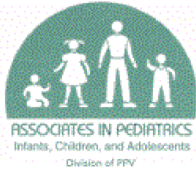
Should you receive a bill from us and you find yourself in a financial bind, PLEASE call us to discuss setting up a payment plan. If more charges are added to the balance, new payment arrangements will need to be made. We are happy to help and are here to assist you.

By signing this form, I acknowledge that I have read, understood, and agreed to pay for all services rendered following the terms outlined in the financial policy of Pediatric Partners of Virginia.

Children's Names and DOBs: ____

______________________________ ______________________________ ____________

Signature of Guarantor Printed Name Date



Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 804-464-2018.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

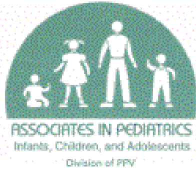
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.



Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.