PediaCare of Virginia

Patient Registration

Patient Name: _____Date of Birth: _____
Male_____ Female_____

Address: _____City: _____State: _____Zip: _____

Mother/Guardian: _____ Date of Birth: _____
Home #:_____ Cell #:_____ Social Security #_____-_____-_____
Employer: _____ Occupation:_____ Work#:_____

Father/Guardian: _____ Date of Birth: _____
Home #: _____ Cell #: _____ Social Security #_____-_____-_____
Employer: _____ Occupation: _____Work#: _____

Emergency contact: (Other than parents)
Name: _____ Relationship to patient: _____ Phone#:_____

Name of person(s) authorized to accompany and give consent for treatment at appointment time.
Name: _____Relationship to patient: _____ Phone#: _____
Name: _____Relationship to patient: _____ Phone#: _____
Name: _____Relationship to patient: _____ Phone#: _____

Anyone not listed would need written consent from parents at the time of appointment. Please note proper photo ID maybe required.

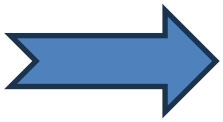
☺Who may we thank for referring you to our office? _____

Email: _____

Authorization of Treatment and Assignment of Benefit

I authorize PediaCare of Virginia to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to PediaCare of Virginia for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the current guidelines for Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian Signature: _____ Date: _____



PediaCare of Virginia, PLC

Patient Responsibility

PCV, PLC; requires this form to be signed. We appreciate your cooperation

Financial Responsibility:
If PediaCare of Virginia is in network with your insurance you are responsible for providing us the most updated and correct insurance information. You are personally responsible for any medical fees incurred with PediaCare of Virginia, PLC. Also, will be responsible for any charges incurred by not providing the information needed in order to bill your insurance company. All insurance copayments are **due at the time of service** and all other balances should be cleared within a **90-day period**. If insurance information is not provided or do not have insurance on the day of service you will be financially responsible for the visit and any test performed. The charges are due on the day of service and will not be billed to your home unless indicated otherwise. PediaCare of Virginia will NOT submit or return any payment.
Initial: _____

Appointment Scheduling:
In order to continue to accommodate our patients we ask that you give us 24-hour notice for canceling or rescheduling appointment especially for well child visits. **NO SHOWS are charged to the patient at $50.00 per missed visit.** For all routine well appointments we reserve the right to reschedule appointment if 15minutes late from original appointment time. Walk-In appointments are welcomed in accordance to our schedule for **sick visits** only.
Initial: _____

Record Release:
PCV, PLC follows the standard Virginia Code for Medical Records. Full medical record fees according to the Virginia Code § 8.01-413 is ten-dollar ($10.00) processing fee, Fifty (.50) cents per page for the first fifty pages; and fifteen (.15) cents per page thereafter. Our office requires signed authorization from parents or Legal Guardian of the patient in order to release any medical information. (Virginia Code § 32.1-127.1:03) Please allow 14 days for processing after both payment and authorization is obtained. Only immunization records and one yearly physical form are free of charge. A $5.00 fee will be charged for any additional copies you may need.
Initial: _____

Acknowledgment of Receipt of Notice of Privacy Practices:
By signing below, I acknowledge that I have seen and reviewed a copy of this office's "Notice of Privacy Practice" as require under the Privacy Rule regulation of Public Law 104-191, The Health Insurance Portability and accountability Act of 1996(HIPAA)

Name of Patient: _____ Date of Birth: _____

Signature of Parent/Legal Guardian: _____ Date: _____

This form does not expire!