☐ Newborn

Hosp: Time:

☐ New Patient

☐ Existing/Update

PIEDMONT PEDIATRICS, PLC

20 Rock Pointe Lane, Warrenton, Virginia 20186 • 540-347-9900 • Fax 540-349-0920

PATIENT REGISTRATION

Please print • Fill in all areas

Account No

Child's First Name	Last Name	Nickname	Birthdate	Gender	Preferred Language	Race (enter number for each child) 1-American Indian/Alaska Native 2-Asian 3-Black/African American 4-Hispanic 5-Native Hawaiian/Pacific Islander 6-More than one Race 7-White	Ethnicity Hispanic/ Latino?	Smoking Status (age 13+)
				M F			Y N	Y N
				M F			Y N	Y N
				M F			Y N	Y N
				M F			Y N	Y N
				M F			Y N	Y N

Parent 1/Legal Guardian

☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Other

☐ Married ☐ Unmarried ☐ Divorced *Does child reside with Parent 1/Legal Guardian? Yes / No

Parent 1/Legal Guardian's Full Name	Date of Birth	Social Security Number	Home Phone Number
Home Address		City/State	Zip
Parent 1/Legal Guardian's Employer Name & Address			Work Phone Number
Parent 1/Legal Guardian's Email			Cell Phone Number
Contact Preference? (circle one) Cell Home Work			

Parent 2/Legal Guardian

☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Other

☐ Married ☐ Unmarried ☐ Divorced *Does child reside with Parent 2/Legal Guardian? Yes / No

Parent 2/Legal Guardian's Full Name	Date of Birth	Social Security Number	Home Phone Number
Home Address		City/State	Zip
Parent 2/Legal Guardian's Employer Name & Address			Work Phone Number
Parent 2/Legal Guardian's			Cell Phone Number
Contact Preference? (circle one) Cell Home Work			

Emergency Contact (Friend or Relative)

Name	Relationship	Phone Number

Insurance Information

*Insurance information and copy of insurance card required to file for benefits

Policy Holder's Name		Copay Amount
Primary Insurance Company	Patient's Identification Number	Patient's Group Number

I certify that the information I have provided above is correct and that as the Parent/Guardian/Guarantor, I have read, understand and fully accept the Conditions of Registration as stated on the next page.

Signature of Parent/Guardian/Guarantor _____ Print Name _____ Date _____

CONDITIONS OF REGISTRATION

FINANCIAL AGREEMENT

Piedmont Pediatrics participates with a majority of insurance plans. It is the patient's responsibility to provide us with correct and current information at the time of your visit, and to make sure that our providers participate with your plan. If you fail to present the correct and current insurance information at the time of your visit, then you agree to be responsible for 100% of our usual and customary charges for that visit.
If we participate with your plan, we will provide the service of filing a claim to your insurance company for most office charges, unless we have received prior notification of non-covered services. Those services along with all copays, deductibles and balances are the patient's responsibility; co-pays are due at the time of service. If you do not pay your copay at the time of service, a $10.00 surcharge may be added to your balance to cover the cost of sending a bill. Any charges not billable to insurance will be disclosed in advance and you will be required to sign a waiver acknowledging our policy before services are rendered. We will file the initial claim to your primary insurance company; we only file secondary insurances for Medicaid and Tricare plans. You must respond to any correspondence from the insurance company requesting patient information in a timely manner or the claim may be turned over to patient responsibility.
Missed Appointments: Our office may charge $80.00 for appointments that are missed without calling to reschedule or cancel 24 hours prior to the scheduled appointment time. After numerous missed appointments, you may be discharged from the practice.
Credit Balances: At times, an overpayment may occur due to insurance processing that may result in less money owed by the guarantor than what was collected. Unless you disagree, if an overpayment is made on your account, we will retain credit balances of $50.00 or less for a period of up to 180 days in order to apply those funds to a future visit. If the credit remains on your account after the 180-day period, we will issue a refund. Overpayments owed to insurance or government payers are refunded according to those payers' guidelines.
After Hours Care: Appointments scheduled after 5:00PM Monday-Thursday or on weekends are considered urgent after-hours care and are subject to an after-hours care fee of $35.00.
Self-Pay: If we do not participate with your health plan or you are uninsured, payment in full will be due at the time of your visit**.**
Payment for Services Performed: Our office accepts cash, checks and most major credit cards. All outstanding balances are due within thirty (30) days unless prior arrangements have been made with the billing department. There is a $35.00 charge for returned checks. All balances over 90 days may be sent to a collection agency or pursued legally. You will be responsible for the collection and legal fees incurred by Piedmont Pediatrics in the collection of your delinquent balance. _____**(initials)**

CONSENT FOR TREATMENT

I hereby consent to the administration of medical treatment, procedures, immunizations and laboratory work as deemed necessary by the medical provider rendering care for the child(ren). I understand that I have the right to decline consent to any of the above at any time prior to its performance. _____**(initials)**

RELEASE OF MEDICAL INFORMATION

I authorize Piedmont Pediatrics to release any and all of my minor child(ren)'s medical records and/or other information and records required by my/our insurance company or its designated review agents who provide insurance benefits on my/our behalf, including if applicable, my employer and/or employer's workers compensation insurance company, the Social Security Administration, or the Centers for Medicare and Medicaid Services, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Piedmont Pediatrics; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my minor child(ren)'s medical records and/or other records and information on my minor child(ren) to Piedmont Pediatrics as required for payment of benefits and/or required for medical or any other reasons; and authorize Piedmont Pediatrics to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied**.** _____ **(initials)**

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize Piedmont Pediatrics to apply for benefits for services rendered to minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my/our insurance company to Piedmont Pediatrics (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency). I irrevocably authorize all such payments to Piedmont Pediatrics. I authorize Piedmont Pediatrics to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my/our benefits**.**_____ **(initials)**

CERTIFICATION

I certify that the information I have reported with regard to my/our insurance coverage is correct and that the above be honored by my/our insurance company. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the foregoing and as the parent/guardian/guarantor, understand and fully accept the terms therein**.**_____ **(initials)**

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic**.** _____ **(initials)**

HIV/HEPATITIS B&C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/Hepatitis B & C testing. In all other cases, the patient shall have the right to informed consent or refusal for HIV/Hepatitis B & C testing. We do not randomly test for HIV. _____**(initials)**

PARENTAL/LEGAL GUARDIAN CONSENT FOR TREATMENT OF A MINOR

I, _____ , the parent or legal guardian of the below mentioned minor child(ren), do hereby grant my authorization and consent to seek medical care to any one or more of the below mentioned adults whose care the minor child(ren) has been entrusted to act as agent(s) for myself in my absence. Medical care includes, but is not limited to, any treatment of illnesses, diseases, well care, immunizations and medical advice. Further, I give permission for the Authorized Individual below to pick up written prescriptions, including ones for controlled substances, in my absence. I further authorize the release of protected health information to the Authorized Individual(s) listed regarding the child(ren) whose names appear on this document.

Child's Name	Child's Date of Birth

Authorized Individual(s)		
Name	Relationship	Phone number

☐ **Yes** ☐ **No** **If my child is over age 16 or above, I give permission for them to be seen/treated without me present. I understand that the provider may call me at the phone number listed on file if there are any questions or issues.**

It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician or healthcare provider in the exercise of his/her best judgment may deem advisable.

This authorization shall remain in effect until _____ or until the child(ren) reach 18 years of age.
Month/Day/Year

I understand that I may revoke this authorization at any time by submitting a written request.

_____

Signature of Parent or Legal Guardian **Printed** Name Date