RVA PEDIATRICS, P.C.

CHARLES V. TERRY, M.D., F.A.A.P.
PETER S. HEYMAN, M.D., F.A.A.P.
LORA G. CHRISTIAN, M.D., F.A.A.P.
MELANI B. DE SILVA, M.D., F.A.A.P.
CHRISTINE M. SELISKAR, M.D., F.A.A.P.
W. COLE HAWTHORNE, D.O, F.A.A.P.
DIBYA SUBEDI, M.D., F.A.A.P.
NICOLE BYRAM, M.D., F.A.A.P.
MATTHEW VAN DE GRAAF, M.D.

2026

Patient's Primary Physician Name:_____ **Patient Account:**_____

Child's Information

Last Name, First Name, MI _____ Sex _____ Date of Birth _____

Race: (please circle) American Indian/Alaska Native; Asian; Black/African American; Hispanic/Latino; Native Hawaiian/Other Pacific Islander; White; More than one race; Refused/Unreported

Parent's Information

Parent/Guardian (Guarantor)	Date of Birth	Parent/Guardian	Date of Birth
_____	_____	_____	_____

Relationship to patient: _____ Relationship to patient: _____

Home address:_____ Home address: _____

City/State/Zip:_____ City/State/Zip: _____

Home phone #: _(____)_____ Home phone #: _(____)_____

Cell phone #: _(____)_____ Cell phone #: __(____)_____
Please indicate preferred number for contact Please indicate preferred number for contact

Email:_____ Email: _____

Employer:_____ Employer: _____

Work #: __(____)_____ Work #:____(____)_____

Parent's marital status: Single, Married, Divorced, Partner (circle one)

Is English your primary language: YES NO (circle one)

If no, please indicate primary language: English, Spanish, French, Hindi, Other _____

Insurance information

Name of Primary Insurance:_____ Effective date: _____
Insurance phone #:_____ Insurance address: _____
Policyholder name:_____ Relationship to patient: _____
Policyholder date of birth:_____ Policyholder's SSN: _____
Policy ID #: _____
Group #: _____

Name of Secondary Insurance:_____ Effective date: _____
Insurance phone #:_____ Insurance address: _____
Policyholder name:_____ Relationship to patient: _____
Policyholder date of birth:_____ Policyholder's SSN: _____

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Policy ID #: _____

Group #: _____

Patient Account: _____

In case of emergency, notify (other than parent):

Name: _____ Phone #: _(____)_____

Relationship to patient: _____

Siblings: full name and DOB _____

_____

Who referred you to our practice: _____

How would you like your reminder to be sent: Text (____-____) or Voice (____-_____)

(Standard text message fees from your carrier may apply)

Preferred Pharmacy: _____ Address: _____

Pharmacy phone #: _____

I hereby authorize RVA Pediatrics, P.C. to release information to the insurance company named herein. I hereby authorize payment directly to RVA Pediatrics, P.C. or benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney or agency for collection, that I will be responsible for agency or attorney's fees as well as court cost and interest.

_____ _____

Guarantor Signature Date

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Lora G. Christian, M.D., F.A.A.P.
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www.rvapediatrics.com

AFTER HOURS AND
EMERGENCIES:
1 (877) 819-0320

rva pediatrics

RVA Pediatrics Financial Policy

Thank you for choosing RVA Pediatrics, P.C. as the health care provider for your child. We are committed to the care and treatment of your child. This financial policy is an important part of your child's care.

Payment

Payment is due at the time of service. Per the contract you have with your insurance company, co-pays must be paid at the time of service.

1. Co-pay payments are due at the time of visit, regardless of who brings the child in for the service. Grandparents, aunts, babysitters, etc., will be expected to bring in payment for your co-pay, co-insurance, or deductible. If you are reachable by phone, we can take your credit card information over the phone. We can send a receipt home with your child's caregiver. For separated or divorced parents, financial responsibility still belongs to the parent bringing the child in for treatment that day. We will not bill another parent. It is your responsibility to bring what you will owe when you arrive.

2. Payment is determined from benefits we receive from your insurance company. Regardless of what is quoted or misquoted by them, you are ultimately responsible for any deductibles, co-insurance, or co-pays that are not paid by your insurance company. This includes services they do not think are medically necessary, or do not cover, but our providers deem necessary, appropriate, and/or a standard of care for pediatrics. For all deductible plans, you will be required to pay $75 at the time of service and the balance 30 days after the claim has been processed.

3. Newborns: most insurance carriers allow 30 days to add your newborn to your plan. Please do so promptly. Newborn bills will be held and sent to the insurance company once it can be verified that the newborn has coverage. If coverage cannot be verified within 6 weeks, the charge will be released to the parent.

4. Well and office visits at the same time: Your insurance company may cover well visits and office visits differently. It is your responsibility to know how your policy covers each type of visit. While some insurance companies may pay for well visits at 100% (i.e., there is no cost to you), office visits may include a co-pay, co-insurance, or deductible. If, during a well visit, your child is sick or has an issue that is not related to the normal growth and development of your child, and they need treatment, your provider may bill the insurance for both services.

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Medicaid

RVA Pediatrics does NOT participate with Medicaid/Medicare. We are unable to bill Medicaid/Medicare for any office visits. Our providers cannot authorize prescriptions when the patient has Medicaid/Medicare. Our providers are unable to submit authorizations to Medicaid/Medicare. Unfortunately, due to these reasons, our providers will not be able to care for your child. If at any point your insurance changes, and you choose to be insured through Medicaid/Medicare, you will need to transfer the care of your child to another practice. Our practice will provide you a list of Medicaid participating providers. We will continue to see your child for 30 days after the date of notice.

If you have Medicaid as a secondary, we will bill your commercial insurance policy only. Prescriptions cannot be processed using Medicaid.

True Self Pay

If you are self-pay and do not have insurance coverage at all, we expect payment on the date of service. We do not have a cash price discount for services or testing. You are required to pay $75 up front with any leftover balance to be paid within 30 days.

If you choose to receive vaccines through our practice, instead of the Health Department, full payment for those vaccines is due at time of service and will be collected prior to the administration of the vaccines.

All outstanding balances not paid within 90 days are subject collections. All costs incurred in collecting a delinquent account will also be added to your charges. We will exhaust every effort prior to seeking outside collections help. If you have an outstanding balance, please contact our billing department (804-754-7422.) Depending on the amount of the balance, payment or budget plans may be utilized and will be granted on an individual basis. Any payment or budget plans not met or not attempted to be met will be subject to collections and all costs associated.

There is an additional fee charged in the amount of $30 for all returned checks.

Form Fees and Sports Physicals

Our practice charges a $15 form fee for any forms (school, medication, FMLA, etc.) if needed outside of a check-up. This is to be paid at time of drop off. RVA Pediatrics makes every effort to scan completed forms to the patient chart, however, it is ultimately the responsibility of the parent to keep record of the form.

Our practice also offers sports physicals for patients who have had a complete well child exam within the last year. There is a $50 fee for sports physicals, to be paid at the time of service, as this is not billed to insurance. If you are unable to pay the sports physical charge at the time of visit, we will ask you to reschedule when you have payment. If you are seen for a sports physical, but another medical issue is addressed during the visit, we may bill the visit as a sick visit, and a co-pay, co-insurance or deductible may be applicable.

_____ _____

Parent/Guardian printed Date

_____

Parent/Guardian signature

CONSENT to Use and Disclosure of *Protected Health* Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by RVA Pediatrics, P.C. or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. RVA Pediatrics, P.C. may or may not agree to restrict the use or disclosure of protected health information. If RVA Pediatrics, P.C. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

RVA Pediatrics, P.C. reserves the right to modify the privacy practices outline in the notice.

Signature

I have reviewed this consent form and give my permission to RVA Pediatrics, P.C. to use and disclose my health information in accordance with it.

_____

Name of Patient (Print or Type)

_____

Signature of Parent

_____

Date

_____ _____

Signature of Patient Representative (if other than parent) Relationship of Patient Representative to Patient

Notice of Privacy Practices

Privacy Practices Acknowledgement

RVA Pediatrics, P.C.

Patient Chart # _____

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

Patient Name: _____ Birthdate: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances, which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 16, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

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rva pediatrics

RVA PEDIATRICS IMMUNIZATION POLICY

Our practice firmly believes in the effectiveness of vaccines to prevent illness and to save lives. We firmly believe in the safety of vaccines.

Our practice has reviewed, and will continue to review the available literature, evidence based research, and current studies regarding vaccines. As a result, we firmly believe that vaccines are fundamentally safe and effective, and they DO NOT cause Autism or other developmental delays.

Our practice understands that you want what is best for your child and so do we. We know that, in light of the recent measles virus outbreak, there has been much conflicting information on immunization and vaccine safety. We can help you get the reliable information you need to make an informed decision

Our practice firmly believes that vaccinating children and young adults is among the most important health promoting intervention we perform as healthcare providers and that you can perform as parents. Broad-based vaccination has contributed extensively to disease prevention and is a fundamental part of pediatric care.

We have many children coming in and out of our office daily, some of which are too young to be vaccinated and are therefore vulnerable to severe, potentially life-threatening infection. It is our duty to protect each of our patients to the best of our ability from any infection that could be contracted in our office.

To accomplish this goal together, our practice follows the guidelines and schedules for immunizations established by the American Academy of Pediatrics. All patients must obtain the required immunizations unless there is a medical contraindication. We do not recognize any "alternative" immunization schedules, nor do we make exceptions for religiously-based beliefs about vaccinations.

While we understand that parental choice may play a role in the vaccination of children, we request that you abide by our policy. If this is not an acceptable choice for you, we respectfully request that you seek out another pediatric group for your children's care.

Thank you for your understanding and cooperation.

IMMUNIZATION POLICY

RVA Pediatrics, P.C.

Patient Chart # _____

ACKNOWLEDGEMENT FORM

I have received the RVA Pediatrics Immunization Policy, and I have been provided an opportunity to review it. I agree to abide by this policy to have my child properly vaccinated or I may be dismissed from the practice.

Patient Name: _____ Birthdate: _____

Signature: _____

Date: _____

RVA Pediatrics, P.C.

PERMISSION TO DISCUSS PHI
(other than the parent)

Patient Name: _____

Date of Birth: _____ Account #: _____

I, _____, parent or guardian of _____, a minor, hereby give permission for the following people to have access to my child's personal health information, including, but not limited to, medical records, treatment plans, immunizations, test results, and prescriptions, both written, verbal, or electronically transmitted:

******Parents do NOT need to be listed (if patient is minor)******

- _____/_____
  relationship
- _____/_____
  relationship
- _____/_____
  relationship
- _____/_____
  relationship

☐ **I do not give permission to discuss my account with anyone other than myself.**

I understand that I may revoke this authorization at any time by sending written notification to: RVA Pediatrics, P.C., 10410 Ridgefield Parkway, Richmond, VA 23233.

I understand that once any information is disclosed to a third party listed above, RVA Pediatrics, P.C. is not liable for any re-disclosure by that party and the information may no longer be protected by federal or state law.

_____
Signature of Parent or Guardian (or child over 18 years of age)

_____
Date

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