WARRENTON PEDIATRICS, LLC

559 Frost Avenue, Suite 101 • Warrenton, Virginia 20186 • 540-349-3225 • Fax 540-349-1204

Date		Account No.
	ADDRESS UPDATE	

Name(s) of Child(ren) :_____

Mother ❒Mother ❒Stepmother ❒Married ❒Unmarried ❒Divorced If divorced, does child reside with Mother? **YES** / **NO** (Circle One)

Mother's Full Name	Social Security Number	Home Phone Number ( )	
Home Address	City	State	Zip
Mother's Employer Name & Address		Work Phone Number ( )	
Mother's Home E-mail	Mother's Work E-mail	Cell Phone Number	Pager Number

Father ❒Father ❒Stepfather ❒Married ❒Unmarried ❒Divorced If divorced, does child reside with Father? **YES** / **NO** (Circle One)

Father's Full Name	Social Security Number	Home Phone Number ( )	
Home Address	City	State	Zip
Father's Employer Name & Address		Work Phone Number ( )	
Father's Home E-mail	Father's Work E-mail	Cell Phone Number	Pager Number

I understand that without complete and timely information Warrenton Pediatrics, LLC may not be able to contact me or be able to file for my (our) insurance benefits. I certify that the information I have reported above is correct and that as the Patient/Parent/Guardian/Guarantor I have read, understand, and fully accept the Conditions of Registration as stated <u>on the back</u> of this document.

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

CONDITIONS OF REGISTRATION

THE PRACTICE
Warrenton Pediatrics, LLC and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT
The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

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.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS
I do hereby authorize the Practice to apply for benefits for services rendered to myself or 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 the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION
I authorize The Practice to release any and all of my or 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 workman's 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 the Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to the Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize the Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied.

REFERRALS AND AUTHORIZATIONS
I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from the Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify the Practice prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform the Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT
I agree that payment in full is due at the time of treatment. I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by my children, stepchildren or any other extended family members, including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to, other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per the Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by the Practice is given strictly as a courtesy and implies no responsibility on the Practice's part for filing, follow through or conformation. I agree to pay a $10.00 billing fee for each payment, including co-payments and co-insurance, not made at time of visit. I agree to pay the Emergency/Walk-in fee of $50.00 in addition to the office visit if I arrive without an appointment. I agree to pay a $15 form fee. I agree to pay a $25.00 fee for missed appointments that are not cancelled at least 24 hours in advance. I agree to pay a $15 fee for each after hour telephone call for medical advice. I understand that billing, Emergency/Walk-in, prescription refills, form, missed appointment, and after hours telephone advice fees will be my financial responsibility and will not be sent to insurance. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as an attorney fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility.

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.

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 carriers. 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.