WARRENTON PEDIATRICS, LLC

28 Blackwell Park Ln, Suite 103 • Warrenton, Virginia 20186 • 540-349-3225 • Fax 540-349-1204

❒ New Patient
❒ Existing/Update

PATIENT REGISTRATION

Account No.

Patient Information *PLEASE PRINT –FILL ALL AREAS*

CHILD'S FIRST NAME	LAST NAME	NICK NAME	BIRTHDATE	SEX	INSURANCE ID#	DRUG ALLERGIES
1				M F		
2				M F		
3				M F		
4				M F		
5				M F		

Mother ❒Mother ❒Stepmother ❒Married ❒Unmarried ❒Divorced

If divorced, does child reside with Mother? **YES** / **NO** (Circle One)

Mother's Full Name	Date of Birth	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	Date of Birth	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	

Emergency Contact (Friend or Relative)

Name	Relationship	Home Phone Number ( )

Insurance Information *Insurance info and copy of insurance cards needed to file for benefits*

Policy Holder's Name	Social Security Number of Subscriber		Co-Payment / Co-Insurance Amount	
Primary Insurance Company	Sex of Policy Holder ❒Male ❒Female		Birthdate of Policy Holder	Effective Date
Policy Holder's Employer	Employer Plan? ❒Yes ❒No		Identification/Policy Number	
Insurance Address	Insurance Network		Group Number	
City	State	Zip	Insurance Phone Number for Eligibility/Verification ( )	

I certify that the information I have reported above is correct and that as the 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 _____

PAYMENT IS DUE AT TIME OF SERVICE

Read Conditions of Registration on the Back of this Form

WARRENTON PEDIATRICS, LLC

NOTICE OF PRIVACY PRACTICES

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

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires 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, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

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

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

- **Treatment** means providing, coordinating, or managing health care and related services by one of more health care providers. An example of this would be a physical exam.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

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

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with you written authorization. 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 then actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

Warrenton Pediatrics, LLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my child (ren)'s protected health information. I understand that this information can and will be used to:

- **Treatment** – Conduct, plan and direct my child (ren)'s treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- **Payment** – Obtain payment from third-party payers.
- **Healthcare Operations** – Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received and/or reviewed your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my child (ren)'s protected health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may at any time request, in writing from the Privacy Officer, a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my child(ren)'s protected health information is used or discussed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient(s) Name *List all children*

Parent/Patient/Guardian _____

Signature _____ Date _____

Relationship _____

OFFICE USE ONLY

I attempted to obtain the parent's/patient's/guardian's signature in acknowledgement of receipt and/or review of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initials:	Reason:

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You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a 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 from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practiced with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy a revised Notice of Privacy Practices from this office.

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

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries:

Warrenton Pediatrics, LLC
Attn: Privacy Officer
28 Blackwell Park Lane, Suite 103
Warrenton, VA 20186
540-349-3225

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Service Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 877-696-6775

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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 _____ (initials)
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 _____ (initials)
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/HEPITITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPITITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS _____ (initials)
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 _____ (initials)
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 _____ (initials)
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 _____ (initials)
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, step children 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 are 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 prescription refill fee for refills on prescriptions. 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. Service charges 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 service charge as an attorney fee, plus court costs and service charge 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 service charge, shall become an additional liability for which I (we) assume full responsibility.

COPY OF SIGNATURE _____ (initials)
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 _____ (initials)
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 forgoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

Medical Authorization for Minors

I, _____, the parent or legal guardian of the below mentioned minor child(ren), do hereby grant my authorize 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 agent below to pick up written prescriptions for controlled substances in my absence.

CHILD	DATE OF BIRTH

AGENT NAME	RELATIONSHIP	ADDRESS	PHONE

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 or 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

Signature of Parent or Legal Guardian: _____

Printed Name: _____

Date: _____