WARRENTON AND LINTON HALL PEDIATRICS, LLC

28 Blackwell Park Ln, Suite 103 Warrenton, Virginia 20186 Phone 540-349-3225 Fax 540-349-1204
13910 Estate Manor Dr. Gainesville, VA 20155 Phone 571-446-0700 Fax 703-754-1359

Patient Registration

FIRST NAME	LAST NAME	NICKNAME	DATE OF BIRTH	SEX
1.				
2.				
3.				

Parent/Legal Guardian (please circle one) MOTHER FATHER STEPMOTHER STEPFATHER OTHER _____

FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PHONE NUMBER
ADDRESS			
EMAIL			

Parent/Legal Guardian (please circle one) MOTHER FATHER STEPMOTHER STEPFATHER OTHER _____

FULL NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	PHONE NUMBER
ADDRESS			
EMAIL			

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER

Please list the individuals you authorize to be involved in your children's medical treatment, including bringing them to appointments and obtaining medical information:

NAME	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION *(PLEASE NOTE: INSURANCE INFORMATION IS REQUIRED TO FILE FOR BENEFITS)*

Primary insurance company	Policy Holder	Policy number	Group number
Secondary insurance company	Policy Holder	Policy number	Group number

CONDITIONS OF REGISTRATION

- **CONSENT FOR TREATMENT**

The undersigned 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.

- **AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS**

I 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 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, 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. I agree to pay any applicable charges for having medical records copied. If an entire medical record is needed, a fee of $5 per disk or .72 per page.

- **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.

- **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 those for whom I am the guarantor. 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. Assistance in this matter granted by The Practice is given as a courtesy and implies no responsibility on The Practice's part for filing, follow-through or confirmation. I agree to pay a $25.00 fee for missed appointments that are not cancelled at least 24 hours in advance. I understand that missed appintments 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 $35.00 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 the maximum allowed service charge, 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 regarding my (our) insurance coverage is correct and accurate. 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 certify that I have read the foregoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

***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.**

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

WARRENTON AND LINTON HALL PEDIATRICS, LLC

NOTICE OF PRIVACY PRACTICES – PLEASE READ CAREFULLY AND KEEP FOR YOUR RECORDS

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 your 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.

- 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 must abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and make the new notice provisions effective for all protected health information we maintain. We will post and you may request a written copy of 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.

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
P: 202-619-0257 Toll Free: 877-696-6775

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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.

Parent/Patient/Guardian Signature _____ Date _____