

# PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC

OFFICIAL USE ONLY  
DATE

INITIAL

FAMILY HISTORY NUMBER

FATHER \_\_\_\_\_  
NAME DOB SSN

MOTHER \_\_\_\_\_  
NAME DOB SSN

PARENTS' MARITAL STATUS SINGLE MARRIED SEPARATED DIVORCED WIDOWED

CHILD LIVES WITH PARENTS MOTHER FATHER OTHER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
STREET APARTMENT #  
CITY STATE ZIP CODE

NAME OF NON-CUSTODIAL PARENT (IF APPLICABLE) MOTHER FATHER OTHER \_\_\_\_\_

THEIR ADDRESS (IF APPLICABLE) \_\_\_\_\_  
STREET APARTMENT #  
CITY STATE ZIP CODE

## INSURANCE INFORMATION

MEDICAL INSURANCE SUBSCRIBER # GROUP #

## TELEPHONE NUMBERS (PLEASE CHECK PREFERRED NUMBER)

HOME \_\_\_\_\_   
MOTHER'S WORK \_\_\_\_\_   
FATHER'S WORK \_\_\_\_\_   
CELL PHONE # (MOTHER) \_\_\_\_\_   
CELL PHONE # (FATHER) \_\_\_\_\_   
CELL PHONE # (TEENAGER) \_\_\_\_\_

## EMERGENCY CONTACT (IF PARENT NOT AVAILABLE)

NAME \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
TELEPHONE # \_\_\_\_\_   
CELL PHONE # \_\_\_\_\_

FATHER \_\_\_\_\_  
EMPLOYER OCCUPATION

MOTHER \_\_\_\_\_  
EMPLOYER OCCUPATION

PRIMARY DOCTOR AT PEDIATRIC ASSOCIATES \_\_\_\_\_

## ALL CHILDREN (INCLUDE NEWBORN)

REFERRED BY: \_\_\_\_\_

LAST NAME	FIRST NAME	MIDDLE	DOB	SEX	SSN
_____	_____	_____	____/____/____	M_F	- -
_____	_____	_____	____/____/____	M_F	- -
_____	_____	_____	____/____/____	M_F	- -
_____	_____	_____	____/____/____	M_F	- -
_____	_____	_____	____/____/____	M_F	- -

## DRUG ALLERGIES

\_\_\_\_\_  NONE  
 \_\_\_\_\_  NONE  
 \_\_\_\_\_  NONE  
 \_\_\_\_\_  NONE  
 \_\_\_\_\_  NONE

PLEASE READ AND SIGN BACK OF FORM

## CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY GUARANTEE

- 1. CONSENT TO MEDICAL CARE:** By my signature below, I warrant that I am the parent of the registered child(ren) named in the Patient Registration Record on the reverse side of this page. I hereby request and authorize the physicians and other health care providers of Pediatric Associates of Charlottesville and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the condition(s) that have brought about my seeking medical care services for my child(ren) at the offices of Pediatric Associates. I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examinations and treatment rendered by the physicians and professional staff of Pediatric Associates of Charlottesville.
- 2. RELEASE OF MEDICAL RECORD INFORMATION:** I hereby authorize Pediatric Associates of Charlottesville to disclose all or any part of the contents of the medical record of the patients named in this Registration Record to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s). This authorization is given with the full knowledge and understanding that such disclosure may contain information which may result in a denial of insurance benefits or which otherwise may not serve the interests of the registered patient(s) or myself.
- 3. ASSIGNMENT OF INSURANCE BENEFITS:** I hereby request and authorize that any and all insurance benefits due and payable for medical services rendered to the registered patient(s), be paid directly to Pediatric Associates of Charlottesville.
- 4. FINANCIAL AGREEMENT AND GUARANTEE:** I accept full and complete financial responsibility for all medical services rendered to the registered patient(s) and I agree to pay any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies as well as to pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plans. I further acknowledge, understand and agree, that in the event I fail to make such payments in accordance with the payment policies of Pediatric Associates of Charlottesville, or in the event of default of my financial obligations to pay for services rendered, Pediatric Associates of Charlottesville may terminate the "doctor-patient" relationship with the registered patient(s) in accordance with the Code of Virginia. Further, in the event of default of my financial obligations, I agree to pay all costs associated with collection actions taken by Pediatric Associates of Charlottesville to enforce payment, including reasonable attorneys fees, court costs, and/or collection agency fees, including but not limited to, a collection processing fee not to exceed \$85.00.  
  
I understand that in the event the patient(s) are not covered by a medical insurance plan, I will be required to make a minimum payment of \$20 at the time of each office visit before medical care will be rendered. I further understand that the payment of the deposit represents only a partial payment of the total fees that may be charged for the medical services to be rendered, and that I will receive a statement for the total charges incurred, which I agree to pay, in full, in accordance with the credit and collection policies of Pediatric Associates of Charlottesville.
- 5. HIV/HEPATITIS B OR C TESTING:** I acknowledge that I am hereby informed in accordance with Section 32.1-45.1 of the Code of Virginia, as amended, that if the provisions of health care service to the registered patient(s) exposes any health care provider to the patient's body fluids in a manner which may transmit immunodeficiency virus or HIV or Hepatitis B or C viruses, that the patient shall be deemed to have consented to testing for infection with HIV or Hepatitis B or C viruses, and to the release of such test results to the person(s) exposed, as provided by law.
- 6. CORRECT INFORMATION:** The undersigned certifies that he/she has provided correct information in this Patient Registration Record and understands that any false statements or concealment of material may in fact be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient's parent or legal representative, duly authorized to execute the above and to accept its terms.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient(s):** \_\_\_\_\_