Primary Doctor at Pediatric Associates _____

Patient Name | Date of Birth | Gender (M,F,I, TM, TF,O) | Patient's SSN

Billing Address | City | State | Zip Code

Cell Phone | Work Phone | Home Phone

Email Address | Occupation/Student | Employer/School

Best Contact Number: ❑Home ❑Work ❑Cell (❑OK to send text messages)

EMERGENCY CONTACTS: Add at least one person

Name | Relationship | Phone number

Insurance Information: ❑Private, ❑Medicaid, ❑Self Pay
Responsible Party (responsible for the insurance): ❑ Self, ❑Other, (if other fill out remainder of this box)

Name | Date of Birth | Relationship to Patient

Street Address | City | State | Zip Code

Cell Phone | Work Phone | Home Phone

PREFERRED PHARMACY_____

Permission to speak with your parents/guardians/other adults
I give the doctors and nurses of Pediatric Associates permission to discuss my health with the following people:

Name | Relationship | Name | Relationship

Unless you check the following we will **not** discuss reproductive health (STIs, pregnancy, birth control) or mental health with others or allow others to call for refills.

Check below if you give permission to:

- ❑ Pediatric Associates to discuss **reproductive health with the above people,**
- ❑ Pediatric Associates to discuss **mental health with the above people**
- ❑ the above people to **call for refills**

Signature **Date**

FILL OUT THE BACK PAGE

Financial Policy
I accept full financial responsibility for all medical services rendered. I agree to pay all insurance co-payments, deductibles, and co-insurance under the terms of my health insurance plan. I accept full financial responsibility for all medical services rendered. I understand that co-payments are due on the date services are rendered. I understand that in the event that I fail to make such payments or default on my payments that the doctor-patient relationship may be terminated. In the event of default of my financial obligations, I agree to pay all relevant costs associated with collection actions taken by Pediatric Associates. I accept full responsibility for assigning Pediatric Associates as my PCP on my insurance. I understand that patients without health insurance will be required to pay a $50.00 fee at time of service, and any additional charges will be billed to me. I authorize that all insurance benefits due and payable for medical services rendered be paid directly to Pediatric Associates. I authorize Pediatric Associates to disclose any parts of my medical record to my insurance company so that an insurance claim may be processed, or as may be required by the contract with the insurance company. I am responsible for charges accrued by me. I understand that Pediatric Associates is HIPAA compliant and will protect my personal information. I certify that I have provided the correct information on this Patient Registration and understand that I may be prosecuted for any false statements or concealment of material under applicable federal and state laws.

Consent to Medical Care
I accept the conditions of the financial policy printed on this form. I hereby request and authorize the providers of Pediatric Associates of Charlottesville to perform any medical diagnostic procedures, 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 of medical care services. Additionally, I acknowledge that I am hereby informed in accordance with the Code of Virginia Section 32.1, that if the provisions of health services expose any health care worker to my body fluids in a manner that may transmit HIV or hepatitis, that I shall be deemed to have consented to testing for the infections and to release the test results to the person(s) exposed.

_____

Signature Date

Language: ❑English, ❑Spanish, ❑Arabic, ❑Portuguese, ❑French, ❑Italian, ❑Russian, ❑Hindi, ❑Tamil, ❑Other_____

Race: ❑Decline to answer, ❑American Indian/Alaska Native, ❑Asian, ❑Black/African American, ❑Native Hawaiian/Other Pacific Islander ❑Hispanic, ❑White, ❑Other_____

Ethnicity: ❑Decline to answer, ❑Hispanic or Latinx, ❑Not Hispanic or Latinx, ❑Other _____

Pediatric Associates of Charlottesville conducts clinical research trials in conjunction with **Pediatric Research of Charlottesville**
May we have permission for Pediatric Research of Charlottesville to contact you if your child appears to be eligible to participate in a research study?

❑**Yes**, feel free to contact me if there is an appropriate study for which my child may be eligible

❑**No,** do not contact me for any clinical research study