# PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC

Patient Registration Record Page 1 of 2 (see reverse for page 2)

OFFICIAL USE ONLY
DATE

INITIAL

FAMILY HISTORY NUMBER

Father _____
Last Name First Name DOB SSN

Mother _____
Last Name First Name DOB SSN

Parents' Marital Status Single Married Separated Divorced Widowed Partnered

Patient Lives With _____

Mailing Address _____

Street Address _____

Telephone numbers (check preferred number)
Home _____ ❍
Mother's work _____ ❍
Father's work _____ ❍
Mother's cell _____ ❍
Father's cell _____ ❍
Adolescent's cell _____ ❍

**Emergency Contact**
Name _____
Relationship _____
Home # Cell # _____

Father _____
Employer Occupation

Mother _____
Employer Occupation

Primary Doctor at Pediatric Associates _____

**List all family members (INCLUDING NEWBORNS) who are patients of Pediatric Associates**

Last Name First Name List Drug Allergies below

1. _____ DOB_____ M F Doctor _____ _____ ❑ None
2. _____ DOB_____ M F Doctor _____ _____ ❑ None
3. _____ DOB_____ M F Doctor _____ _____ ❑ None
4. _____ DOB_____ M F Doctor _____ _____ ❑ None
5. _____ DOB_____ M F Doctor _____ _____ ❑ None

Consent to Medical Care

By my signature below, I warrant that I am the parent or legal guardian of the registered child(ren) listed above, or I am a patient who is 18 years old or older. 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 patient's condition and/or provide well child care. Additionally, 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 services exposes any health care worker to the patient's body fluids in a manner that may transmit immunodeficiency virus or HIV or Hepatitis, that the patient shall be deemed to have consented to testing for the infections and to release the test results to the person(s) exposed.

_____
Name Date Relationship to Patient

Consent to the Treatment of Minors

I authorize the providers at Pediatric Associates of Charlottesville to provide medical care to my child(ren) in my absence when accompanied by the following persons:

_____
Name Relationship to patient

_____
Name Relationship to patient

**Please Read, Initial and Sign Back of Form**

# PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC



## FINANCIAL AGREEMENT

Please initial:

_____ I accept full financial responsibility for all medical services rendered to my children. I agree to pay all insurance co-payments, deductibles, and co-insurance under the terms of their health insurance plan.

_____ I am a patient who is 18 years old or older and I accept full financial responsibility for all medical services rendered.

_____ Co-payments are due on the date services are rendered. A $5.00 Billing fee will be added to your account if a co-pay is not made at the time of service.

_____ 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 the PCP on my child(ren)'s health insurance.

_____ Patients without health insurance will be required to pay a $20.00 fee at time of service. Any additional charges will be billed to you.

_____ I authorize that all insurance benefits due and payable for medical services rendered be paid directly to Pediatric Associates of Charlottesville.

_____ I authorize Pediatric Associates to disclose any parts of my child(ren)'s medical record to my child's 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 my child(ren) under the age of eighteen whether unaccompanied or in the presence of a parent or caregiver.

_____ I accept responsibility for charges for my children over eighteen.

_____ I understand that Pediatric Associates is HIPAA compliant and will protect my child(ren)'s personal information.

Pediatric Associates of Charlottesville conducts clinical research trials in conjunction with Pediatric Research of Charlottesville. Clinical trials study many different aspects of health. They may involve studying vaccines, infectious diseases, migraines, asthma and ear treatments.

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?

❑ Y**es**, feel free to contact me if there is an appropriate study that my child may be eligible to participate in.

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

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.

Signature Date Relationship to patient