PATIENT REGISTRATION RECORD – 18 Years Old Or Older

PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC

OFFICIAL USE ONLY
DATE

INITIAL

FAMILY HISTORY NUMBER

Patient Last Name _____ Primary Dr. at Pediatric Associates _____

First Name _____ Middle Name _____ Patient's Date of Birth _____

Nickname/Name patient is called *(if different from first name)* _____ Patient's Sex *(circle one)* Male Female

Mailing Address _____ Patient's SS# _____

City _____ Street Address is the same as mailing address ❍

State _____ Zip _____ *if different*, Address _____

Please check preferred number to call (❍) City _____ State _____ Zip _____

Home Phone ❍ _____ Patient cell ❍ _____ email address _____

Patient's Employer _____

Mother's name _____ Mother's cell ❍ _____ email address _____

Father's name _____ Father's cell ❍ _____ email address _____

Other important phone #s (significant other, roommate, stepparent, grandparent, other...) _____

Name _____ relationship _____ phone # _____ email address _____

Responsible Party (person who is responsible for medical bills)

❍ I am responsible for my medical bills.

❍ My parent, as verified by signature below, accepts responsibility for my medical bills.

Responsible Party's name _____

Date of Birth _____ Sex _____ Relationship _____

Emergency Contact _____

Name _____

Phone # _____

Relationship _____

Insurance Information _____
Medical Insurance Company Policy # Group #

_____
Subscriber (Policy Holder) Policy Holder date of birth

Primary Pharmacy _____

MEANINGFUL USE **Meaningful use is a government mandate for healthcare providers to improve health care quality, safety, and efficiency through the promotion of health information technology.

Please check one:
**Race: ___ American Indian/Alaska Native ___ Asian ___ Black/African American
___ Native Hawaiian or Other Pacific Islander ___ Hispanic ___ White ___ Decline to Report

Please check one:
**Ethnicity: ___ Hispanic or Latin ___ Not Hispanic or Latin ___ Decline to Report

Please check one:
**Language: ___ English ___ Spanish ___ Russian ___ Indian (includes Hindi & Tamil) ___ Other

CONSENT TO TREATMENT

I have reviewed and accept the conditions of the financial policy printed on the reverse. I certify that I have provided correct information on this Patient Registration form and understand that any false statement or concealment of material may be prosecuted under applicable federal and state laws.

I hereby request and authorize the providers of Pediatric Associates of Charlottesville (PAC) to perform medical diagnostic procedures and medical and 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, as amended, that if the provisions of health care services exposes any health care worker to my body fluids in a manner that may transmit immunodeficiency virus or 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.

_____
Patient's Signature Print Name Date

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

_____
Parent's Signature Print Name Date

_____
Billing Address City State Zip

Please Read, Initial and Sign Back of Form

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Permission to speak with your parents/guardians

❑ I give the doctors and nurses of Pediatric Associates permission to discuss my health with the following people.

Name _____ Relationship _____

Name _____ Relationship _____

Check any exclusions, do not discuss the following:

❍ Reproductive Health (STDs, pregnancy, birth control...)

❍ Mental Health (includes ADD, ADHD)

❍ Other _____

(specify)

❑ I do not give the doctors and nurses of Pediatric Associates permission to discuss anything with my parents.

Check one:

❍ my parent/guardian may call for refills.

❍ my parent/guardian may not call for refills.

_____

Patient's Signature

Insurance Information

Medical Insurance Company	Policy #	Group #
Subscriber (Policy Holder)	Policy Holder's Birthdate	
Preferred Pharmacy		

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 their health insurance plan.

IMBS (Pediatric Associates billing service) will accept payments to my account by my parent(s)/guardian(s).

Co-payments are due on the date services are rendered. A $5.00 billing fee will be added to my account if I do not make this co-payment at the time of service.

I understand that if I fail to make payments on my account, 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 and delegated collection companies.

I accept full responsibility for assigning Pediatric Associates as the Primary Care Physician on my 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 me.

I understand that Pediatric Associates of Charlottesville is 100% HIPPA compliant and will protect my personal information.

I authorize Pediatric Associates to disclose all or any parts of my medical record to insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered.

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

I certify that I have provided correct information on this Patient Registration form and understands that any false statements or concealment of material may be prosecuted under applicable federal and state laws.

_____

Patient's Signature Print Name Date