PATIENT REGISTRATION RECORD 18 YEARS OR OLDER

PEDIATRIC ASSOCIATES OF CHARLOTTESVILLE, PLC

_____
Primary Dr at Pediatric Associates

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

Mailing Address | City | State | Zip Code

Cell Phone | Home Phone | Work Phone

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

Email Address | Employer or School

If Street Address is Different From Mailing Address:

Street Address | City | State | Zip Code

Emergency Contact Information:

○ Mother, ○ Father, ○ Stepmother, ○ Stepfather, ○ Grandmother, ○ Grandfather, ○ Foster Parent, ○ Other_____

Name | Phone Number | Email address

Parent's Information:

○ Mother, ○ Father, ○ Stepmother, ○ Stepfather, ○ Grandmother, ○ Grandfather, ○ Foster Parent, ○ Other_____

Name | Phone Number | Email address

Parent's Information:

○ Mother, ○ Father, ○ Stepmother, ○ Stepfather, ○ Grandmother, ○ Grandfather, ○ Foster Parent, ○ Other_____

Name | Phone Number | Email address

Other important phone numbers (significant other, roommate, stepparent, grandparent, other)**:**

1._____ 2._____

Name | Relationship | Phone number | Name | Relationship | Phone number

3._____ 4._____

Name | Relationship | Phone number | Name | Relationship | Phone number

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 in each group.

Race: ____American Indian/Alaska Native ____Asian ____Black/African American ____Native Hawaiian/Other Pacific Islander ____Hispanic ____White ____Decline to Report

Ethnicity: ____Hispanic or Latin ____Not Hispanic or Latin ____Decline to Report

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 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 the patient's body fluids in a manner that may transmit 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.

_____

Signature **Print Name** **Date**

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Permission to speak with your parents/guardians

○ I **do not** give the doctors and nurses of Pediatric Associates permission to discuss anything with my parents/guardians

○ 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 your parents.
I give the doctors and nurses of Pediatric Associates permission to discuss ○ **reproductive health,** ○ **mental health** with the above people

Check one:

○ My parent/guardian **may** call for refills

○ My parent/guardian **may not** call for refills

_____

Signature **Print Name** **Date**

Responsible Party (who pays the bill): ○ I am responsible for my medical bills and the information is the same as above
○ My parent, as verified by signature below, accepts responsibility for my medical bills

_____

Parent's Name Date of Birth Relationship to Patient

_____

Billing Address City State Zip Code

Insurance Information _____

Medical Insurance Company Policy # Group #

_____

Subscriber (Policy Holder) Policy Holder Date of Birth

FINANCIAL POLICY

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

I accept full financial responsibility for all medical services rendered.

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 the PCP on my/my child's insurance.

Patients without health insurance will be required to pay a $50.00 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.

I authorize Pediatric Associates to disclose any parts of my/my child's medical record to the insurance company so that an insurance claim may be processed, or as may be required by the contract with the insurance company.

I understand that Pediatric Associates is HIPAA compliant and will protect the patient's personal 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 by prosecuted under applicable federal and state laws.

_____

Signature **Date** **Relationship to Patient**

_____

Print Name