Pediatric Associates of Alexandria

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PATIENT REGISTRATION BH

PLEASE PRINT –FILL ALL AREAS IN BLACK INK

FIRST NAME	LAST NAME	MIDDLE INITIAL	BIRTHDATE	SEX
				M F

Mailing Address

Home Address		Social Security Number	Home Phone Number ( )
City	State	Zip	Cell Phone Number ( )
Employer name & Address			Work Phone Number ( )

Authorization To Disclose Health Information

I, _____, am 18 years of age (or older). I give Pediatric Associates of Alexandria authorization to disclose my health information to the following person(s):

Name: Relationship:

_____

_____

This form remains in full effect until rescinded in writing by the patient.

Emergency Contact (Friend or Relative)

Name	Relationship	Home Phone Number ( )

Insurance Information *Insurance info and copy of insurance cards needed to file for benefits*

Policy Holder's Name & Address		Social Security Number of Subscriber	Co-Payment / Co-Insurance Amount	
Primary Insurance Company	Identification / Policy Number	Sex of Policy Holder ❒Male ❒Female	Birthdate of Policy Holder	Effective Date

Try our new patient portal, ask our receptionist for details, sign up by providing us with your email:

PLEASE MAKE SURE FORM IS COMPLETELY FILLED OUT
PAYMENT IS DUE AT TIME OF SERVICE

(TURN OVER)

Read Conditions of Registration on the Back of this Form

CONDITIONS OF REGISTRATION

THE PRACTICE
Pediatric Associates of Alexandria, Inc. and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT
The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION
In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/HEPITITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPITITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS
I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION
I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Health Care Financing Administration, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons I agree to pay any applicable charges for having records copied. Such charges not to exceed .50 per page for the first 50 pages and .25 per page thereafter in addition to a $10.00 Administrative/regular postage/handling fee.

REFERRALS AND AUTHORIZATIONS
I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from The Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify The Practice prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT
I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by my children, step children or any other extended family members, I (we) are financially responsible for; including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with the services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or conformation. **I understand that I am responsible for and agree to pay the $10.00 late fee for each co-payments not paid at the time of visit. I understand that I am responsible for and agree to pay the assessed $40.00 Emergency Walk-In Fees in addition to the office visit if I arrive without a scheduled appointment, excluding scheduled walk in clinic hours. I understand that I am responsible for and agree to pay a $50.00 Late Missed Appointment Fee for all scheduled appointments that I was more than 15 minutes late for. I also agree to pay a $100.00 Missed Appointment Fee for all Missed Appointments or that were not cancelled with at least 24 hours advance notice. I understand that missing three scheduled appointments may terminate my relationship from the practice. Rx refill outside of office visit is self-pay, always $40.00. Letters outside of office visit is self-pay, always $25.00. I understand that I am responsible for and agree to pay a $20.00 "Emergency After Hours fee" for all after hour's calls to the covering provider. These after hour calls are considered an emergency; and will be charged to the member's account on the date services were rendered. The after hour calls are not covered by commercial and or Medicaid policies and are the member's responsibility. I understand that I am responsible for and agree to pay a $10.00 administrative fee for each form I request to be completed.** I understand that I am responsible for the entire balance in my child's account; including co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason. I understand and agree that I am expected to pay all balances within 30 days of services being rendered. I understand and agree that if for any reason my personal check is returned for any reason, including insufficient funds on my account I will be assessed and responsible for a $50.00 Returned Check Fee in addition to ALL original fees for services. Interest of one and one-half percent per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree to pay one-third of the unpaid principal and interest as a collection fee, plus court costs and interest in the amount of one and one-half percent per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) assume full responsibility. PAA is required to report all services rendered, to your insurance carrier; even those that occur outside of normal business hours (M-F 8am-4:50pm). I understand that I am responsible for and agree to pay all balances rendered patient responsibility by my insurance carrier.

COPY OF SIGNATURE
I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION
I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

Information *Insurance info and copy of insurance cards needed to file for benefits.*

I agree to terms & conditions of registration. I certify that the information I have reported is true and correct. As the Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on the Conditions of Registration Form. *****In cases of divorce or separation, unless otherwise specified in a court order, I understand that both parents will be permitted to schedule appointments, bring the child(dren) in for exams, and have full access to the child's medical records. If you have any concerns in this area, please contact the office supervisor for further questions.

Signature of Patient	Print Name	Date

Updated:12/16