VIRGINIA PEDIATRIC AND ADOLESCENT MEDICINE, PLC

❒ New Patient
❒ Existing/Update

PATIENT REGISTRATION

Account No.

Patient Information

PLEASE PRINT –FILL ALL AREAS

CHILD'S FIRST NAME	LAST NAME	NICK NAME	BIRTHDATE	SEX	INSURANCE ID#	DRUG ALLERGIES
1				M F		
2				M F		
3				M F		
4				M F		
5				M F		

Mother ❒Mother ❒Stepmother ❒Married ❒Unmarried ❒Divorced

If divorced, does child reside with Mother? **YES / NO** (Circle One)

Mother's Full Name	Date of Birth	Social Security Number	Home Phone Number
			( )
Home Address		City	State / Zip
Mother's Employer Name & Address			Work Phone Number
			( )
Mother's Home E-mail	Mother's Work E-mail	Cell Phone Number	Pager Number

Father ❒Father ❒Stepfather ❒Married ❒Unmarried ❒Divorced

If divorced, does child reside with Father? **YES / NO** (Circle One)

Father's Full Name	Date of Birth	Social Security Number	Home Phone Number
			( )
Home Address		City	State / Zip
Father's Employer Name & Address			Work Phone Number
			( )
Father's Home E-mail	Father's Work E-mail	Cell Phone Number	Pager Number

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	Social Security Number of Subscriber	Co-Payment / Co-Insurance Amount
Primary Insurance Company	Sex of Policy Holder ❒Male ❒Female	Birthdate of Policy Holder / Effective Date
Policy Holder's Employer	Employer Plan? ❒Yes ❒No	Identification/Policy Number
Insurance Address	Insurance Network	Group Number
City	State / Zip	Insurance Phone Number for Eligibility/Verification ( )

I certify that the information I have reported above is correct and will notify Virginia Pediatric and Adolescent Medicine, PLC of any changes immediately.

Signature of Parent/Guardian/Guarantor	Print Name	Date
Signature of Parent/Guardian/Guarantor	Print Name	Date

PAYMENT IS DUE AT TIME OF SERVICE

CONDTIONS OF REGISTRATION

THE PRACTICE

Virginia Pediatric and Adolescent Medicine, PLC and/or its physicians, employees, agents or assignee 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 not limited to, surgery, laboratory and x-ray procedures. Services may also include Telephone Triage Services as provided by University Hospital Rainbow Babies Call Center after normal business hours.

HIV/HEPATITIS B & C VIRUSES AND TESTING NOTIFICATION

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

AUTHORIZATION & ASSIGNMENT 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).

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 Centers for Medicare and Medicaid Services, 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 information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for 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 medical records copied.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorizations 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 of the 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 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 agree that payment in full is due at the time of treatment. 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, including but not limited to grandchildren, nieces and nephews. I also understand that I (we) may be billed separately for services rendered by other professional including but not limited to other physicians, radiologists, and laboratory work, as appropriate and in accordance with services rendered. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with 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 confirmation. I agree to pay the Emergency/Walk-in fee of $50.00 in addition to the office visit if I arrive without an appointment. I agree to pay the After Hours Fee of $50.00 fee in addition to the office visit for any appointment scheduled after normal business hours (after 5pm M–F and Saturdays). I agree to pay Sunday/Holiday Fee of $28.00 fee in addition to the office visit for any appointment scheduled on a Holiday or Sunday. I agree to pay a $20.00 fee for each after hour telephone call for medical advice including calls returned by Rainbow Babies Call Center. I agree to pay a $20.00 form fee. I agree to pay a $35.00 fee for missed appointments that are not cancelled at least 24 hours in advance. I agree to pay a $10.00 billing fee for each payment, including co-payments and co-insurance, not made at the time of the visit. I agree to pay a $20.00 prescription refill fee for refills on prescriptions. I understand that Emergency/Walk-in, after hour telephone advice fee, form fee, missed appointment, billing and prescription refill fees will be my financial responsibility and will not be sent to insurance. Should any balances arise due to insurance co-payments, co-insurances, deductibles, termination of coverage, not adding dependent to insurance plan, non-payment of premium or non-payment at the time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for $30.00 returned check fee in addition to the original fees for services. Service charges of one and one-half percent per month, eighteen percent 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 service charge as an attorney fee, plus court costs and service charge 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 service charge, shall become an additional liability for which I (we) assume full responsibility.

CELL PHONE USE

We respectfully request that you turn off your cell phone during your child's visit. Any recording, photographic, video or audio is prohibited.

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 foregoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

I certify as the Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration.

_____	_____	_____
Signature of Parent/Guardian/Guarantor	Print Name	Date

_____	_____
Patient Name	Date of Birth

Virginia Pediatrics and Adolescent Medicine, PLC
5275 Lee Highway Suite 200
Arlington, VA 22207
(703)717-4090 phone (703)717-4091 fax

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under Health Insurance Portability and Accountability Act of 1996 HIPPA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand Virginia Pediatric and Adolescent Medicine, PLC *Notice of Privacy Practices* containing more complete description of the uses and disclosures of my health information. I understand that Virginia Pediatric and Adolescent Medicine PLC, has the right to change its *Notice of Privacy Practices* from time to time and I may contact at any time during business hours and obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Virginia Pediatric and Adolescent Medicine, PLC restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Virginia Pediatric and Adolescent Medicine, PLC is not required to agree to my requested restrictions, but if does agree the Virginia Pediatric and Adolescent Medicine, PLC is bound to abide by such restrictions.

☐ I DO NOT authorize Virginia Pediatric and Adolescent Medicine, PLC to discuss my billing/medical information with any other individual.

I authorize Virginia Pediatric and Adolescent Medicine, PLC to discuss my billing/medical information with:

☐ Parents of minor child authorized only

☐ Other: Name:_____ Relationship:_____

Patient Name: _____ Relationship to Patient:_____

Signature: _____ Date: _____

I received a copy of this acknowledgement (initials): _____

OFFICE USE ONLY

Virginia Pediatric and Adolescent Medicine, PLC attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date:____/____/____ Initials:_____ Reason:_____

HIPAA Notice of Privacy Practices

Revised 2019

Effective as of January 31, 2019
Revised January 31, 2019

Virginia Pediatrics and Adolescent Medicine
5275 Lee Highway Suite 200
Arlington, VA 22207
703-717-4090

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Telephone Triage Services: The practice may use the services of University Hospital *Rainbow Babies Call Center*, your information may be disclosed for advice purposes as indicated above under "Treatment". Service times may vary based on practice needs.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS: The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. Please be advised we require a signed request in order to release information via email since it is not considered a secure means of transmission for health protected information. We will be happy to email requested information with your signed release, or we can mail to your home address. You can also pick up at the office. For the same reason email sent to us is also not considered secure. You are waiving your right to privacy by doing so.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Janet Dombroski	703-717-4090	jdvapeds@gmail.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Initial History (Pediatric)

Name of Patient_____ Sex: ___Male ___Female DoB ___ /___ /___ Chart #

Form Completed by _____ Relation to patient _____ Date ___ /___ /___

Family

Are mother and father ☐ married ☐ separated /divorced ☐ other?

If separated / divorced, what is the patient's custody status?_____

_____

If one or both parents are not living in the home, how often does child see that parent(s)?_____

_____

Are there siblings living away from home? ☐ Yes ☐ No

If yes, give name, age and where they live:_____

_____

List all family members living in the patient's home

Name	Relation	Birth Date	Health Problems
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		___ /___ /___	
		/ /	

Current Medical History

Are immunizations up to date? ☐ Yes ☐ No

Is your child having any medical problems? ☐ Yes ☐ No

Do you consider your child to be in good health? ☐ Yes ☐ No

Current Medications:

Drug Allergies? ☐ Yes ☐ No

Review of Systems and Past Medical History

Does the patient have or has ever had any of the following:	Yes	No	*Explain*
1. a serious medical problem?	☐	☐	
2. been hospitalized or had surgery?	☐	☐	
3. had a serious injury or accident?	☐	☐	
4. chickenpox? When?_____	☐	☐	
5. allergies, asthma, bronchitis, respiratory infections?	☐	☐	
6. repeated ear infections, tubes, difficulty with hearing?	☐	☐	
7. problems with eyes or vision?	☐	☐	
8. heart problems or a heart murmur?	☐	☐	
9. anemia, bleeding problems or blood transfusion?	☐	☐	
10. abdominal pain, constipation requiring doctor visits?	☐	☐	
11. recurrent vomiting, recurrent diarrhea, blood in stools?	☐	☐	
12. bladder or kidney infections, bed-wetting after 5 yrs.?	☐	☐	
13. recurrent skin problems (acne, eczema, etc)?	☐	☐	
14. headaches, convulsions, other neurologic problems?	☐	☐	
15. diabetes, thyroid or other endocrine problems?	☐	☐	
16 . If female, has she started her menstrual periods?	☐	☐	
If yes, is she having any problems?	☐	☐	

History Update *(date / initial) Changes in history noted in chart on day of update.*

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

_____ ___ _____ ___ _____ ___ _____ ___ _____ ___ _____ ___

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Name of Patient_____ Date ___ /___ /___ Chart #_____

Development *Are you concerned about the patient's...*

	Yes	No	
1. physical development?	☐	☐	_____
2. mental or emotional development?	☐	☐	_____
3. learning ability?	☐	☐	_____
4. attention span or activity level?	☐	☐	_____

If in school, has the patient had...

1. tutoring outside of the classroom?	☐	☐	_____
2. placement in a special or resource class?	☐	☐	_____
3. to repeat a grade?	☐	☐	_____
4. educational or psychological testing?	☐	☐	_____
5. behavioral problems?	☐	☐	_____

Maternal and Newborn History

Pregnancy *Check if the mother had any of the following problems:*

☐ excessive wt. gain ☐ urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ venereal disease ☐ other ☐ none

_____

_____

Did the mother smoke, use drugs or alcohol during pregnancy? ☐ Yes ☐ No

Birth

Birth Weight _____ Length _____ Apgar _____ Was baby born at: ☐ Term ☐ Early ☐ Late

If early, how many weeks gestation? _____ Was labor difficult or prolonged? ☐ Yes ☐ No

Was delivery difficult or complicated? ☐ Yes ☐ No _____

_____

_____

Newborn *Check if the patient had any of the following problems:*

☐ feeding problems: ☐ Breast _____ ☐ Formula _____

☐ slow weight gain ☐ multiple formula changes ☐ colic ☐ jaundice ☐ recurring vomiting ☐ recurring diarrhea

☐ blood in stools ☐ other ☐ none _____

_____

Family History

If a family member has or has had any of the following problems, check the appropriate box and list the family member:
M-Mother F-Father S-Sibling GM-Grandmother GF-Grandfather A-Aunt U-Uncle

1. ☐ _____ Allergies	12. ☐ _____ Ear infections / tubes	23. ☐ _____ Learning prob. / Attent. span
2. ☐ _____ Anemia / Blood disorders	13. ☐ _____ Eczema	24. ☐ _____ Liver disease
3. ☐ _____ Arthritis	14. ☐ _____ Emotional / Behavioral	25. ☐ _____ Mental illness
4. ☐ _____ Asthma	15. ☐ _____ Epilepsy or convulsions	26. ☐ _____ Mental retardation
5. ☐ _____ Birth defects	16. ☐ _____ Eye or visual problems	27. ☐ _____ Migraine Headaches
6. ☐ _____ Bladder / Kidney	17. ☐ _____ Heart attack / stroke before 50 yrs	28. ☐ _____ Obesity
7. ☐ _____ Cancer	18. ☐ _____ Heart problems, other	29. ☐ _____ Respiratory infections
8. ☐ _____ Deafness	19. ☐ _____ Hereditary problems	30. ☐ _____ Stomach / GI
9. ☐ _____ Diabetes before 50 yrs	20. ☐ _____ High blood pressure before 50 yrs	31. ☐ _____ Thyroid or other endocrine prob.
10. ☐ _____ Drug / Alcohol abuse	21. ☐ _____ High cholesterol	32. ☐ _____ Tuberculosis
11. ☐ _____ Drug allergies	22. ☐ _____ Immunity problems / HIV	33. ☐ _____ Other

Provider Comments

History Reviewed by_____