Blue Ridge Pediatric Associates, Ltd.
PATIENT REGISTRATION FORM

Patient Information:

Patient Name (Full):_________________________________Nickname: ________________ Sex: M__ F__

Address: ____ City: ____________________ State: _________

Zip: ________ Home Phone: _________________ Patient SSN: ___________ DOB: ____/____/_______

Do all children in family have the same guarantor (s), address, and insurance coverage? □ Yes □ No

Please list all siblings, including full name, nickname, SSN, & DOB)

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Parent/Guarantor Information

Mother's Name: _______________________________ DOB:____/____/_______ SSN: _______________

Address: ____ City: ____________________ State: _________

Zip: ________ E-mail Address: ________________________________ Home Phone: ________________

Employer: __________________________ Work Phone: __________________ Cell Phone: ____________

Father's Name: _______________________________ DOB:____/____/_______ SSN: _______________

Address: ____ City: ____________________ State: _________

Zip: ________ E-mail Address: ________________________________ Home Phone: ________________

Employer: __________________________ Work Phone: __________________ Cell Phone: ____________

Other Responsible Party (e.g. grandparent, step-parent, caregiver, foster guardian). Please list ANY persons you would like to authorize permission to have access to your appointment and health information or to bring your child for his/her appointment.

Name: _______________________________ Relationship: ______________ Phone: _________________

Name: _______________________________ Relationship: ______________ Phone: _________________

Name: _______________________________ Relationship: ______________ Phone: _________________

Preferred Pharmacy: _____________________________________ Address: ________________________

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Primary Insurance Information

Insurance Co. Name: ____________________________________ Phone Number: ____________________________

Address, City, State & Zip Code: ____

Policy ID: _____________________________________ Group ID: ____

Subscriber Name: ___________________________________ Relationship to Patient:__________________________

Subscriber DOB: _____________________________ Subscriber SSN: _____________________________________

Does your plan require referral and/or pre-authorization? □ Yes □ No Copay Amount: _______________________

Secondary Insurance Information

Insurance Co. Name: ____________________________________ Phone Number: ____________________________

Address, City, State & Zip Code: ____

Policy ID: _____________________________________ Group ID: ____

Subscriber Name: ___________________________________ Relationship to Patient:__________________________

Subscriber DOB: _____________________________ Subscriber SSN: _____________________________________

Does your plan require referral and/or pre-authorization? □ Yes □ No Copay Amount: _______________________

Emergency Contact Information

In case of emergency contact: ____

Relationship to patient: _________________________________ Emergency Contact Phone: ____________________

Consent to Release Information

Protected Health Information (including billing information) of the patient **may be released** to the following individual (s) *see also "Consent For Use and Disclosure of Protected Health Information."*

1. ____
2. ____
3. ____

By signing this document, I am affirming that I am the legal custodian of the patient (or have provided written authorization from legal custodian to seek medical treatment for patient), that all information supplied is accurate, that I have received and had the opportunity to review a notice of privacy practices from Blue Ridge Pediatric Associates, Ltd., and that I have reviewed and signed Blue Ridge Pediatric Associates, Ltd.'s financial agreement.

Signature: ____ Date: ____

Relationship to Patient: ____

Blue Ridge Pediatric Associates, Ltd.
PATIENT REGISTRATION FORM

Blue Ridge Pediatric Associates, Ltd.
337 Westside Station Drive, Winchester, Virginia 22601
(540) 667-5400

PAYMENT IS REQUIRED AT THE TIME MEDICAL SERVICES ARE RENDERED

Deemed Consent for Designated Blood Bourne Pathogens & Consent for Medical Care: I understand that Virginia law requires health care providers to notify me that hepatitis B and C or HIV (AIDS) Virus testing on a sample of my child's or ward's blood may be done if a health care worker is exposed to my child's or ward's blood or body fluids. I understand that this following notice is to advise that this is in effect at this facility:

As health care providers under the Virginia Acts of Assembly Sections 32.1-45.1, wherever any health care worker associated with or working for Blue Ridge Pediatric Associates, Ltd., is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or hepatitis B or C, Blue Ridge Pediatric Associates, Ltd. will proceed to test the patient through his or her physician and the health care worker (s) who was/were exposed. When a person is tested, Blue Ridge Pediatric Associates, Ltd. automatically tests for hepatitis B and C for the safety of all concerned.

I voluntarily consent to medical care at Blue Ridge Pediatric Associates, Ltd., which may include examination, tests, photographs, and treatments by doctors and staff. No promises have been made to me as to the results of this treatment or examination.

□_____________ (parent/guardian initials)

Fees & Payments: As a courtesy to its patients, Blue Ridge Pediatric Associates, Ltd. (through its affiliate ***Physician Business Solutions)*** is pleased to assist in the submission of medical insurance claims to insurance companies for payment. I understand that it is my responsibility to confirm that the physician that I see at Blue Ridge Pediatric Associates, Ltd., is a participating provider under my policy. Further, I understand that my insurance company may not cover 100% of my bills for services provided, and that I will be responsible for my entire account balance.

I understand that it is my responsibility to provide Blue Ridge Pediatric Associates, Ltd., with appropriate and current insurance information—and to notify Blue Ridge Pediatric Associates, Ltd., immediately upon any change in my insurance coverage—to ensure efficient claims billing and payment. In the event that I fail to provide all necessary and current insurance information, I understand that my insurance company may deny payment of claims relating in to services rendered to me, and *I understand that I may be fully responsible for my entire account balance.*

Furthermore, I understand that it is my responsibility to have obtained any and all necessary referrals and authorizations required prior to treatment by Blue Ridge Pediatric Associates, Ltd. If my insurance requires a referral and I do not have one, then *I understand that I may be fully responsible for the entire bill for rendered services*, or have the referral delivered to the office before I leave.

I understand that I will be responsible for paying, on behalf of my children or wards, co-payments, deductible, and any fees relating to services rendered that are not fully (or at all) covered by my insurance company. Finally, I understand that my co-payments are to be made at the time that services are rendered.

□_____________ (parent/guardian initials)

Patient Discharge / Collection Fees: In the event of failure to pay for medical services rendered to my children or wards, *I understand that the minor patient (s) may be discharged from Blue Ridge Pediatric Associates, Ltd.* Additionally I understand that I may be referred to a collection agency for non-payment of fees due for services rendered by Blue Ridge Pediatric Associates, Ltd. I understand that I will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process (such as court costs), that these fees and costs will be added to my account

balance. I understand that I will be responsible for paying the entire amount of my balance due in addition to the collection agency fee.

□_____________ **(parent/guardian initials)**

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Newborn Visits: I understand that Blue Ridge Pediatric Associates, Ltd. is unable to file insurance claims for newborns until they have been added to my insurance policy and verification from the insurance company has been received by me. This verification will be a new card or a letter stating that the newborn has been added to the policy. Prior to written proof of coverage, I understand that my newborn's account will be considered self-pay. I understand that Blue Ridge Pediatric Associates, Ltd. will hold the account for sixty (60) days. If insurance verification is not received, the claims will become my financial responsibility.

□_____________ **(parent/guardian initials)**

Returned Check Fee: I understand that in the event that my check is returned for insufficient funds, I agree to provide cash, money order or certified check for the full amount of the payment owed, in addition to a $30.00 returned check charge.

□_____________ **(parent/guardian initials)**

Missed Appointment Fee: I understand that I may be assessed a $25.00 fee if I miss an appointment without having provided a 24-hour advance notice of cancellation and that *failure to pay this fee may result in the minor patient being discharged from the service of Blue Ridge Pediatric Associates, Ltd.*

□_____________ **(parent/guardian initials)**

Assignment of Benefits: I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Blue Ridge Pediatric Associates, Ltd. for services rendered. I further consent to the use and disclosure of protected health information as regulated by HIPPA, and authorize the release of any information needed for the purposes of treatment, payment, and health care operations, but not limited to the processing these insurance claims. A copy of this authorization may be used in place of the original.

I understand that I am financially responsible for charges not paid by my insurance company.

□_____________ **(parent/guardian initials)**

I, THE UNDERSIGNED HAVE READ AND UNDERSTAND THIS INSURANCE INFORMATION & PAYMENT AGREEMENT. I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL, OR OTHER INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS OF MY CHILDREN OR WARDS, OR OTHERWISE OBTAIN PAYMENT, AND ACCEPT FULL RESPONSIBILITY FOR PAYMENT OF ANY FEE (S) NOT CONVERED BY INSURANCE.

I permit a copy of this authorization to be used in lieu of the original.

Parent/Guarantor Signature: ________________________________ Date: ______________________________

Relationship to patient: ____

Print Patient Name: ____