PIEDMONT PEDIATRICS, PLC

20 Rock Pointe Lane, Warrenton, Virginia 20186 • 540-347-9900 • Fax 540-349-0920

PATIENT (AGE 18+) REGISTRATION

Account No

Please print • Fill in all areas

First Name	Last Name	Nickname	Birthdate	Gender
				M F

Preferred Language	Race	Ethnicity	Smoking Status
	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ More Than One Race ☐ White	Hispanic/Latino? ☐ Y ☐ N	☐ Y ☐ N

Patient Contact Information

Address	Home Phone	Cell Phone
Social Security Number	Email Address	
Contact Preference? (circle one) Cell Home		

Emergency Contact (Friend or Relative)

Name	Relationship	Phone Number

Insurance Information

*Insurance information and copy of insurance card required to file for benefits

Policy Holder's Name	Policy Holder's Relationship to Patient	Policy Holder's Date of Birth
Policy Holder's Address (if different from patient)		
Primary Insurance Company	Patient's Identification Number	Patient's Group Number

I certify that the information I have provided above is correct and that I have read, understand and fully accept the Conditions of Registration as stated <u>on the next page</u>.

Signature of Patient Date Print Name

CONDITIONS OF REGISTRATION (patient age 18+)

CONSENT FOR TREATMENT ___________(initials)
I hereby consent to the administration of such medical treatment, diagnostic and/or therapeutic procedures and immunizations and laboratory work as required by the physician.

HIV/HEPATITIS B&C VIRUSES TESTING NOTIFICATION __________ (initials)
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/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 AND ASSIGNMENT OF INSURANCE BENEFITS___________ (initials)
I do hereby authorize Piedmont Pediatrics to apply for benefits for services under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to Piedmont Pediatrics (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency). I irrevocably authorize all such payments to Piedmont Pediatrics. I authorize Piedmont Pediatrics to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

RELEASE OF MEDICAL INFORMATION ___________ (initials)
I authorize Piedmont Pediatrics to release any and all of my medical records and/or other information and records required by my insurance company or its designated review agents who provide insurance benefits on my behalf, including if applicable, my employer and/or employer's workers 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 Piedmont Pediatrics; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my medical records and/or other records and information to Piedmont Pediatrics as required for payment of benefits and/or required for medical or any other reasons; and authorize Piedmont Pediatrics to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied.

COPY OF SIGNATURE___________ (initials)
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____________ (initials)
I certify that the information I have reported with regard to my insurance coverage is correct and that the above be honored by my insurance company. 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 and understand and fully accept the terms herein.

FINANCIAL AGREEMENT ____________(initials)
Piedmont Pediatrics participates with a majority of insurance plans. It is the patient's responsibility to provide us with correct and current information at the time of your visit, and to make sure that our providers participate with your plan. If you fail to present the correct and current insurance information at the time of your visit, then you agree to be responsible for 100% of our usual and customary charges for that visit.
If we participate with your plan, we will provide the service of filing a claim to your insurance company for most office and hospital charges, unless we have received prior notification of non-covered services. Those services, along with all copays, deductibles and balances are the patient's responsibility and must be paid at the time of service. If you do not pay your copay at the time of service, a $10.00 surcharge may be added to your balance to cover the cost of sending a bill. Any charges not billable to insurance will be disclosed in advance and you will be required to sign a waiver acknowledging our policy before services are rendered. We will file the initial claim to your primary insurance company; we do not file with secondary insurances. You must respond to any correspondence from the insurance company requesting patient information in a timely manner or the claim may be turned over to patient responsibility. Our office policy is to allow for one subsequent refiling. If, after the second filing, the claim remains unpaid, the balance may be transferred to your responsibility and payment will be expected upon receipt of statement.
<u>Credit Balances</u>: At times, an overpayment may occur due to insurance processing that may result in less money owed by the patient than what was collected. Unless you disagree, if an overpayment is made on your account, we will retain credit balances of $50.00 or less for a period of up to 180 days in order to apply those funds to a future visit. If the credit remains on your account after the 180-day period, we will issue a refund. Overpayments owed to insurance or government payers are refunded according to those payers' guidelines.
Small Balance/Credit Write-off Policy: We will adjust any balance of $5.00 or less. Refunds of $5.00 or less will be adjusted under our small balance write-off policy if those amounts remain on account after 180 days.
<u>Payment for Services Performed</u>: Our office accepts cash, checks and most major credit cards. All outstanding balances are due within thirty (30) days unless prior arrangements have been made with the billing department. There is a $35.00 charge for returned checks. All balances over 90 days may be sent to a collection agency or pursued legally. You will be responsible for the 33.33% collection and legal fees incurred by Piedmont Pediatrics in the collection of your delinquent balance. Our office will charge $80.00 for appointments that are missed without calling to reschedule or cancel 24 hours prior to the scheduled appointment time. We understand that emergencies happen and when it is appropriate, we will waive the no-show fee.
<u>After Hours Care</u>: Appointments scheduled after 5:00PM Monday-Thursday or on Saturday 9:00am to 12:00pm are considered urgent after-hours care and are subject to an after-hours care fee of $35.00.
<u>Self-Pay Patients</u>: If we do not participate with your health plan or you are uninsured, payment in full will be due at the time of your visit.

PATIENT AGE 18+
CONSENT TO SHARE HEALTH INFORMATION WITH OTHER ADULTS

Patient's Name ____ Date of Birth _________________________

The phone number I would like Piedmont Pediatrics to contact me ______________________________________

I understand that by law 18-year-olds are adults. As an adult, I have the right to keep health records confidential *regardless of who pays for my insurance or whether I live at home*.

Providers at Piedmont Pediatrics believe that parents should be partners with their children's care at every age; however, it is up to the patient to whom he/she gives permission to share privileged information. Therefore, we ask all of our patients that are over the age of 18 to consent as follows:

I give permission to healthcare providers and staff at Piedmont Pediatrics to speak with the adults listed below at any time regarding medical conditions that may affect me personally, including my health care status and/or treatment related to:

Choose one: ☐ All healthcare conditions ☐ My health status, EXCLUDING sensitive conditions such as alcohol or drug use, sexual activity, pregnancy or sexually transmitted diseases, and mental health issues

Consent given to:

Name	Relationship	Phone Number

☐ **I do NOT give my consent to any provider to speak with or share any my health information with my parents or any other adult.**

I understand that I may revoke this authorization at any time by submitting a written request.

____

Patient's Signature Date

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Printed Name of Patient