PediatriCare of Northern Virginia

Packet Updated 07/2022

Patient Registration

1st Child's Last Name: _____ First Name: _____ MI:_____
Sex _____ Date of birth: _____ Social Security #_____
Ethnicity: Hispanic or Non-Hispanic (*Please circle one*)
Race: American Indian or Alaskan Native /Asian / Black / Hawaiian / White (***Circle all that apply***)

2nd Child's Last Name: _____ First Name: _____ MI: _____
Sex _____ Date of birth: _____ Social Security #_____
Ethnicity: Hispanic or Non-Hispanic (*Please circle one*)
Race: American Indian or Alaskan Native /Asian / Black / Hawaiian / White (***Circle all that apply***)

3rd Child's Last Name: _____ First Name: _____ MI: _____
Sex _____ Date of birth: _____ Social Security #_____
Ethnicity: Hispanic or Non-Hispanic (*Please circle one*)
Race: American Indian or Alaskan Native /Asian / Black / Hawaiian / White (***Circle all that apply***)

What language should we contact you in? English or Spanish
Primary Language spoken in the home? _____

***Primary phone number for the family (one only please):** _____

***Family's Primary Address:** _____ Apt #:_____
City: _____ State: _____ Zip Code: _____

Phone numbers/email:

Parent 1: Name: _____ **Biological Relation to Patient**: _____
Lives with patient (circle one)? Yes No Parent's Primary Language: _____
Social Security #: _____ Date of birth: _____
Cell phone: _____
Parent's email: _____ Work email: _____
Address(if different from above): _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Employer: _____
Occupation: _____ Work phone:_____

Parent 2: Name: _____ **Biological Relation to Patient**: _____
Lives with patient (circle one)? Yes No Parent's Primary Language: _____
Social Security #: _____ Date of birth: _____
Cell phone: _____
Parent's email: _____ Work email: _____
Address(if different from above): _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Employer: _____
Occupation: _____ Work phone:_____

Parents relationship status: Married Divorced Separated Single

If parents are divorced or separated please fill out this section:
Is there a legal agreement? Yes No **If Yes, the legal paperwork MUST be provided to the office.**
Who has custody? _____
Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ___ Yes ___ No
If yes, please explain
_____
_____

****If any sections are incomplete, this form may be invalid****

Who is the primary contact? Please circle only One Parent 1 or Parent 2

For the Primary Contact – circle ONE on each line
How would you ideally prefer to be contacted regarding:

☆ ***Recall*:** Home Address / Text to Cell / Home e-mail
***General Notices*:** Home Address / Text to Cell / Home e-mail
***Patient Portal*:** Text to Cell / Home e-mail
***Appointment Reminders*:** Cell Phone / Text to Cell / Home e-mail

Who should receive the billing statement:
Name: _____
Relationship to patient: _____
Address: _____
Phone: _____ E-mail: _____

How would you prefer to receive billing statements? Home Address / Home e-mail / Work e-mail

Emergency Contacts, other than parents:

Name & Relationship			**Do they have permission to bring the child(ren) in?**	
1: _____	Relation:_____	ph#:_____	Yes	No
2: _____	Relation:_____	ph#:_____	Yes	No

Insurance:
Insurance Carrier: _____
Policy Holder's Last Name: _____ First Name: _____
Policy Holder's Birth Date: _____ Social Security Number: _____
ID# _____ Group# _____

Privacy Constraints (Check One):

☆ ____ No Restrictions. Okay to leave message / send mail.
____ Restrictions – Person to person with patient / guardian only.
____ Restrictions: _____

***** _____ ***** _____
Parent or Legal Guardian Signature **Date**

Notice of Privacy Practices (HIPAA)

This summary does not take the place of the full Notice of Privacy Practices.
I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPAA), 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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I understand that the full Notice of Privacy Practices policy can be viewed on our website and at your request, our staff will gladly provide you a copy. I also understand that PediatriCare of Northern Virginia, P.C. may amend the Notice from time to time. All amendments apply retroactively.

***** _____ ***** _____
Parent or Legal Guardian Signature **Date**

****If any sections are incomplete, this form may be invalid****

PediatriCare of Northern VA, P.C. (703) 330-3939
8640 Sudley Rd, Suite 306, Manassas, VA 20110 *15195 Heathcote Blvd, Suite 250, Haymarket, VA 20169*

Patient Medical History

Patient Name:_____ DOB:_____

Pregnancy & Birth	**Mother's Age at child's Birth?**
Any problems during pregnancy? ☐ Excessive Weight Gain ☐ Excessive Swelling ☐ UTI ☐ Toxemia ☐ Venereal Disease ☐ Other (Please Explain)	
Medication during Pregnancy? ☐ Yes ☐ No Exclude Vitamins & Iron	
During pregnancy did Mom ☐ Smoke ☐ Drink Alcohol ☐ Do street Drugs	
At Birth, how many gestational weeks was your child? (e.g. term = 40 weeks)	
Type of Delivery? ☐ Vaginal ☐ Cesarean Section Birth Weight Length	
Problems with baby at birth? Breathing: ☐ Yes ☐ No **Jaundice:** ☐ Yes ☐ No	
Problems soon after Birth?	
Feeding: ☐ Breast Milk ☐ Formula Type of Formula:	
Feeding Problems? ☐ Colic ☐ Recurrent Vomiting ☐ Recurrent Diarrhea ☐ Multiple Formula Changes	

Past Medical History	**Allergic Reactions?** **Medicine:** ☐ Yes ☐ No **Food:** ☐ Yes ☐ No
Animals: ☐ Yes ☐ No **Insect Bites:** ☐ Yes ☐ No **Please List**	
Medications taken on a regular basis? (excludes vitamins)	
Hospitalizations – (when-where-why)	
Serious Injuries – (when-where)	

Past, Present & Recurrent Illnesses

	Yes	No		Yes	No
Measles	☐	☐	Mumps	☐	☐
Chicken Pox	☐	☐	Whooping Cough	☐	☐
Scarlet Fever	☐	☐	Ear Infections	☐	☐
Asthma/Wheezing	☐	☐	Eczema/Hives	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐
Bleeding Tendency	☐	☐	Urinary Infections	☐	☐
Blood Transfusions	☐	☐	Joint Problems	☐	☐
German Measles	☐	☐	Problems Hearing	☐	☐
Seizures	☐	☐	Problems w/vision	☐	☐
Strep Throat	☐	☐	Other	☐	☐

Family Medical History	**List all blood relatives of your child who have had the following problems – use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (FM) Father's Mother, (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin**			
Anemia/Blood Disorders	Allergies	Alcoholism	Arthritis	Aids/HIV
Asthma	Allergy Shots	Cancer	Cystic Fibrosis	Cholesterol Problems
Birth Defects	Diabetes	Eczema	Ear Tubes	Epilepsy/Seizures
Drug Problem	Early Deafness	Emotional/Behavioral Problems	Growth Problems	Heart Attack/Stroke
Heart Disease	High Blood Pressure	Hereditary Problems	Intellectually Challenged	Muscular Dystrophy
Migraines	Tuberculosis	School Problems	Sudden Infant Death	Other

Signed _____ **Date**_____

Updated eff 07/2022

Our Financial Policy

PediatriCare of Northern VA, P.C. follows both State and Federal guidelines in billing for services rendered to our patients. This requires us to obtain specific information for each individual patient in the family. We understand that the collection of this information can seem overwhelming, however, it is necessary in order to provide you more efficient service.

Please read carefully the information listed below. If you have any questions, our office staff will be happy to answer your questions. If assistance is required in resolving a billing issue, please contact the Billing Department between 9:00am and 4:30pm Monday – Friday, 703-330-3939.

1. A valid government ID is requested at the time of service from the person authorizing the health care services for the child(ren). Please note that if this right is being granted to a caregiver (i.e. nanny or grandparent) that is not the child's legal guardian, we must have written authorization from the legal guardian.
2. If there is a financial arrangement between individual parental parties concerning financial responsibility for medical care of their children, this arrangement is between the two parties and does not absolve the parent that brings the child for services from their financial obligation to our practice.
3. The parent/guardian must provide accurate demographic and insurance information prior to patient treatment. If you are covered by health insurance, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage and benefits as a courtesy. Accepting your insurance is not a guarantee of benefits or payment. You will be held accountable for any unpaid balances by your plan.
4. It is the parent/guardian's responsibility to know which benefits are not covered by the insurance program in which they participate, as the office staff does not have access to this information. Further, the parent/guardian is fully responsible for all fees that are denied as non-covered services, deductibles, coinsurance and co-payments. If the parent/guardian has questions concerning their coverage, they should contact their employer's human resource department, their insurance agent, or their insurance company directly.
5. It is the responsibility of the parent/guardian to open and read the explanation of benefits sent to them from their insurance. If they believe there has been an error in processing their claim, they need to call the insurance company directly. PediatriCare of Northern VA's billing department will be happy to assist in getting the claim resolved.
6. Based on PediatriCare of Northern VA's contracts with various insurance companies, we must bill for services rendered within a timely manner (defined by the individual contracts). If it is found that the correct information was not provided by the parent for the services rendered and we miss the timely filing time limit, the patient will be responsible for the entire amount owed.
7. If uninsured, the parent/guardian is fully responsible for all fees. Uninsured patients will receive a 25% discount if the full balance is paid at the time of service. Payment is expected prior to being seen for all well-child care.
8. Payment is due at the time services are rendered. Co-payments not paid at the time of service will be billed an additional $15.00 fee. After the explanation of benefits from the insurance company is received, any balance that is determined to be patient responsibility is due within thirty (30) days. Should timely payments not be made, any and all outstanding balances over 30 days will be charged to the credit card on file. Well-child care will be deferred until all balances are paid in full.
9. There is a $10 processing fee for a credit or debit card that is declined for any reason. There is a $50.00 fee for all returned checks. Writing a "bad check" is punishable under law. If the account is not resolved fully within 7 days of notification from your bank that the funds were not available, we reserve the right to terminate any and all services provided to your family.
10. Fees for Forms (to include, but not limited to physical/sports forms, FMLA, forms for legal purposes): There will not be any charge for forms which are presented at the physical/well check appointment. However, forms requested outside of the physical/well appointment will have a minimum fee of $10. FMLA forms will be assessed a fee of $25.
11. If a patient arrives 15 minutes or more past their appointment time, your appointment may be rescheduled in order to keep the other patients and the doctors on time.
12. Missed Appointment/Late Cancellation Policy – We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Cancellations are requested 24 hours prior to well-care appointments and 2 hours prior for same day sick visits. PediatriCare of Northern VA, P.C. charges a $60 fee for appointments that are missed or same day canceled. This fee is not covered by your insurance company.
13. Should your child/children miss an appointment (No Show) and/or fail to cancel, we reserve the right to discharge you from the practice.
14. Any appointments that take place on a Saturday or on a federal/observed federal holiday will incur an additional $60 fee that is billed to your insurance company.
15. When our office is closed or it is outside of normal business hours, there is a $25 fee for calls made to our after-hours on call service. This fee is not covered by your insurance company. After-hours calls are handled by the Rainbow Children's Hospital Call Center staff. They do not have access to your child's medical record. We encourage parents to call the office during regular hours, free of charge, for advice of a non-urgent nature, when our nurses have direct access to your child's medical record.

I understand by signing below that I have read, understand, and accept the policy listed above.

Patient's (Legal) Name	**Date of Birth**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Signature _____ **Date** _____

Printed Name _____ **Relationship** _____