Pediatric Partners of Virginia

18+ Registration Form

Patient Information:

Legal Last Name	Legal First Name	Middle Name	Nickname	Date of Birth	Sex
					□ M □ F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

I prefer to be reminded of future appointments by: □ Home Phone □ Cell Phone □ Text Message

Preferred Pharmacy Location: _____ Phone: _____

Primary Email: _____

Who is responsible for charges not covered by insurance? □ Self □ Other: _____

If other please complete the following:

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Alternate/Emergency Contact (Parent or Other): _____
Alternate Contact Phone: _____ Relationship to patient(s): _____

INSURANCE INFORMATION – YOU MUST HAVE YOUR INSURANCE CARD FOR OUR RECEPTIONIST

Primary Insurance: _____ Policy ID: _____ Group Number: _____
Policy Holder/Subscriber: _____ Date of Birth: _____

Secondary Insurance: _____ Policy ID: _____ Group Number: _____
Policy Holder/Subscriber: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE BENEFITS/ CONSENT TO TREAT/ PRIVACY POLICY

I understand that I am financially responsible for all professional charges that my children may incur. All copayments and non-covered charges are due at time of service. All costs not paid by insurance are due upon receipt of statement.

I hereby authorize payment of medical benefits direct to Pediatric Partners of Virginia. I further authorize the release of any medical information necessary for processing the insurance claim. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations. Acknowledgement of receipt of HIPAA Notice of Privacy Practices: I have received or have been given the opportunity to receive a copy of HIPAA Notice of Privacy Practices for Pediatric Partners of Virginia.

Patient Signature (Patient Signature if 18 or older) _____ Printed Name _____ Date