PEDIATRICS & NEWBORN CARE
Sunil Gupta, MD FAAP
www.PediatricsNBC.com

Patient Registration

CHILD _____ **Sex ☐ Male ☐ Female DOB** _____/_____/_____ **Allergies** _____

CHILD _____ **Sex ☐ Male ☐ Female DOB** _____/_____/_____ **Allergies** _____

CHILD _____ **Sex ☐ Male ☐ Female DOB** _____/_____/_____ **Allergies** _____

CHILD _____ **Sex ☐ Male ☐ Female DOB** _____/_____/_____ **Allergies** _____

CHILD _____ **Sex ☐ Male ☐ Female DOB** _____/_____/_____ **Allergies** _____

CHILD/CHILDREN LIVE WITH ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other-Specify Relationship _____

Has your child/children ever been seen by this practice before? ☐ Yes ☐ No

MOTHER/GUARDIAN:

Name _____ **DOB** _____/_____/_____

Address _____ **City/State/Zip** _____/_____/_____

Home Phone _____-_____-_____ **Cell Phone** _____-_____-_____ **Work Phone** _____-_____-_____

Occupation _____ **Employer** _____

FATHER/GUARDIAN:

Name _____ **DOB** _____/_____/_____

Address _____ **City/State/Zip** _____/_____/_____

Home Phone _____-_____-_____ **Cell Phone** _____-_____-_____ **Work Phone** _____-_____-_____

Occupation _____ **Employer** _____

EMEGENCY CONTACT PERSON:

Name _____ **Relationship to Patient(s)** _____

Phone Number _____-_____-_____ **Alternate Phone Number** _____-_____-_____

How Did You Hear About Us? ☐ Internet ☐ Phonebook ☐ Newspaper ☐ Insurance Plan ☐ Friend ☐ Physician ☐ Other

INSURANCE INFORMATION:

Insurance Co. Name _____ **& Phone Number** _____-_____-_____

ID # _____ **Group Number** _____

Name of Policyholder _____ **Relationship to Patient(s)** _____

Insured's Employer Name & Number _____ **&** _____-_____-_____

BY SIGNING BELOW I AM STATING THAT I AM LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND THAT I HAVE READ, UNDERSTAND AND AGREE TO ALL OF THE CONDITIONS LISTED ON THE BACK OF THIS FORM. I ATTEST THAT THE INFORMATION I HAVE PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____/_____/_____
Signature (Required) **Today's Date**

_____ _____
Printed Name **Relationship to Patient**

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Consent to Treatment-I agree that by virtue of presenting the patient to the office that I consent to the patient being examined and treated as medically advised. Furthermore I affirm that I am the parent or legal guardian for the child(ren) and am legally authorized to consent for his/her/their medical care.

Significant Exposure-Section 32.1-45.1 (A) and (B), Code of Virginia (1950, as amended) provides that in the event of frank exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV) is considered to have been given by the patient and/or healthcare worker thereby granting this office the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of this office.

Authorization & Assignment of Benefits- I authorize the release of medical and insurance information to any of my medical providers or insurance companies necessary for the completion of insurance forms or to coordinate patient care. I hereby authorize payment directly to Pediatrics and Newborn Care, LLC for all medical benefits otherwise payable to me under the terms of my insurance. I authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for services provided.

Financial Responsibility-I understand and personally guarantee, in consideration of services and materials provided, to be financially responsible for any and all deductibles, co-insurance, co-payments or any charges not paid by my insurance. Not all services provided by this office may be a covered benefit with my insurance plan. I accept that it is my responsibility to know what services are or are not covered by my specific insurance plan and agree to pay accordingly. Co-payments, non-covered services and all outstanding balances are due in full at time of service unless prior arrangements have been made with the practice manager. There is a $5.00 administrative fee for any co-payment not made at time of service.

I am aware that there is a $10 fee for the completion of physical or similar forms required for daycare, school, sports, etc. This fee is not covered by insurance.

If this office does not participate with my insurance plan or I do not have insurance, I will be responsible for payment in full at the time of service. In the event that my insurance coverage changes or terminates I will notify this office immediately. If I present to an appointment without appropriate insurance information I will be required to pay in full at the time of service.

I am aware that whomever brings the patient to an appointment is responsible for making any co-payments at time of service. I am aware that all children under the age of 18 years old must be accompanied to their appointment by a parent or legal guardian. In the event a parent or legal guardian cannot be present, written and signed authorization must be presented to the office identifying the adult who may legally bring the patient to appointments, have access to medical and other information and consent to treatment. The signed authorization must also specify a phone number at which the parent/legal guardian can be reached.

Billing-Patient bills are mailed once a month. Payment in full is due within 30 days. Late fees and finance charges may apply to balances not paid within 30 days. I agree to pay all cancelled appointment fees, returned check fees, finance charges, court fees, collection fees and attorney fees that are accrued in the collection of any debt.

Office Policy and Procedures: Patients should arrive on time for all appointments. I understand it is my responsibility to cancel an appointment by 5pm on the prior business day or there will be a $25 charge. This fee is not covered by insurance. I understand that if I am more than 15 minutes late for a Well Child Check-up, my appointment will be rescheduled and we reserve the right to charge $25.

Insurance/Referrals –I agree that it is my responsibility to know and understand my insurance policy and benefits. It is the policyholder's responsibility to make sure specific laboratory, radiology or specialist consultation/services accepts your insurance.

If your insurance requires you make a primary care physician (PCP) selection, our facility or one of our providers must be designated as the PCP. I understand that I will be financially responsible for charges incurred at time of service if Pediatrics & Newborn Care or one of it's providers is not listed with my insurance company as PCP. If your insurance requires a written referral or preauthorization number to see a specialist this referral must be initiated by the PCP. Once a doctor/nurse practitioner advises you to see a specialist or to have a procedure requiring preauthorization, you must notify our office of the specialist/facility name and appointment date and allow 3 business days notice to process your request.

Medical Records-Medical records may take up to 15 days to be copied and is subject to fees as allowed by Virginia's Health Records Privacy statute 32.1-127.1:03 J. The request must be made in writing. Medical records of a minor child shall be maintained until the child reaches the age of 18 or for six years after the last patient encounter regardless of age, whichever is longer. I authorize this office to share Immunization and child locator information with other health care providers.

I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

*****I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION BELOW:**

X_____ _____/_____/_____

Signature (Required) **Today's Date**

_____ _____

Printed Name **Relationship to Patient**