Premier Pediatrics of Manassas

Patient Registration

Patient Information- <u>Please list patient & all children 17 years old or younger living in household.</u>

_____ DOB ___/___/_____ M / F Race _____ Ethnicity_____
Last name First name Middle initial

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Last name First name Middle initial

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Last name First name Middle initial

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Last name First name Middle initial

Preferred Pharmacy: _____
Primary Language spoken in the home? _____

Phone numbers/email:

Parent 1: Name: _____ **Relationship to Patient**: _____
Lives with patient (circle one)? Yes No
Social Security #: _____ Date of birth: _____
Cell phone: _____

Parent's email: _____
Address (if different from above): _____Apt #: _____
City: _____ State: _____ Zip Code: _____
Employer: _____
Occupation: _____Work phone:_____

Parent 2: Name: _____ **Relationship to Patient**: _____
Lives with patient (circle one)? Yes No
Social Security #: _____ Date of birth: _____
Cell phone: _____

Parent's email: _____
Address (if different from above): _____Apt #: _____
City: _____ State: _____ Zip Code: _____
Employer: _____
Occupation: _____Work phone:_____

Parent's 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**

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

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
____ 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 Premier Pediatrics of Manassas 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****

Our Financial Policy

Premier Pediatrics of Manassas 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 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 4:00pm Monday – Friday, 703-330-9222.

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. Premier Pediatrics of Manassas's billing department will be happy to assist in getting the claim resolved.
6. We believe that routine annual physical examination with screening lab work is very important to maintain good health. However, insurances benefits may vary. Some insurance companies cover "wellness" and others cover visits when you have a complaint. It is possible you may be charged a sick visit if provider spent ample time discussing complaint during well visit. Please learn about your benefits prior to your appointment so you will know what is covered by your insurance plan.
7. Based on Premier Pediatrics of Manassas'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.
8. Newborns with Medicaid pending (sick and well visits) the fee is $50 deposit which will be reimbursed after insurance payment is received. We have not received Medicaid information by the 4 months of age will be expected to pay visits in full. Older children with Medicaid pending any physical or sick visits must be paid in full at time of service.
9. If uninsured, the parent/guardian is fully responsible for all fees and paid at the time of service.
10. 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.
11. 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.
12. $15 Fees for Forms (including physical/sports forms, FMLA, forms for legal purposes. FMLA forms will be assessed a fee of $25.
13. 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.
14. 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 an appointment. Premier Pediatrics of Manassas charges a $50 fee for appointments that are missed, or same day canceled. This fee is not covered by your insurance company.
15. Should your child/children miss an appointment (No Show) and/or fail to cancel, we reserve the right to discharge you from the practice after **(3) no shows.**
16. Any appointments that take place on a Saturday or on a federal/observed federal holiday will incur an additional $50 fee that is billed to your insurance company.
17. 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. 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** _____