Virginia Pediatric & Adolescent Center

FINANCIALLY RESPONSIBLE PARTY (Please Print Clearly): TODAY'S DATE: _____

Guarantor Name (First, Middle, Last) _____

Date of Birth_____ Sex_____ Social Security_____

Marital Status_____ Relationship to Patient_____

Address_____Apartment_____

City_____ State_____ Zip Code_____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Best Contact Phone (_____) _____

E-mail Address*_____ Initials_____

***By giving your email address, you are allowing us permission to send you confidential information about your child**

Employer_____Occupation_____

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Other Parent/Guardian (First, Middle, Last) _____

Date of Birth_____ Sex_____ Social Security_____

Employer_____Occupation_____

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Additional Phone (_____) _____

Address if different from above:

Address_____ Apartment_____

City_____ State_____ Zip Code_____

E-mail Address*_____ Initials_____

PLEASE LIST ALL CHILDREN'S INFORMATION (FIRST, MIDDLE, LAST):

Name_____ Sex_____ DOB_____

Name_____ Sex_____ DOB_____

Name_____ Sex_____ DOB_____

Name_____ Sex_____ DOB_____

PHARMACY INFORMATION

Name_____ Address_____

City_____ State_____ Zip Code_____

Phone (____) _____ Fax: (____) _____

PRIMARY INSURANCE INFORMATION: must be filled in completely.

Insurance Name_____ ID_____ Group_____

Effective Date_____ Subscriber's Name_____ Sex_____

SSN_____ Date of Birth_____ Relationship _____

SECONDARY INSURANCE INFORMARTION: must be filled in completely.

Insurance Name_____ ID_____ Group_____

Effective Date_____ Subscriber's Name_____ Sex_____

SSN_____ Date of Birth _____ Relationship _____

Did someone in our practice refer you? _____ (Yes or No) If so, who? _____ (Name)

PLEASE SIGN THE BACK FOR HIPPA →

Virginia Pediatric & Adolescent Center

Authorization Form

Patient Name: _____ Date of Birth: _____

AUTHORIZATION FOR TREATMENT
I consent to examination, treatment and procedures, which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.

ACCIDENTAL EXPOSURE AUTHORIZATION STATEMENT
Any patient who exposes a health care provider or his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis B and C testing and disclosure of the results to the person exposed. This deemed consent also applies to a health care provider who exposes a patient to body fluid in the above stated manner.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby assign payment directly to Virginia Pediatric & Adolescent Center, P.C. for services covered by my insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION
I authorize Virginia Pediatric & Adolescent Center, P.C. to release to my insurance carrier and its designated agents any information concerning medical care, advice, treatment or supplies provided to the patient for purposes of administration, review, investigation or evaluation of coverage claims and utilization of services. I agree that a photographic copy of this authorization is as valid as the original.

This authorization may be revoked by either me or by the above named carrier at any time in writing. I assume financial responsibility for and agree to make payment in full to Virginia Pediatric & Adolescent Center, P.C. for all charges for services or medical supplies furnished not covered or paid by my insurance carrier.

HEALTH INFORMATION PRIVACY POLICY
I understand that Virginia Pediatric & Adolescent Center, P.C. has a health information privacy policy in place that conforms to the regulations of HIPAA (Health Information Portability and Accountability Act). I know that upon request I have a right to a copy of this policy.

Parent/Guardian Signature_____ Date: _____

AUTHORIZATION TO LEAVE INFORMATION ON ANSWERING MACHINE
(Please read and sign **ONE** or the other**)**

In the event that providers at Virginia Pediatric and Adolescent Center, P.C. cannot speak to me directly in person or by telephone, I give permission to Virginia Pediatric and Adolescent Center, P.C. to leave a message on my answering machine, which may contain laboratory results or other personal information pertaining to the health care of the patient.

Telephone numbers where such information can be left are _____
_____
_____

Parent/Guardian Signature_____ Date: _____

I **DO NOT** give permission to Virginia Pediatric and Adolescent Center, P.C. to leave any messages on my answering machine, which may contain laboratory results or other personal information pertaining to the health care of the patient.

Parent/Guardian Signature_____ Date: _____