Associates in Pediatrics
A Division of Pediatric Partners of Virginia
11551 Nuckols Road. Suite F.
Glen Allen, VA 23059

Patient Name: ____________________________Date of Birth:_____________ Gender:_____________
Primary Phone:______________________ Emergency Contact Name:___________________ Contact Ph:_________________

Home Address ____________________________________ City ______________________ State_____ Zip ________

Primary Physician Name: ___________________________________

Parent/Guardian Name: _____________________________________
Relationship to Minor child?
Mother___ Father___ Stepmother___ Stepfather___ Grandmother___ Grandfather___ Sibling___

(Guardian Address if different than patient)
Address ____ City __________________________State _____ Zip ______

Guarantor Name: ___________________________________ SSN: ______________________ DOB: __________

Home Phone: _________________ Cell Phone: _________________ E-Mail Address:____________________________

Address __________________________ City ___________________________ State:______ Zip__________

Insurance Information – Policy holder name, DOB and child's Ins ID required

Primary Insurance Co: __________________Policy Holder Name: __________________________DOB: ____________
Patient Ins ID: ____________________________Group Number: ____________________

Do you have a second insurance policy? Please Provide a copy of your insurance card, and verify the following

Secondary Ins Co:_______________________ Policy Holder Name: _________________________DOB: ____________
Patient Ins ID: ____________________________Group Number: ____________________

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges incurred on this account and I assign all insurance benefits to Associates in Pediatrics. I am responsible for any portion of the account not paid in full by insurance. Please note that payment of any co-pay, deductibles or visit amounts will be collected at the time of service. **Unpaid Balances:** Sums due hereunder are payable at practice office. If balances are not paid according to the terms, then the account will be considered past due. It is further understood and agreed that if this account or any debt owed to practice is referred to a collection agency or attorney, parent or guardian agrees to pay, in addition to the balance of account (which includes but is not limited to, principle, accrued interest, and late charges), all collection fees in the amount of forty percent (40) of the total unpaid balance due, plus court cost and filing fees incurred by practice. Parent or guardian agrees to pay the aforesaid costs of collection whether or not suit is filed. I agree and authorize the practice and its agents to contact me by telephone, text message or e-mail that is associated with my child's account, including wireless telephone numbers and e-mail. I further authorize practice and its agents to contact me using any method of contact available including by not limited to using pre recorded or artificial voice messages and or an automatic dialing device as applicable.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize Associates in Pediatrics to disclose all or any part of the patient's medical record and/or clinic charges to any person or corporation (i) which is or may be liable or under contract to Associates in Pediatrics for reimbursement, subrogation and/or direct recovery and coordination of benefits for this and all future claims including but not limited to hospital/medical service companies, worker's compensation carriers, welfare funds, governmental agencies and (ii) any health care provider for continued patient care. Associates in Pediatrics may also disclose and transmit to state and federal agencies vaccine records. Except, as above, Associates in Pediatrics will require the patient's, or in the case of a minor child, a natural parent or legal guardian's, written consent to release information about the patient. I also agree that in all instances, the original medical records remain the property of Associates in Pediatrics.

PATIENT ACKNOWLEDGEMENT:

The Associates in Pediatrics Notice of Privacy Practices provides information about the privacy right of our patients; and how we may use and disclose protected health information (PHI) about our patients. Federal regulation requires that we give our patients or their authorized representative the opportunity to review our Notice before signing this acknowledgement. A copy of our Notice will be made available to you at your request.

If you have any questions about your rights or our privacy practices please send a letter to the following address. A response will be sent within seven (7) business days.

Privacy Officer – Associates in Pediatrics
11551 Nuckols Road, Suite F. Glen Allen, VA 23059

By signing below, you acknowledge that you have been provided with notice of the Privacy Practices, Release of Information and your financial responsibility.

Signature of Patient or Authorized Patient Representative: ____ Date: ____________

Printed Name of Authorized Patient Representative: ____