WOODBRIDGE PEDIATRICS REGISTRATION FORM

Patient_____ DOB: ____/____/___ Sex: □M □F
Primary Email address_____

Preferred Pharmacy: Name, location and phone #:_____

Mother/Guardian_____ DOB: ____/____/____ SS#_____

Address_____ Home #:_____
City/State/Zip_____ Cell # _____

Father/Guardian_____ DOB: ____/____/____ SS#_____

Address_____ Home #:_____
City/State/Zip_____ Cell # _____

Patient's Sibling_____ Sex: □ M □ F DOB: ____/____/____
Patient's Sibling_____ Sex: □ M □ F DOB: ____/____/____
Patient's Sibling_____ Sex: □ M □ F DOB: ____/____/____
Patient's Sibling_____ Sex: □ M □ F DOB: ____/____/____

Primary Contact: □ Mother □ Father □ Guardian_____

EMERGENCY CONTACT

Emergency Contact Person (other than parents) _____ Relationship_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I, _____, parent or legal guardian of _____, do hereby authorized the following individuals (over age 18 years) to schedule appointments and/or accompany my child to medical appointments ***for sick care only***. They may act on my behalf regarding any medical treatment my child may need in my absence. I understand that ***well care appointments require the presence of a parent or legal guardian***. Please advise the individuals listed below to bring photo identification to appointments. Authorized individuals include (name/relationship):

_____/_____

_____/_____

_____/_____

_____
Signature **Date**

****PLEASE REMEMBER ALL WELL CARE APPOINTMENTS REQUIRE THE PRESENCE OF A PARENT OR LEGAL GUARDIAN.***

CONSENT AGREEMENT FOR PRIVACY NOTICE

I have received a written copy of **Woodbridge Pediatrics Privacy Notice**. I also understand my rights regarding my individually identifiable health information (IIHI) as presented in the Privacy Notice and I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment, or other healthcare operations (TPO) only. Other uses of my IIHI will require an authorization form from me for the specific intention of the disclosure.

I also authorize Woodbridge Pediatrics to use the name of the patient and family members as needed for identification purposes in public areas of the office.

Signature _____ **Date** _____

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

I authorize Woodbridge Pediatrics to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Woodbridge Pediatrics, Ltd., for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I also authorize the release of medication history for E-Prescribing to my preferred pharmacy. I give permission for my provider to view my child's prescription history from external sources.

I understand that I am 18 years of age or older and financially responsible for all charges, co-payments and any charges not paid by my insurance.

I authorize my health care provider to use an automated telephone system and/or e-mail and to use my name, address, and phone number to leave a message with limited protected health / appointment information. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system and answering machine**.**

I understand that Woodbridge Pediatrics engages in Telehealth services. I am aware that confidential information may be discussed, and I understand that I am responsible to ensure privacy at my location. I agree that I will not record through either audio or video any of the sessions, unless this is agreed upon.

As part of our commitment to improve the quality and the coordination of medical care for the children we serve, Woodbridge Pediatrics has elected to participate in the Children's National Health System's IQ Network. As a part of the Children's IQ Network, this written single consent will allow the sharing of information with any provider within the IQ Network whom you have elected to be involved in your child's treatment. Your child's healthcare information is encrypted (encoded) and can be accessed only by health care providers who are caring for your child and have a need to know. You do have the option to opt out of the Children's IQ Network. If you choose to opt out, you will need to sign a separate consent form. Please request form from receptionist if you choose to opt out.

Release of Medical Records and Immunization History

I authorize Woodbridge Pediatrics to release and/or send medical information/records with regard to my child's health condition to other consultants and/or referring physicians, licensed healthcare facilities, health departments, and /or any education facilities as appropriate. Woodbridge Pediatrics will share immunization information with other physicians, hospitals, and health departments for purposes of ensuring that he/she receives age appropriate immunizations. Furthermore, I understand that the information may be released by forwarding a photocopy through the U.S. postal service or by confidential facsimile.

Conditions Under Which Minors are Considered Adults for Purpose of Consent Virginia:

I understand in Virginia, minors are considered adults for the purpose of consent to: 1) treatment of venereal diseases, infectious or contagious diseases which require the physician to make a report to the Department of Health; 2) services related to birth control, pregnancy, or family planning (excluding sterilization); 3) outpatient treatment, care or rehabilitation for substance abuse; and 4) outpatient treatment, care or rehabilitation for mental illness or emotional disturbances.

Deemed Consent Virginia

I understand that Virginia law (VA Code Ann. § 32.1-45.1) provides that if my physician or any person employed by my physician is exposed to my child's body fluids in a way that might possibly transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to allow testing for HIV and/or Hepatitis B or C infection. The results of this testing must be made available to the person who has been exposed to those body fluids. If the person whose blood specimen is sought for testing refuses to provide such specimen, any person potentially exposed to the HIV or hepatitis B or C viruses, or the employer of such person, may petition the general district court for an order requiring the person to provide a blood specimen or to submit to testing and to disclose the test results in accordance with the law.

ACKNOWLEDGEMENT OF ABUSE-FREE ZONE

At Woodbridge Pediatrics, we appreciate and respect our staff. It is our belief that our staff should have a work environment free from verbal and physical abuse. We expect you to treat each one of our staff members as you would like to be treated. Outbursts against our staff will not be tolerated and may result in your dismissal from our practice.

Parent/Guardian's Signature:_____Date:_____

WOODBRIDGE PEDIATRICS, LTD. Practice Policy

We are committed to providing you with the best possible care and would like you to understand our policies.

For patients with participating insurance plans, all co-payments are due at time of service; a $10 fee will be assessed for co-payments that are not paid in full at time of service. **Although your insurance may not charge a copay for Well Care, please be aware that your insurance may charge you a copay for any additional problems addressed by the Physician during Preventative Well Care.** If you are being seen for a condition/problem that is not a covered benefit of your insurance policy, it is your responsibility to pay at time of service.

Payment for your office visit is required at the time of service for the following:

•Patients without insurance •Patients with private insurance, who are not covered by one of our participating plans

•Patients who do not provide us with complete insurance information.

There is a $10 form fee applied for any forms that require a doctor's signature. Fee does not apply for forms signed during well visits.

All accounts that have unpaid balances after 90 days will be turned over to a collection agency. You will be responsible for any fees charged by the collection agency and all costs and expenses including reasonable attorneys' fees, we incur in such collection efforts.

Woodbridge Pediatrics reserves the right to change their fees at any time.

WOODBRIDGE PEDIATRICS, LTD
POLICY FOR MISSED APPOINTMENTS

All appointments need to be cancelled with **at least 24 hours notice**. If you do not cancel your appointment in the appropriate amount of time the following fees will be applied:

- **$75.00** missed appointment fee for Well Care/Physicals
- **$30.00** missed Physician appointments
- **$10.00** missed Nurse appointments

I understand that if I have multiple children scheduled, each child will be charged a missed appointment fee. It is also our policy to dismiss patients who do not show up for any three scheduled appointments. Three missed appointments in a family will result in dismissal from the practice.

If you are more than 15 minutes late for your appointment, we reserve the right to cancel the appointment and fees will apply.

I understand by signing I have **read and agree** to the above paragraphs. I understand that I am 18 years of age or older and financially responsible for all charges, co-payments and any charges not paid by my insurance.

Signature:_____Date:_____