WOODBRIDGE PEDIATRICS REGISTRATION FORM

Patient_____ Sex: □M □F DOB:____/____/___Chart#_____
Primary Email address_____
Preferred Pharmacy: Name, location and phone #:_____

Mother/Guardian_____SS#_____ DOB:____/____/____

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

Father/Guardian_____SS#_____ DOB:____/____/____

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

*Sibling*_____ Sex: □ M □ F DOB:____/____/____
*Sibling*_____ Sex: □ M □ F DOB:____/____/____
*Sibling*_____ Sex: □ M □ F DOB:____/____/____
*Sibling*_____ Sex: □ M □ F DOB:____/____/____

Children live with: □ Mother □ Father □ Guardian_____

Information Requested for Purpose of Federal Compliance Reporting

Providing this information is optional. All patients receive the same medical care regardless of the answer.

Which racial group would you place your child(ren)?

____ White ____ African American or Black ____ More than one race ____ I prefer not to answer
____ American Indian or Alaska Native ____ Pacific Islander ____Asian or Asian American ____Other

Which ethnic group would you place your child(ren)?

____Hispanic or Latino ____Not Hispanic or Latino ____I prefer not to answer
What is your preferred language?_____ ____I prefer not to answer

EMERGENCY CONTACT

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

INSURANCE INFORMATION

*Primary*_____ Claims Address_____
Policy #_____ Group #_____ Co-payment $_____
Policy holder name_____ Relationship to patient_____
*Policy holders address:*_____ *Policy holders Date of Birth:*_____

*Secondary*_____ Claims Address_____
Policy #_____ Group #_____ Co-payment $_____
Policy holders name:_____ Relationship to patient_____
*Policy holders address:*_____ *Policy holders Date of Birth:*_____

*Medicaid/Champus/Other*_____ Current Card #_____ Dr. listed on card: _____

PLEASE DO NOT FORGET TO READ & SIGN THE OTHER SIDE OF THIS FORM: THANK YOU

Turn Over Turn Over

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 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 I AM 18 YEARS OF AGE OR OLDER AND FINANCIALLY RESPONSIBLE FOR ALL CHARGES, CO-PAYMENTS AND ANY CHARGES NOT PAID BY MY INSURANCE.

PARENT/GUARDIAN'S (PERSON RESPONSIBLE FOR PAYMENT)

SIGNATURE:_____**DATE:**_____

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.

Patient _____

Parent Representative _____

Signature _____ Date _____

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.

My signature below indicates that I agree to abide by the above "abuse free environment" policy.

_____
Signature Date

11/2014

WOODBRIDGE PEDIATRICS, LTD. Practice Policy 2017

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.**

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.

If you need to use a specified laboratory or x-ray facility, it is your responsibility to inform our office before the service is rendered. Any laboratory order that you have not completed within 30 days will be deleted from our system.

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 is due at the time services are rendered. We accept cash, checks, and credit (MasterCard, VISA, and Discover). Returned checks will be charged a $50 fee. There is a $10 form fee applied for any forms that require a doctor's signature.

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.

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.

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.

It is your responsibility to know and understand your own insurance policy. If you have any questions about our services, fees, or other aspects of your care, please do not hesitate to contact us.

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.

Parent/Guardian's (Person responsible for payment)

Signature:_____ Date:_____

PLEASE DO NOT FORFGET TO READ & SIGN THE OTHER SIDE OF THIS FORM: THANK YOU

Turn Over

Turn Over

1/2017

WOODBRIDGE PEDIATRICS, LTD

POLICY FOR MISSED APPOINTMENTS

I, _____, a parent or legal guardian of:

List Child(ren) Name and Date of Birth:

_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #
_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #
_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #
_____	_____	_____
(Child's First & Last Name)	Date of Birth	Child's account #

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 two scheduled appointments. Two 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.

CONSENT AGREEMENT FOR PRIVACY NOTICE

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.

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.

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:_____

WOODBRIDGE PEDIATRICS, LTD.
MEDICAL AND FAMILY HISTORY FORM

Patient's Name_____ Date of Birth_____ Today's Date_____

Parent's/Guardian's Name_____

Allergies/Reactions to medications, foods or vaccines:_____

_____

Medications your child is currently taking, please include Prescriptions, Over The Counter, Herbal medications:_____

_____

Which **Pharmacy** would you like your prescriptions sent to: Name, Location and Phone Number_____

_____

DELIVERY AND BIRTH HISTORY

Where was your child born? Please include the Hospital and State_____

How was your child delivered? ___Vaginal ___Caesarean ___Adoption ___ Other_____

If known, how old was the birth mother at time of delivery?_____

Was your child breech/feet first? ___Yes ___No

Was your child premature? If so then how many months/weeks?_____

What was your child's Birth Weight?_____ Birth Length?_____

Did your child pass the Hearing Screen? ___Yes ___No

Please indicate any medical problems during the baby's newborn period._____

_____

DEVELOPMENT

How old was your child when he/she first: Sat up without help_____, Walked without help_____,

Spoke his/her first words_____

Please check off any concerns you have: ____ Physical Development, ____ Speech, ____ School Performance

Briefly state any developmental concerns/issues you would like to speak to the provider about_____

_____

PAST MEDICAL HISTORY

Has your child ever been hospitalized overnight? ___No ___Yes, when and why_____

Has your child ever had surgery? ___No ___Yes, when and why_____

Has your child ever had a serious injury? ___No ___Yes, when and why_____

Is your child effected by any of the following? (check all that apply) ____My child has No Significant Past Medical History

___ADD/ADHD ___ Anemia ___Autism ___Broken Bones ___Chicken Pox ___Concussions ___Constipation

___Diarrhea ___Diabetes ___Depression ___Ear Infection ___Eczema ___Food Allergies ___Heart Murmur

___Heart Disease ___Hearing Loss ___Rashes ___Reflux/GERD ___Seasonal Allergies ___Sickle Cell Anemia

___Seizures ___Urinary Problems ___Vaccine Reactions ___Wheezing/Asthma ___Other issues (explain)_____

_____

_____

PLEASE DO NOT FORGET TO FILL OUT THE OTHER SIDE OF THIS FORM. THANK YOU

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SOCIAL HISTORY

Who does your child live with?_____

Are the Parents ____Married ____Unmarried ____Separated ____Divorced

Was the house your child lives in built before 1978? ____No ____Yes
Do you have a pool? ____No ____Yes
Are there any guns in the home? ____No ____Yes
Are there any pets in the home? ____No ____Yes
Does your child go to a babysitter or attend daycare? ____No ____Yes
Is your child in after school care? ____No ____Yes
Are there any smokers in the home? ____No ____Yes If so, where do they smoke?_____
Have you been exposed to anyone with TB (Tuberculosis) ? ____No ____Yes
Any foreign travel within the past five years? ____No ____Yes If so, when, where and for how long?_____
_____

FAMILY HISTORY

Please state which of the following relatives have the conditions below (if none leave blank)
Please enter **M**=Mother, **F**=Father, **G**=Grandparent, **B**=Brother, **S**=Sister, **A**=Aunt, **U**=Uncle

____Asthma ____Anemia ____Allergies ____ADD/ADHD ____Autism ____Auto Immune disorder
____Birth defects ____Blood Disorders ____Chicken Pox ____Cystic Fibrosis ____Cancer ____Diabetes
____Depression ____Ear infection ____Eczema ____Epilepsy ____GI Disease ____High Cholesterol
____Heart Disease ____Hearing Problem ____Heart Murmur ____High Blood Pressure ____Kidney Disorder
____Liver Disease ____Migraine Headaches ____Reflux/GERD ____Rashes ____Seizures ____Sickle Cell
____Stroke before 55 ____ Sudden Death ____Thyroid Disease ____Tuberculosis ____Urinary Problems
____Vision Problems

Other information you feel the physician should know about your child?_____
_____
_____
_____