Name: DOB: PCC#

CONDITIONS OF REGISTRATION

CONSENT FOR TREATMENT

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their children). The procedures may include, but are not limited to, minor surgery, laboratory and x-ray.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS B & C Testing. We do not randomly test for HIV.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS

I do hereby authorize Advanced Pediatrics to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to Advanced Pediatrics. I irrevocably authorize all such payments to Advanced Pediatrics. I authorize Advanced Pediatrics to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

RELEASE OF MEDICAL INFORMATION

I authorize Advanced Pediatrics to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my insurance company or its designated review agents who provide insurance benefits on my behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Health Care Financing Administration, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Advanced Pediatrics, and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to Advanced Pediatrics as required for payment of benefits and/or required for medical or any other reasons; and authorize Advanced Pediatrics to release the above mentioned records for any of the above reasons.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from Advanced Pediatrics or insurance company prior to such non-emergency services being rendered. I further understand that I must notify Advanced Pediatrics prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedure are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)'s claims. Any denial of claims is between the policy holder/subscriber and their insurance. I agree to inform Advanced Pediatrics immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment. I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred. I also understand that I may be billed separately for services rendered by other professionals including, but not limited to other physicians, radiologists and laboratory work, as appropriate and in accordance with the services rendered. Advanced Pediatrics will file for insurance benefits and accept payments per their contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policy holder and the insurance company. Any assistance in this matter granted by Advanced Pediatrics is given strictly as a courtesy and implies no responsibility on Advanced Pediatrics part for filing, follow through or conformation. I agree to pay a $50.00 fee for missed appointments that are not cancelled at least 24 hours in advance. Should any balances arise due to insurance co-payments, coinsurance, deductibles, termination of coverage, not adding a dependent to insurance plan, no-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for a $25.00 returned check fee in addition to the original fees for services. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my account are not made, I authorize Advanced Pediatrics to retain the services of an attorney to assist with the collection of any outstanding balance and to notify the credit bureaus of my delinquencies. I understand that this will affect my credit rating. If this account is placed with and attorney for collection, I agree to pay 35% of all attorney's fees incurred in collection as well as interest at the rate of 18% APR on all overdue balances. Any expenses incurred by such collection actions, including court costs, shall become an additional liability for which I assume full responsibility.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION

I certify that the information I have reported with regard to my insurance coverage is correct and that the above be honored by my insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

I AM AWARE THAT THE PARENT/GUARDIAN WHO REQUESTS TREATMENT IS RESPONSIBLE FOR THIS BILL REGARDLESS OF ANY LEGAL AGREEMENT WITH YOU OR YOUR SPOUSE.

Signature of Parent/Guardian/Guarantor	Printed Name	Date

Advanced Pediatrics Chart:

Please read and sign the following statement: I authorize my family insurance benefits to be paid directly to this office and the release of any pertinent medical information. I understand that I am financially responsible for any services not covered by my insurance, as verified by the information below.

Signature: _____ Date: _____

PATIENT INFO:

Patient PCC Number: _____ Primary Physician: _____
Patient Name: _____
Date of Birth: _____ Age: _____ Sex: _____
Race: _____
Ethnicity: _____
O Hispanic - O Not Hispanic - O Prefer Not To Answer
Preferred Language: _____
Pt Confidential Communication Preference: _____
O Mail O Cell # O Work # O Home # O Text # O E-Mail

Other Parent Info Name: DOB:

SIBLINGS:

Name	Born	Gender	Relation to Custodian

CUSTODIAL PARTY:

Name: _____ Old ID: _____ PCC#: _____
Address: _____
City/State/Zip: _____
Main Phone: _____ Work Phone: _____
Mom's Cell: _____ Dad's Cell: _____
Email: _____

RESPONSIBLE PARTY:

Name: _____ Old ID: _____ PCC#: _____
Address: _____
City/State/Zip: _____
Main Phone: _____ Work Phone: _____
Mom's Cell: _____ Dad's Cell: _____
Email: _____

INSURANCE INFO:

Primary Insurance: _____
Subscriber #: _____ Group#: _____
Subscriber Name: _____ Employer: _____
Effective Date: _____ Birthdate: _____ Sex: _____