Northern Virginia Pediatric Associates

Providing The Highest Standards Of Healthcare For Children

Patient Registration

New ❑ Existing ❑ Date _____

Please check primary doctor: ❑ Atiyeh, ❑ Halpin, ❑ Mouchahoir, ❑ Kelly, ❑ Baldrate , ❑ Henrikson ❑ Bae,
❑ PA Woodley, ❑ FNP-C Nelson, ❑ PNP-C Romaka, ❑ FNP-C Scott, ❑ FNP-C Douglass

First Child*:*

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____
Date of Birth: _____ Birth Sex: ❑ *Male* ❑ *Female* Identifies As: _____

Second Child*:*

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____
Date of Birth: _____ Birth Sex: ❑ *Male* ❑ *Female* Identifies As: _____

Third Child*:*

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____
Date of Birth: _____ Birth Sex: ❑ *Male* ❑ *Female* Identifies As: _____

Fourth Child*:*

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____
Date of Birth: _____ Birth Sex: ❑ *Male* ❑ *Female* Identifies As: _____

Fifth Child*:*

Last Name: _____ First Name: _____ Middle Initial: _____ Preferred Name: _____
Date of Birth: _____ Birth Sex: ❑ *Male* ❑ *Female* Identifies As: _____

For additional children, please ask for an additional form

Patients' Primary Address: _____ _____ _____ _____
Street City State Zip

Best Contact Phone (list only one): _____ This number is used for all communication and reminder calls.
Best Email (list only one): _____ Used for secure messaging and updates.
Messages containing my child's personal health information can be left on this number ❑ Yes ❑ No

Contact Information:

Parent/Guardian 1 ❑ Primary Contact (check only one)

Full Name: _____ Relation to Patient: _____
Cell Phone: _____ Home phone: _____
Email: _____
Address: _____ Apt #: _____
City: _____ State, ZIP Code: _____

Parent/Guardian 2 ❑ Primary Contact (check only one)

Full Name: _____ Relation to Patient: _____
Cell Phone: _____ Home phone: _____
Email: _____
Address: _____ Apt #: _____
City: _____ State, ZIP Code: _____

Northern Virginia Pediatric Associates
Providing The Highest Standards Of Healthcare For Children

Parents' relationship status (check one): ❑ Married ❑ Divorced ❑ Separated ❑ Single

If separated or divorced, are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ❑ Yes ❑ No (if yes, legal paperwork must be provided)

Insurance Information

Insurance Carrier: _____

Policy Holder's Last Name: _____ First Name: _____

Policy Holder's Date of Birth: _____ Social Security #: _____

ID #: _____ Group #: _____

Is Policy Holder Guarantor ❑ Yes ❑ No If no, who is Guarantor? _____

Name Address

Assignment and Release

I, the undersigned, certify that the information I have provided is correct and do hereby authorize Northern Virginia Pediatric Associates, PC. and/or its physicians to apply for benefits from my insurance company to Northern Virginia Pediatric Associates, PC. If applicable, I further request payment of government benefits be assigned to Northern Virginia Pediatric Associates, PC. I permit a copy of this authorization to be used in place of the original on all insurance claim submissions whether manual, electronic or telephonic.

I further authorize Northern Virginia Pediatric Associates to release any and all of my child's/children's/self's medical records and/or other records and information; (1) needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Northern Virginia Pediatric Associates, PC.; (2) to any hospital, lab, doctor, or other healthcare provider and grant permission for any hospital, lab, or other healthcare provider to release their medical records of my child/children/self to s. Records will be provided to either parent upon written request and without notice to the other, unless there is legal documentation presented to our office showing the parent bringing the child for treatment has sole legal and physical custody, or that there is a termination of parental rights, or restricted access to medical records.

Additionally, I acknowledge that I am hereby informed in accordance with the Code of Virginia Section 32.1, that if the provisions of health care services expose any health care worked to the patient's body fluids in a manner that may transmit immunodeficiency virus or HIV or Hepatitis, that the patient shall be deemed to have consented to testing for the infections and to release the test results to the person(s) exposed.

Consent to Treat

I hereby give my permission to any of the Practice Providers or their designated alternates, to take necessary medical action in the case of an emergency for my child/children when I am not immediately available.

Notice of Privacy Practices (HIPAA)

This summary does not take the place of the full Notice of Privacy Practices.

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certification.*
- *Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services*
- Records will be provided to either parent upon written request and without notice to the other, unless there is legal documentation presented to our office showing otherwise

A full Notice of Privacy Practices policy can be viewed on our website and at your request; our staff will gladly provide you a copy.

Parent or Legal Guardian Signature: _____ Date: _____

Printed Name of Parent or Legal Guardian: _____