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

Patient Registration New ❑ Existing ❑ Date _____

☐ I understand that if I am a new or returning patient, I must upload my previous immunization records via FollowMyHealth before my first appointment can be scheduled.

Please check primary doctor: ❑ Atiyeh, ❑ Halpin, ❑ Mouchahoir, ❑ Baldrate , ❑ Henrikson, ❑ Bae, ❑ Clark, ❑ Haidar
❑ PA Woodley, ❑ FNP-C Nelson, ❑ DNP, PNP-C Hawa

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: _____ Date of Birth: _____
Address: _____ Apt #: _____
City: _____ State, ZIP Code: _____

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

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

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

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: _____

Northern Virginia Pediatric Associates, PC

www.northernvirginiapediatrics.com

OFFICE POLICIES

We are honored that you have selected Northern Virginia Pediatric Associates (NVPA) as your child's healthcare provider. Our practice follows the guidelines for immunizations and routine lab tests recommended by the *American Academy of Pediatrics*. Details regarding our Vaccine Policy can be found on our website under the Insurance & Policies Tab / Vaccine Policy.

APPOINTMENTS/OFFICE VISITS; Office Hours: NVPA prides itself on having very accessible office hours to accommodate most busy schedules. We are open seven (7) days a week and on holidays. Our weekend and holiday hours are reserved for urgent sick appointments, and we cannot accommodate routine well visits or chronic issues. Current Office Hours can be found on our website under the Contact Tab. Please note additional fees may apply and our lab hours differ slightly from our office hours.

After Hours Calls: Medical emergencies command and receive the doctor's immediate attention. One of our pediatricians is available for emergencies 24 hours a day by calling our same telephone number, (703) 532-4446.

Calls after the office closes will be answered by our Triage Nurse Service. Please be available for a return call, have a pen and paper ready, and be prepared to give any necessary information, including a 24-hour pharmacy number. Should your call not be returned within the hour, please call back and leave another message.

A $20.00 administrative fee will be charged for all calls received after the office has closed.

To be fair to all patients, we ask that you be on time for scheduled appointments. Every effort will be made to accommodate patients who arrive more than 15 minutes late, however, to maintain the flow of patients on time for their appointment, your child may have to wait in the waiting room longer and/or the appointment may need to be rescheduled for another time.

Missed Appointments and Cancellations: Appointment reminder calls are sent out as a courtesy. It is ultimately the responsibility of the parent/guardian/patient to remember appointments.

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. **As of April 1, 2025, a fee of $100.00 will be assessed for missed appointments and/or cancellations with less than 24-hours' notice for Well Visits, Extended Visits/Consults and ADHD/Mental Health Visits/Consults. A $50.00 fee will be assessed for all other types of missed appointments.**

Unaccompanied Minors: If a child is accompanied by an adult other than a parent or legal guardian, a consent form must be authorized by a parent or legal guardian. Patients under 18 years of age can only be seen if accompanied by a parent or authorized adult having a signed authorization on file. An unaccompanied minor will only be treated in the rare instances allowed by law (Virginia Statute 54.1-2969).

Please be aware that Quest Diagnostics will not treat a patient under the age of 18 without an authorized adult present.

PRESCRIPTION REFILLS: Prescription refill requests (other than ADHD and mental health medications) should be requested directly by the patient contacting their pharmacy. The pharmacy will then contact our office to verify the prescription. Refills can also be taken care of by the provider during an office visit.

ADHD AND MENTAL HEALTH MEDICATION MANAGEMENT: Patients needing neurodevelopmental and/or mental health medications (ex: ADHD, anxiety, depression, mood disorders) must be seen every month until the proper medication and dose have been established. Thereafter, medication management visits are required, and patients need to be seen at least every three (3) months and medications may only be prescribed for up to 90 days at a time. Patients also need to be seen if there is a change in dosing or a change in medication, or if a medicine side-effect is suspected.

We discourage any refill requests made outside of an office visit for ADHD and mental health prescriptions. In extenuating circumstances, these prescriptions will require a request be sent through the patient's Keona portal to include the medication name and dose. **These requests made outside of an office visit will incur an administrative fee of $20.00** and will require five (5) business days for completion.

When possible, we will send prescriptions directly to the pharmacy, but when there are supply shortages, hand-written prescriptions for those medications must be picked from the office.

FORMS: All forms required by our office can be found on our website, on Keona or may be picked up at our office. Referral request forms require 5-7 business days for completion. Except for emergency room visits, referrals cannot be backdated.

One school/camp/sports health form can be completed upon request at the patient's annual Well Visit at no charge. **Each additional form completed, and any form completed outside of a Well Visit, will be charged an administrative fee of $20.00.**

The office will do everything possible to complete forms at the time of the visit, however, any **forms sent outside of a Well Visit may require up to 5-7 business days to be completed.** When available and requested, forms can be expedited (24 to 48 hours Mon-Fri) and will incur a fee of $50 per form.

Some school and sports forms can be found on our website under the forms tab and on Keona. Patient name, DOB and any medication information must be filled in prior to submitting. Forms can be dropped off at the office or uploaded through patient's Keona Account.

CONSENT AND COMMUNICATIONS: Keona is our secure online communication portal. Using Keona saves time, avoids telephone tag and allows for concise and efficient feedback from our nurses and providers. Forms, results, immunization records, etc can also be uploaded and downloaded. Additional information and instructions on how to set up an account can be found on our website, just look for the Keona logo.

Your children are our top priority. So that we may dedicate our time to providing each child with the best care possible and with the best interest of the child in mind, we expect that all parties involved communicate with one another regarding all aspects of their child's healthcare.

- Unless legally restricted or court-ordered, we cannot deny access to either parent regarding a patient's care or health information.
- Due to the volume of calls we receive daily; we are not able to contact any other parent or legal guardian when appointments are made or cancelled.
- We will depend on the adult present with the child at the time of the office to convey any information to all parties involved (parents or legal guardians) in need of that information.
- If we are contacted by another parent or legal guardian after the visit, we will make every attempt to answer their questions unless we are prohibited from doing so by court order. Given that such communication may take almost as much time as the original appointment, it may increase the charge for the appointment or may incur a separate, additional charge that may not be covered by insurance.

Health Information Request: Any request for copies of office notes, test results, immunizations or other records should be sent via your Keona Account.

Patients 18 years and over: Any health information (i.e., vaccination records, test results and medical records) for patients 18 years and older cannot be released to anyone other than the patient, unless the patient has signed a release. Over 18 Authorization release can be found on our website under the forms tab.

COPIES OF MEDICAL RECORDS/TRANSFER OF RECORDS: Transfer Request forms can be found on our website under the Patient Forms tab. Please allow 5-7 business days for the transfer of records. Records can be mailed or picked up at the office. **There is a $30.00 administrative fee for making a copy of a medical record or for the transfer of a record.**

ON-SITE LABORATORY SERVICES: For our patients' convenience, we offer comprehensive laboratory services on our premises, staffed by both NVPA and Quest Diagnostics. Lab work needed outside of a same day office visit, requires an appointment. To ensure all lab orders have been ordered, requests for a lab appointment need to be sent through Keona.

We bill your insurance company for lab tests run in our office**. Any lab tests sent out to Quest for processing will incur a $25.00 convenience fee.** Should you wish not to pay this fee, you may go to the laboratory that contracts with your insurance company. Tests processed by Quest will be billed to your insurance company directly by Quest. Any questions regarding a Quest patient balance should be directed to Quest.

The following tests are run in our office and billed to your insurance with no additional fee applied:

87426 (Covid Antigen Test)	87880 (Strep Test)	81000 (Urinalysis)
87635 (Covid PCR)	87651 (PCR Strep)	87807 (RSV Test)
87637 (PCR, RSV, Flu A&B tests)	87804 (Flu A & B Tests)	82948 (Glucose Blood Strip)
85018 (Hemoglobin)	86308 (Mono Spot)	

Any bill you receive from our office regarding the above tests will have been processed by your insurance company and determined as the patient responsibility. Any questions regarding this balance should be directed to your insurance company.

INSURANCE AND BILLING POLICIES: To ensure that insurance billing be as seamless as possible, we ask that you please read the information below carefully. Should you have any questions, our team will be happy to answer them. You can reach the business office by dialing our main number (703) 532-4446, and press Option 5.

NVPA follows the guidelines established by the *American Academy of Pediatrics* for rendering appropriate, quality medical care regardless of the provisions you have with your insurance company. It is the parent/guardian's responsibility to know if we participate with their insurance and to understand their benefit coverage prior to any services being rendered. Any questions regarding participation or coverage should be directed at your insurance company.

Newborns: Newborns should be added to your insurance after you are discharged from the hospital. Care for your newborn is not covered by your insurance until the baby is officially registered on your plan. Most insurance companies require this to be done before your child is 30 days old.

Billing Insurance: As a courtesy, we will bill participating insurance companies. The guarantor is responsible for all charges processed by their insurance company that are determined to be non-covered services, deductibles, coinsurance and/or co-payments. Any questions regarding these balances should be directed at your insurance company.

Notifying Changes: It is the responsibility of the guarantor to notify our office of changes in insurance and/or demographics in a timely manner. Failure to notify the office of changes may result in claims being denied for timely filing, and unpaid charges will be billed as patient/guarantor responsibility. **Unless otherwise directed, the guarantor will be the insurance policy holder.**

Copayments: It is a contractual agreement between you and your insurance company to know what your co-payment is and to pay it at the time of service regardless of whether our staff requests it. **Co-payments that are not paid at the time of service will incur a $10.00 administrative fee.** Any questions regarding your co-payment should be directed to your insurance company.

Self-Pay: Self-pay patients are expected to pay in full at the time of service unless prior arrangements have been made.

Diagnosis and Well Visits: If we discover an abnormality or address a pre-existing condition during a routine preventative well visit, an additional diagnostic code may be needed, and your insurance company may apply a co-payment or deductible for that portion of the visit.

Provider Return Calls: Calls returned by a provider for patient evaluation/advice may be billed to your insurance based on the length of time required for the call and documentation. Depending on your insurance coverage, you may be responsible for charges for a telehealth visit.

Pre-Travel Visits: Travel visits and travel vaccines may not be covered by some insurances and parent/guardians may be responsible for some or all the charges. Any questions regarding coverage for travel visits and travel vaccines should be directed to your insurance company.

Billing Statements: Please do not ignore patient billing statements. If you receive a billing statement from our office, charges have been submitted to, and have been processed by, your insurance company. Although our business office is available to answer any questions you may have, we ask that you please call your insurance company prior to calling our office with questions regarding co-pays, co-insurance, deductibles and/or coverage.

Past Due Balances: Past due balances of more than 90 days with no payment activity or payment plan in place, will be assessed a monthly $25.00 late fee. Past due balances of $ 500.00 or more will also incur 6% interest. Past due accounts of over 90 days will require payment prior to scheduling a Well Visit. Past due accounts may also be turned over to our collection agency and the patient may be dismissed.

Medicaid: We are not contracted with Medicaid, or Medicaid Replacement Plans, and CANNOT see patients that have Medicaid or Medicaid Replacement Plans. If you have Medicaid, or a Medicaid Replacement Plan, or plan to apply for either, you will need to find a provider that accepts Medicaid insurance.

PRIOR AUTHORIZATIONS: On occasion, your insurance will require a Prior Authorization (PA) to fill a prescription. This is something that our providers are unable to foresee and is entirely dependent on your individual medical plan benefits. For the most part, the turn-around time for a PA decision is 5-7 business days but this can vary significantly.

Your insurance carrier may deny a PA and provide alternative medications. Should a patient / parent not agree with their insurance company's denial, they may initiate an appeal. For more information regarding Prior Authorizations, the appeal process, and patient's responsibilities go to Policies Tab / Prior Authorizations.

Should you have any questions or need any additional information, please ask a staff member. If they are not able to help you, they can direct you to someone that can.

Thank you for your understanding and cooperation regarding these policies.

****Fees and policies are subject to change. Please refer to our website for the most up to date information. Website: www.northernvirginiapediatrics.com**

Please sign and return the following page to reception, thank you.

By signing below, you acknowledge that you understand NVPA's Office, Insurance and Billing Policies, Laboratory Billing Consent and Communication Between Caregivers including but not limited to, non-payment of copays, charges for missed appointments, outstanding balances, lab convenience fee and confirm patients are not covered under Medicaid or a Medicaid Replacement Plan. You also acknowledge you will communicate these policies with all parties involved in your child's care. You are also aware fees and policies are subject to change and will communicate these policies with all parties involved in your child's care.

_____

Parent / Guardian Name (please print) Parent / Guardian Signature Date

PATIENTS:

Last Name	First Name	DOB