F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

PATIENT REGISTRATION FORM – PATIENTS 18 YEARS OLD OR OLDER

PATIENT'S INFORMATION

Name: _____ Soc. Sec.# ☐☐☐☐☐☐☐☐☐ Date of Birth _____ Sex____

Street Address _____

City/State/ZIP _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Employer's Address _____ _____

Are you a Student? _____ If so, Full-time or Part-time? _____ Where? _____

**** I elect to receive appointment reminders by : ☐ TEXT ☐ EMAIL**

PATIENT'S INSURANCE INFORMATION

Primary Insurance _____ Identification # _____ Group # _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Effective Date _____ Policy Holder's Relationship to Patient _____

Secondary Insurance _____ Identification # _____ Group # _____
Policy Holder's Name _____ Policy Holder's Date of Birth _____
Effective Date _____ Policy Holder's Relationship to Patient _____

WHICH PHARMACY DO YOU USE ? _____

Please present copies of all applicable insurance cards.

Person responsible for payment _____ ***Relationship to Patient*** _____

EMERGENCY CONTACT INFORMATION

Emergency Contacts (List 2 persons)

Name _____ Relationship to patient _____
Address _____
Home Phone _____ Work Phone _____ Cell Phone _____

Name _____ Relationship to patient _____
Address _____
Home Phone _____ Work Phone _____ Cell Phone _____

Name of Person Completing This Form _____
Signature _____ ***Date*** _____

REVISED 7/2018

******OFFICE USE ONLY ***** **Reviewed by:** ***Signature*** _____ ***Date:*** _____

F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

Financial Policy/Record Retention Policy

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS: We submit charges for services rendered to your insurance company as a courtesy to you. If the patient is covered by one of the health insurance plans with which we participate, we are required by the plan to collect co-payments and deductibles at the time of service. It is imperative that you bring your insurance card and mailing address of your health insurance plan with you to every visit, making us aware of any changes in your coverage. Failure to provide us with current insurance information could result in a reduction of your benefits and higher out-of-pocket costs for you.

I, the undersigned, assign directly to F. Read Hopkins Pediatric Associates, Inc., all medical insurance benefits, if any, otherwise payable to me, for services rendered. Payment in full is due at the time of service unless other arrangements have been made in advance. Any balance not paid at the time of service will be considered an extension of credit and may incur finance charges up to eighteen percent (18%). I understand that I am financially responsible for all charges whether or not paid by insurance, and in the event any amount due remains unpaid after a bill is rendered, I agree to pay a collection penalty of twenty-five percent (25%) of the then principal account balance and any other fees, including reasonable attorney fees. If you pay by check and it is returned for any reason, you will be charged a return check fee as allowed by law. You also agree to allow us, our agent, successors or assigns to turn your check into an electronic transaction at our discretion and to debit your checking account for any return check fees. In order to facilitate prompt payment, we offer several forms of payment. These include cash, check, money order, debit transactions, VISA, MasterCard, Discover, and American Express.

I authorize the release of any medical or incidental information to my insurance carrier to determine benefits payable for services rendered, or to meet insurance requirements for quality assurance. Fax and/or electronic transmission of medical records is allowed if indicated. I certify that the insurance information I have provided to F. Read Hopkins Pediatric Associates is correct.

MEDICAL RECORD RETENTION: I understand that medical records will be retained for a minimum of six years following the last patient encounter. Records of a minor child, including immunizations will be maintained until the child reaches the age of eighteen or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the child. The records will then be destroyed in a manner that assures confidentiality throughout the process and in its results.

Signature of Biological Mother/ Legal Guardian/Patient	Relationship to Child	Date

Print Name of Biological Mother/Legal Guardian/Patient

Signature of Biological Father/Legal Guardian	Relationship to Child	Date

Print Name of Biological Father/Legal Guardian

07/2018 Revised

***OFFICE USE ONLY *** **Reviewed by:** *Signature*_____ *Date:*_____

F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.
COMPOUND CONSENT FORM

PATIENT(S) NAME:	DATE of BIRTH:

BIOLOGICAL MOTHER/LEGAL GUARDIAN NAME: _____

BIOLOGICAL FATHER/LEGAL GUARDIAN NAME: _____

F. Read Hopkins Pediatrics (FRHP) is dedicated to protecting the privacy of our patients. Except where required by law, FRHP will NOT authorize treatment, disclose, or discuss any information regarding your/your child's health or financial information with anyone other than the parent or legal guardian, unless otherwise listed below. **Please consider adding certain people such as step-parents, grandparents, relatives over the age of 18, babysitters, or other care providers that may need to seek treatment or advice in your absence.**

NAME	Relationship to Patient	Phone #	Permission for the following Circle all that apply
			• Bring in for appointment • Seek medical advice • Pick up prescripts/forms • Obtain lab results • Discuss financial/insurance info
			• Bring in for appointment • Seek medical advice • Pick up prescripts/forms • Obtain lab results • Discuss financial/insurance info
			• Bring in for appointment • Seek medical advice • Pick up prescripts/forms • Obtain lab results • Discuss financial/insurance info
			• Bring in for appointment • Seek medical advice • Pick up prescripts/forms • Obtain lab results • Discuss financial/insurance info

If you would like to have the ability to verbally request FRHP to fax school notes or immunization records to your child's school, please complete the section below:

SCHOOL NAME	PATIENT	FAX #	PERMISSION TO FAX THE FOLLOWING (Circle all that apply)
			SCHOOL NOTES IMMUNIZATION RECORDS
			SCHOOL NOTES IMMUNIZATION RECORDS
			SCHOOL NOTES IMMUNIZATION RECORDS

F. Read Hopkins may post photos received from parent or legal guardian in office: yes no

I elect to receive communication such as appointment reminders, lab results, forms, etc. by: (circle)

VOICEMAIL TEXT EMAIL FAX

For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

TELEPHONE COMMUNICATIONS:

You authorize us, our successors or assigns, to call, email or send you a text message to any number, email address you provide or at any number at which we reasonably believe we can contact you, including calls or texts to mobile, cellular, or similar devices, and including calls using automatic telephone dialing systems and/or prerecorded messages, for any lawful purpose, including but not limited to: (1) suspected fraud or identity theft; (2) obtaining information necessary or desirable; (3) your account transactions or servicing; and (4) collecting on your Account. Numbers you provide include numbers you give us and/or numbers from which you call us, our successors or assigns. You agree to pay any fee(s) or charge(s) that you may incur for incoming calls from us, our successors or assigns, and/or outgoing calls to us, our successors or assigns, to or from any such number, without reimbursement from us.

Signed_____ (Patient/Subscriber, or Parent of Minor) Date_____

CONSENT: I consent to allow the providers, nurses, and employees of F. Read Hopkins Pediatric Associates to perform all duties to diagnose, treat, and care for my/my child's health needs. I also understand that I have the right and responsibility to take part in making decisions regarding my/my child's care and plan for treatment.

DEEMED CONSENT: As a health care provider, we are required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

If one of our health care professionals, workers, or employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus ("HIV, the AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling, if necessary.

If you should be directly exposed to blood or body fluids of one of our health care professionals, workers, or employees in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus ("HIV, the AIDS" virus) and for the presence of the Hepatitis B and Hepatitis C viruses. A physician or other health care provider will tell you and that person the result of the test and provide counseling.

PATIENT RIGHTS:

I have the right to revoke this authorization at any time. I may inspect or obtain a copy of the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient/parent/guardian, or at the time the minor child reaches 18 years of age.

Signature of **BIOLOGICAL Mother**/Legal Guardian/Patient _____ Relationship to Patient _____ Date _____

Print Name of **BIOLOGICAL Mother**/Legal Guardian/Patient _____

Signature of **BIOLOGICAL Father** /Legal Guardian _____ Relationship to Patient _____ Date _____

Print Name of **BIOLOGICAL Father** /Legal Guardian _____

F. READ HOPKINS PEDIATRIC ASSOCIATES, INC.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient(s) Name(s): _____ **DOB:**_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature:_____ **Date:**_____
(Parent/Legal Guardian/Patient)

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

☐ **An emergency existed & a signature was not possible at the time.**

☐ **The individual refused to sign.**

☐ **A copy was mailed with a request for a signature by return mail.**

☐ **Unable to communicate with the patient for the following reason:**

_____

Other:_____

_____

Prepared By:_____

Signature:_____ **Date:**_____

REVISED 10-13-16