Union Mill Pediatrics, PC

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⌋ New Patient
⌋ Existing/Update

PATIENT REGISTRATION

Patient Information PLEASE PRINT FILL **ALL** AREAS

CHILD'S FIRST NAME	MIDDLE INITIAL	LAST NAME	NICK NAME	BIRTHDATE MM/DD/YYYY	SEX	SECONDARY INSURANCE? If yes-Provide card	DRUG ALLERGIES * Alert Medical Staff at every visit
1					M F	YES NO	
2					M F	YES NO	
3					M F	YES NO	
4					M F	YES NO	
5					M F	YES NO	

Parent #1 ⌋ Mother ⌋ Father ⌋ Stepmother ⌋ Stepfather ⌋ Legal Guardian Child resides at this address? YES / NO (Circle One)

Full Name	Date of Birth	Social Security Number	Primary Phone Number	
Home Address		City	State	Zip
Employer Name & Address			Work Phone Number	
Home or Work E-mail			Cell Phone Number	

Parent #2 ⌋ Mother ⌋ Father ⌋ Stepmother ⌋ Stepfather ⌋ Legal Guardian Child resides at this address? YES / NO (Circle One)

Full Name	Date of Birth	Social Security Number	Primary Phone Number	
Home Address		City	State	Zip
Employer Name & Address			Work Phone Number	
Home or Work E-mail			Cell Phone Number	

Emergency Contact (Friend or Relative)

Name	Relationship to Patient	Home Phone Number

Insurance information

Written information and copy of insurance card is required to file benefits

Policy Holder's Full Name		Social Security Number of Subscriber		Co-Payment/Co-Insurance Amount
Primary Insurance Company		Sex of Policy Holder M F	Birth date of Policy Holder	Effective Date
Policy Holder's Employer		Employer Plan? Yes No		Identification/Policy Number
Insurance Address		Insurance Network		Group Number
City	State	Zip	Insurance Phone Number for Eligibility/Verification	

I certify that the information I have reported above is correct and that as the Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on the back of this document.

Signature of Parent/Guardian/Guarantor _____ Print Name _____ Date _____

PAYMENT IS DUE AT TIME OF SERVICE

You must read conditions of Registration included with/on the back of this form

THE PRACTICE
Union Mill Pediatrics, PC and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT
The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures as required by the physician rendering care for themselves and/or their child(ren).

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 & ASSIGNMENT OF INSURANCE BENEFITS - I do hereby authorize the Practice 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 (our) insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of benefits.

RELEASE OF MEDICAL INFORMATION - I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to the Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release me or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to the Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize the Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied.

REFERRALS AND AUTHORIZATIONS - In order to receive a referral, Patients are required to have a well check within the last 12 months, and have been seen for the issue requiring a specialist. I understand that it is my responsibility, if I (we) have an insurance plan that requires referrals, pre-certifications or authorization for additional medical services, to request and obtain such from the Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must request a referral from the Practice at (5) full business days prior to my appointment, and that if less than 5 full business days is given a $10 fee will be charged to my account, and further that a $25 fee will be charged for non-urgent same day referral requests. I also agree that I must notify the Practice within 48 hours or in accordance with my insurance company's requirements for any emergency room visit. Additionally, I understand 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 policyholder/subscriber and their insurance. I (we) agree to inform the Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT
I understand that a patient over the age of 18 years can be held financially responsible separate from the parents. I cannot assign financial responsibility to another person and understand that I assume full financial responsibility for each visit. 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 by my children, stepchildren or any other extended family members. I also understand that I (we) 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. The Practice will file for insurance benefits and accept payments per the Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by the Practice is given strictly as a courtesy and implies no responsibility on the Practice's part for filing, follow through or conformation. I agree to pay any of the below fees (which are subject to change without notice) when deemed necessary by practice policies: a $15.00 billing fee for each payment not made at time of visit, including co-payments and co-insurance. A $25 fee for any Saturday visits; a $10 form fee for all forms requested 30 days before or after a well check. I agree to pay a $35.00 fee for missed sick appointments, and $50 for missed physicals/well visits and consultative appointments that are not cancelled at least 24 hours in advance and understand that if I am 10 or more minutes late that my appointment may be considered missed. I agree to pay a $15.00 fee for each after hour's telephone call for medical advice, with the understanding that this fee is waived if triage makes an appointment for the next business day. I understand that billing, emergency/walk-in, prescription refills, form, missed appointment, and after hours telephone advice fees will be my financial responsibility and will not be sent to insurance. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependent to insurance plan, non-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 $35.00 returned check fee in addition to the original fees for services. A late fee of $25 per month will be added to bills over 60 days old. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. I understand that this will affect my (our) credit rating. If this account is placed for collection, I understand and agree that I am responsible for an additional 40% of my total bill, to cover administrative and collection fees, as well as any attorney fees, court costs and late fees, beginning as early as 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I (we) 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 (our) insurance coverage is correct and that the above be honored by my (our) 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 foregoing and as the parent/guardian/guarantor understand and fully accept the terms therein.