TOWN PEDIATRICS, PC **2015**

823-F SOUTH KING STREET PHONE 703-777-5222
LEESBURG, VA 20175 FAX 703-777-5144

□ New Patient □ Existing PATIENT REGISTRATION (Staff Only: Checked ___ Entered ___)

Date	Contact Parent/Guardian

Children (please list all your children) *Please Print*

First Name	Last Name	Nick Name	Sex	Date of Birth
1				

Race: □ Caucasian □ African American □ Asian □ Native American/Alaskan Native □ Native Hawaiian/Pacific Islander
□ Hispanic/Latino □ Other Race: _____ □ Patient declined to provide race
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Patient declined to provide ethnicity
Preferred Language: □ English □ Spanish □Other (Please specify): _____ □ Patient declined to provide language

First Name	Last Name	Nick Name	Sex	Date of Birth
2				

Race: □ Caucasian □ African American □ Asian □ Native American/Alaskan Native □ Native Hawaiian/Pacific Islander
□ Hispanic/Latino □ Other Race: _____ □ Patient declined to provide race
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Patient declined to provide ethnicity
Preferred Language: □ English □ Spanish □Other (Please specify): _____ □ Patient declined to provide language

First Name	Last Name	Nick Name	Sex	Date of Birth
3				

Race: □ Caucasian □ African American □ Asian □ Native American/Alaskan Native □ Native Hawaiian/Pacific Islander
□ Hispanic/Latino □ Other Race: _____ □ Patient declined to provide race
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Patient declined to provide ethnicity
Preferred Language: □ English □ Spanish □Other (Please specify): _____ □ Patient declined to provide language

First Name	Last Name	Nick Name	Sex	Date of Birth
4				

Race: □ Caucasian □ African American □ Asian □ Native American/Alaskan Native □ Native Hawaiian/Pacific Islander
□ Hispanic/Latino □ Other Race: _____ □ Patient declined to provide race
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Patient declined to provide ethnicity
Preferred Language: □ English □ Spanish □Other (Please specify): _____ □ Patient declined to provide language

Mother □ Mother □ Stepmother □ Legal Guardian □Married □Unmarried □Divorced If divorced, child resides with? _____
Father □ Father □Stepfather □ Legal Guardian □Married □ Unmarried □Divorced If divorced, child resides with? _____

Parent/Guardian Full Name	DOB	Parent/Guardian Employer	
Home Address	City	State	Zip
Home Phone Number ( ) -	Work Phone Number ( ) -	Cell Phone Number ( ) -	
Social Security Number	Preferred Number: □ Home □ Work □ Cell Ok to leave voicemail on preferred? Y/N		

Mother □ Mother □Stepmother □Legal Guardian □Married □Unmarried □ Divorced If divorced, child resides with? _____
Father □Father □Stepfather □Legal Guardian □Married □Unmarried □Divorced If divorced, child resides with? _____

Parent/Guardian Full Name	DOB	Parent/Guardian Employer	
Home Address	City	State	Zip
Home Phone Number ( ) -	Work Phone Number ( ) -	Cell Phone Number ( ) -	
Social Security Number	Preferred Number: □ Home □ Work □ Cell Ok to leave voicemail on preferred? Y/N		

Patients 18 years and older

Name	Preferred #: ☐ Home ☐ Work ☐ Cell Ok to leave voicemail on preferred? Y/N	Patient's Primary Phone Number (Not parent/guardian) ( ) -

Emergency Contact other than parents (Relative or Friend)

Name	Relationship	Primary Phone Number ( ) -

Primary Insurance Information **__ Check here if SELF-PAY (*or we do not accept your insurance.*)**

Please be advised, our office doesn't bill absentee parents.The guardian bringing the child is considered financially responsible.

Primary Insurance Company			Identification/Policy Number	
Insurance Network, if applicable			Group Number	
Insurance Address			Insurance phone number for eligibility/verification ( ) -	
City	State	Zip	Insurance Co-Payment/Co-Insurance	
Policyholder/Subscriber (not employer)	Social Security Number of Subscriber	Sex	DOB of Subscriber	Employer Plan? Y *or* N

***PLEASE BE AWARE THAT WE DO NOT FILE TO SECONDARY INSURANCE UNLESS IT IS MEDICAID**

Email Address	**☐ Prefer not to provide**

ASSIGNMENT AND RELEASE

I, the undersigned, certify that the information I have provided is correct and do hearby authorize Town Pediatrics, PC and/or it's physicians (hereafter referred to as Town Pediatrics, PC) to apply for benefits from my insurance company to Town Pediatrics, 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 Town Pediatrics, PC to release any and all of my children'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 Town Pediatrics, PC, and (2) to any hospital, lab, doctor, or other healthcare provider to release their medical records of my child/children/self to Town Pediatrics, PC.

_____ _____

Date Signature of Insured / Parent / Guardian / Patient

Parent Acknowledgement of receipt of Children's IQ Network (CIQN) Information Sheet

I have received and read a copy of Children's IQ Network (CIQN) Information Sheet. I understand that patient information will be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the CIQN. I also understand that I have the right to not share (opt out) health information with other providers within the CIQN.

_____ _____

Date Signature of Insured / Parent / Guardian / Patient

FINANCIAL AGREEMENT

I agree that payment in full is due at the time of treatment, unless other arrangements are made. If payment is not received at time of service, I understand that my account will be charged an additional $15 out of pocket service fee. This fee will be waived for accounts where payment is received within 7 days of the date of service. I further agree that I (parent/guardian/self) am responsible for all fees and services rendered for treatment of my child/children/self. As a courtesy, Town Pediatrics, PC will file claims for most major insurance carriers. Town Pediatrics, PC will not file claims to a secondary insurance company. I (parent/guardian/self) agree to verify with the insurance company that Town Pediatrics, PC is a participating provider. I agree to adhere to the 30 day insurance policy of Town Pediatrics, PC. I understand that it is my responsibility to provide current insurance information within 30 days of the date of service. If I fail to do so, I will be responsible for the charges in full and Town Pediatrics, PC will not file the claim to the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and their insurance carrier. Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-selection of a primary care physician or not adding a dependent to insurance plan, non-payment at the time of service and / or any other reason I agree to promptly pay all charges. I agree that if for any reason my check is returned that I will be responsible for a $50.00 fee in addition to the amount of the claim. If the balance is not paid and / or timely payments of this account are not made, I authorize Town Pediatrics, PC to retain the services of an attorney and / or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I assume responsibility. This agreement is made this day in the County of Loudoun and shall be governed by the laws of the Commonwealth of Virginia.

_____ _____

Date Signature of Insured / Parent / Guardian / Patient