Registration 18 and older

Today's Date: ____________________

REV 11/1/2018

Patient's Information (Please Print)
Full Legal Name: ____Nick Name: ____________________
D.O.B: ______/_______/_______ Sex: M / F Social Security # _______________________________________
Home Address ____
City, State, Zip ____
Home # ______________________Cell # ____________________ Work # ____________________________________
Email Address: ____

Please check the Preferred Number to call: ___ Home ___ Cell ___ Work
Number: ____
Please check the Best Time to call: ___Morning ____Afternoon ____Evening

As a service to our clients, we provide courtesy appointment reminder calls and other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Parents Information: ___ Father ___ Mother __ Step Mom __ Step Dad ___ Other _______________
Full Name____ D.O.B _____/_____/_____
Home Address ____
City, State, Zip:____
Social Security # _____________________ Employer ____
Home # ___________________________ Cell# ________________________ Work # ______________________ Ext ____
I give permission to release information to my parent listed above. Y / N

Other Parent Information : ____ Father ____ Mother ____ Step Mom ____ Step Dad ____Other__________________
Full Name____ D.O.B ______/______/_______
Home Address ____
City, State, Zip:____
Social Security # _____________________ Employer ____
Home # ___________________________ Cell# ________________________ Work # ______________________ Ext ____
I give permission to release information to my parent listed above. Y / N

Pharmacy Information:

Name of Pharmacy: ____ Phone #: ______________________________

Address: ____Fax #: __________________________________

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Consent to Email and Text:
____ (Initials) I consent to receiving text messages regarding appointment reminders, feedback, general health information, and account information to the above listed cell numbers.

____ (Initials) I consent to receiving emails regarding appointment reminders, feedback, general health information, and account information to the above listed email addresses. **We can only send emails to one email address so please provide the one you want emails going to. Email Address: ____**
Y / N I would also like to be signed up for NOVA Pediatrics' Patient Portal. Please ask the front desk for more information regarding the Patient Portal and to get your password and login.

Primary Insurance Information (Please provide card to scan) Effective Date ______/_______/_______
Insurance Company Name ____ Copay Amount __________
Policy # / ID ____ Group # ____________________________________
Policy Holder's Full Name _______________________________________D.O.B.______/______/______ Sex: M / F
Social Security # _____________________ Relationship to Patient __ Parent __ other (explain) __________________
Type of Insurance: _____HMO _____PPO _____Medicaid/HLK Plus/FAMIS PCP ___________________________

Secondary Insurance Information (Please provide card to scan) Effective Date ______/_______/________
Insurance Company Name ____ Copay Amount __________
Policy # / ID ____ Group # ____________________________________
Policy Holder's Full Name _______________________________________D.O.B. ______/_______/_______ Sex: M / F
Social Security # _____________________ Relationship to Patient __ Parent __ Other (explain) __________________
Type of Insurance: _____HMO _____PPO _____Medicaid/HLK Plus/FAMIS PCP ___________________________

Permission to Receive Information regarding the patient:
Family or friends that you give permission to receive medical information.
Name ________________________________ Relationship ____________________Phone # ____________________
Name ________________________________ Relationship ____________________Phone # ____________________
Name ________________________________ Relationship ____________________Phone # ____________________
Name ________________________________ Relationship ____________________Phone # ____________________
Name ________________________________ Relationship ____________________Phone # ____________________
Name ________________________________ Relationship ____________________Phone # ____________________
This authorization will remain in effect until the office is notified in writing.

NOVA PEDIATRICS AND YOUNG ADULT MEDICINE

_______ **Initials:** I was offered/received a copy of the FINANCIAL RESPONSIBILITY POLICY.

_______ **Initials:** I was offered/received a copy of the PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI).

_______ **Initials:** I authorize NOVA Pediatrics to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. MY INITIALS CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_______ **Initials:** I hereby authorize NOVA Pediatrics to accept assignment and apply for benefits on my behalf for covered services rendered to me. I request payment from my insurance company(s) listed on my patient demographics form be made payable to NOVA Pediatrics. I understand and agree that I am financially responsible for any charges not covered by my insurance carrier for this visit. This includes, but is not limited to, co-insurances, co-payments, deductibles and charges not covered by my insurance carrier (for instance, some immunizations, labs and procedures). I am also responsible for services not covered if NOVA Pediatrics has not been listed as the Primary Care Provider (PCP) with the insurance company and on my insurance identification card.

I understand that policies vary among insurance carriers and it is the responsibility to know which benefits are covered or not covered by the insurance program in which I participate. There may be additional charges for disease-related matters addressed during a well checkup. I also understand and agree that if my insurance carrier notifies NOVA Pediatrics that I am not covered, has no well coverage, or has exceeded well checkup coverage, I will be financially responsible for the entire charge and will pay promptly upon receipt of the statement. I understand copayments are due at the time of service and a fee will be assessed if it is not paid. If NOVA Pediatrics does not participate with my insurance plan, I will pay the charges for this service in full at the time of the visit.

I certify that the information I have reported with regard to my insurance coverage is correct and my demographics and insurance information is up to date and I further authorize the release of any information concerning me , to my insurance company in order to determine insurance benefits to which I may be entitled.

_______ **Initials:** Patient's Rights/Data Sharing: As NOVA Pediatrics is a member of the Children's IQ Network, some of your clinical information may be shared with other providers in the network on a need to know basis. The Children's IQ Network® connects Children's National hospital, emergency department, community health centers, independent health care practitioners, regional immunization registries and commercial laboratories. Health data pertaining to you is shared between authorized health care providers within the Children's IQ Network® to ensure that accurate and complete information is available to make your care safer, more efficient, and less costly. I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the Children's IQ Network. I also understand that I have the right to not share (opt out) health information with other providers within the Children's IQ Network.

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_______ **Initials: Release of Medical Records, Immunization History, and Child Locator Information**
I authorize NOVA Pediatrics to release and/or send medical information/records with regard to my child's health condition to other consultants and/or referring physicians, licensed healthcare facility, local or district health department, the department of health, and /or any education facility as appropriate. NOVA Pediatrics will share immunization and child locator information with other physicians, hospital, and health department for purposes of ensuring that he/she receives age appropriate immunizations. The information released may include but is not limited to: name of patient, date of birth, social security number, parents name(s), telephone number, address, and any other records of treatment, examination, and /or diagnosis. Furthermore, I understand that the information may be released by forwarding a photocopy through the U.S. postal service or by confidential facsimile. Conversely, I authorize any of the above listed persons/facilities to release any medical information necessary for my child's (children's) medical treatment to the doctors of NOVA Pediatrics. Ltd.

Print Name of Person Completing Form: ____

Signature of Person Completing this Form: ____ Date____________