Registration 0 – 17 years old

Today's Date: ____________________ REV 8/26/2019

Patient (child's) Information (Please Print)

Full Legal Name: ____Nick Name: ____________________

D.O.B: ______/_______/_______ Sex: M / F Social Security #:______________________________________

Home Address ____

City, State, Zip ____

Home #:______________________Cell #:____________________Email Address: ______________________________

Hospital Born In___________________________________ Name of OB____

Sibling Information

Full Name: ____ D.O.B.: _____/_____/______ Sex: M / F

Full Name: ____ D.O.B.: _____/_____/______ Sex: M / F

Full Name: ____ D.O.B: _____/_____/______ Sex: M / F

Full Name: ____ D.O.B.: _____/_____/______ Sex: M / F

Full Name: ____ D.O.B.: _____/_____/______ Sex: M / F

Full Name: ____ D.O.B.: _____/_____/______ Sex: M / F

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.

Check who the child primarily lives with: ___ Father ___ Mother __ Step Mom __ Step Dad ___ Other _______________

Full Name:____ D.O.B _____/_____/_____

Home Address: ____

City, State, Zip:____

Social Security #:_____________________ Employer:____

Home #: __________________________Cell#:________________________ Work #:______________________ Ext:____

Is this person financially responsible for the account? Y / N

Other parent / Guardian: ____ Father ____ Mother ____ Step Mom ____ Step Dad _____ Other____________________

Full Name: ____ D.O.B ______/______/_______

Home Address:____

City, State, Zip:____

Social Security #:_____________________ Employer:____

Home #:__________________________Cell #: ________________________Work #:______________________ Ext ____

Is this person financially responsible for the account? Y / N If not fill out financially responsible section below.

Please check the Preferred Number to call: ___ Home ___ Cell ___ Work

Number: ____

Please check the Best Time to call: ___Morning ____Afternoon ____Evening

Financially Responsible: ______ Father ______ Mother _______Other ___________________________________

Full Name: ____ D.O.B ______/_______/_______

Home Address: ____

City, State, Zip: ____

Home #: __________________________ Cell#: ________________________ Work #:_____________________ Ext ____

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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 ___________________________

How Did You Hear About Us?

Insurance Book or Website ______ Publication ______ Community Event ______

Internet Search Engine: Google____ Yahoo____ Bing ____ Please list search word(s) used ________________________

If the following referred you, please list their name and address so a thank you card can be sent:

NOVA Employee ____ Physician Name ____ Friend or Family Member ____

Name: ____

Address: ____

Pharmacy Information:

Name of Pharmacy: ____________________________________ Phone #: ____________________________

Address: ____Fax #: _________________________________

Permission to Treat

Family or friends that you give permission to bring your children in to be treated by NOVA Pediatrics in your absence and 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.

_______ **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 my child/dependent. 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). The parent/guardian is 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 the patient's insurance identification card.

I understand that policies vary among insurance carriers and it is the parent/guardian's 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-child checkup. I also understand and agree that if my insurance carrier notifies NOVA Pediatrics that my child is not covered, has no well-child coverage, or has exceeded well-child 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 my child, to my child's insurance company in order to determine insurance benefits to which I may be entitled.

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_______ **Initials:** Patient's Rights/Data Sharing: As NOVA Pediatrics is a member of the Children's IQ Network, some of your child's 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 or your child 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 or the care of your child 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.

_______ **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.

*** Please note that under Virginia law, the person who brings the child in for services is responsible for the payment of the service (this takes priority over custody, child support, or property settlement agreements). ***

Print Name of Person Completing Form: ____

Signature of Person Completing this Form: ____ Date____________