Welcome to King George Pediatrics (KGP). We look forward to meeting you and are pleased to become your primary care medical practice.

There are important steps you can take, prior to your first appointment that will reduce the amount of time you will need to spend at our office on your first visit.

- Bring all of your current medications with you
- Complete and bring the enclosed forms with you
- Sign a medical record release at your previous primary care provider's office to request that your records be sent to us before your first appointment
- If you have recently been hospitalized, had an ER visit or had testing done, please notify us immediately and/or bring those medical records with you
- Bring all of your current insurance ID cards with you
- Bring a picture ID with you
- Bring your co-payment (if applicable) with you
- Bring payment if you are not covered by insurance

Please arrive only 15 minutes early for your first appointment if you have completed and bring all of the enclosed forms. If you haven't, please arrive 30 minutes early for your first appointment to allow extra time to complete the enclosed forms.

If you are unable to keep your first, or any future appointment with us, please call us at 540-775-6891 at least 24 hours in advance to avoid a $45 cancellation fee.

We are looking forward to providing you with the very best primary care services. If you have any questions regarding the information provided to you in this packet, please call our office and our reception staff will be happy to assist you.

Sincerely,

Ilya Zavelsky MD

Ilya Zavelsky MD

PATIENT REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:		Marital status:

Is this your legal name? ● Yes ● No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ● M ● F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by (Please choose one option):

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here? ● Yes ● No		Is this patient covered by insurance? ● Yes ● No	
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Assignment of Insurance Benefits: I hereby authorize payment to this practice for any benefits payable to me for healthcare services provided to the client/patient at this practice. I understand that if health insurance information is provided, this in no way relieves me of financial responsibility for services rendered now or in the future at this practice.

Guarantee of Payment: I understand that I am financially responsible for all amounts payable with regard to fees for healthcare services rendered now and in the future by this practice. In the event of non-payment by me of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33 1/3% of the amount due, court costs and reasonable attorney's fees incurred by this practice if required to collect my debt owed.

Patient/Guardian signature	Date

In an effort to serve all of our patients equally, fairly and to the best of our ability, we ask that you review and understand our Patient Policies and Procedures.

1. Payment Policy;

Insurance; Your personal information sheet and insurance cards are an important part of your medical record. It is your responsibility to make sure you update this information at each visit to keep your record current. As this may seem inconvenient, it is necessary to keep you insurance and contact information updated to insure you receive proper care. We participate in most health insurance plans, including Medicare. If you are not insured by a plan we do business with or are not insured, we can arrange payment plans. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. **Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.** If any disputes/disagreements between your insurance plan and you regarding if and when you were/are covered should arise, payment in full by you will be required regardless of your dispute/disagreement.

Medicare Part B Patients; We participate with Medicare Part B. Medicare does not cover all healthcare services. In the event a service is needed that Medicare Part B will/does not cover, you will be advised prior to providing the service that it is not covered by Medicare and provided with an Advanced Beneficiary Notice. This document is required by Medicare and will explain what the service is that is not covered and why it is not covered by Medicare allowing you to make an informed decision on whether or not you still require the service in question. By signing this form, you hereby authorize King George Pediatrics to release information required by the Social Security Administration or it's intermediaries for purposes of medical claims. Additionally, you hereby agree and assign the benefits payable for covered services to King George Pediatrics and/or its healthcare providers.

Co-payments and Deductibles; All co-payments and deductibles must be paid at the time of service. Co-payment is for Urgent Care services and depending on your policy, might be higher than if you were receiving the services of a primary care physician. This arrangement is part of your contract with your insurance carrier and our contract with your insurance carrier. Failure on our part to collect co-payments and deductibles from patients can be considered fraud and is a violation of our contract and your responsibility with your insurance plan. Please help us in upholding both of our contractual obligations by paying your co-payments at the time of service.

Non-Covered Services; Please be aware that some or perhaps all of the services you receive may be non-covered or not considered reasonably necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. An example of some items that may not be covered is medical supplies and equipment and copies of your medical records.

Proof of Insurance; All patients, parents of a minor or legal guardian must fully complete our patient information form before seeing a healthcare provider. We must obtain a copy of photo identification and a current, valid health insurance card that provides coverage for the date(s) for which you are provided a service by us.

Claims Submission; If you have an insurance plan which we participate with, we will submit your claims to the insurance plan and assist you in any way we reasonably can to help get your claims paid. Your insurance plan may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.**

Payment Arrangements; Payment arrangements/Payment plans can only be made at the time services are provided.

Nonpayment; If any balance due by you is over 90 days past due, you will receive a statement stating that this is your final notice and that payment in full must be received immediately. If said balance remains unpaid, we may refer your account to a collection agency.

Collection Agency; In the event an unpaid balance by you is referred to a collection agency, you hereby agree to pay 18% interest per annum, plus attorneys fees which are hereby stipulated to be 33 1/3% of the outstanding balance, plus court costs in addition to the outstanding balance whether or not suit is filed.

2. Office Policies;

Fee for the Completion of Forms, Reports, and Letters: This is a non-insurance covered service which requires time from the administrative and nursing staff as well as the doctors; therefore a fee of **$15** will be charged for the completion of forms or the writing of letters. Once the **$15** fee is paid for the first form, each form thereafter will be **$5** per form. ***Forms include all forms, reports, and letters.

Transferring of Records: All patients must sign a release of records form to have their records copied or sent to another provider organization. Copies will be provided to the patient for a **$10** administrative fee plus **$0.50** per page up to 50 pages and **$0.25** thereafter. There is no fee to transfer records directly to another provider or organization.

Appointments; Office hours are by appointment only. In scheduling appointments, it is our intent to see you as soon as possible. Our staff and physicians will make every effort to accommodate urgent add on requests. Please be aware that the nature of our practice may cause delays. As a family practice, and due to the nature of your need, you may be seen by our Physician Assistant or for urgent issues you may be referred to King George Pediatrics. We allow 15 minutes prior to your appointment to complete the registration process. We will make every effort to see you on time at your scheduled visit. Individuals arriving early for their appointments may not be taken until the scheduled time, to avoid delaying other patients unnecessarily.

Cancellations; We reserve your appointment exclusively for you. We would request 24 hours notice for rescheduling and/or cancellation of an appointment so that another patient on our waiting list may be able to utilize this slot. **For appointments cancelled with less than 24 hours notice, a cancellation fee of $45 will be charged**.

Late Policy: Every effort is made to keep our physicians schedules on time; therefore if you are more than **15** minutes late, we reschedule your appointment to the next available with a physician in the office; however there is no guarantee that you will be seen immediately or by the originally scheduled physician. If all the physicians' schedules are full you will be asked to reschedule your appointment to a later date.

Physician/Clinical Phone Calls; Your calls will be routed to the appropriate clinical staff. Complete messages may be taken as needed. Please let them know where you may be reached, including both day and evening numbers. Your call will be returned at the first opportunity. Urgent calls will be immediately routed to the designated Clinical staff and prioritized accordingly.

Prescription Refills; For refills, we ask that you provide at least 72 hours notice. Please call the Pharmacy and request them to call our office for authorization on the refill. This will facilitate your request in a timelier manner. The Clinical staff will submit your request to your physician. Once the refill has been authorized, it will be called to your pharmacy. If there is a problem with the request, you will be notified by the Clinical staff.

Testing, Orders, and Results; Testing will not be performed by a facility without a physician's order. You must take your physician's order with you to the testing site. Please be aware there is a 72 hour turnaround time for non urgent calls requesting duplicate copies of original orders from our office. There may also be a fee for duplicate orders. Radiology and Pathology results are generally available within 3-5 working days. You will automatically be called with your results. If you have not received a call from our office within 5-7 working days from the date of your test or procedure, please call and ask for the Clinical staff.

Patient Identification; For your protection and security, photo identification will be requested at the time of treatment, as well as medical records release.

Medical Records; It is important that we maintain current and accurate records on your behalf. Upon registration for each visit at the Practice, you will be asked if there have been any changes in your name, address, telephone number, insurance coverage, medications, allergies, medical conditions and any other information pertinent to your care. It is your responsibility to ensure updates are provided. Your cooperation in keeping us informed helps us to better serve you.

3. Acknowledgement;

Receipt of Notice of Privacy Practices; The privacy and protection of your patient information is of the utmost importance to Gateway Medical Urgent Care. As required by federal HIPAA Regulations, a Notice of Privacy Practices must be provided by all healthcare providers to their patients. At Gateway Medical Urgent Care you will be offered a copy of the Notice of Privacy and a copy is posted in the waiting room. King George Pediatrics reserves the right to modify the privacy practices outlined in the notice.

I have read and understand the above payment policy and by signing below, agree to abide by its guidelines. I have received or have been offered a copy of the Notice of Privacy Practices for King George Pediatrics and by signing below, acknowledge the same.

_____ ___/____/_____ /_____ _____

Signature of Patient/Legal Guardian **Date** **Relationship to Patient (If Applicable)**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS REQUIRED BY FEDERAL LAW AND DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Once you sign our Patient Information consent form, we may use and disclose your medical information in order to treat you, obtain payment, and to operate the practice.

This Notice of Privacy Practices ("Notice") describes the ways in which we may use and disclose your Protected Health Information (PHI) and how you can get access to this information. "Protected Health Information" is information about you that is contained in your medical and billing records maintained by this organization. It includes demographic information and information that relates to your present, past or future physical or mental health and related healthcare services.

If you have any questions about this Notice, please contact our Privacy Officer.

Uses and Disclosures of Protected Health Information: We may use and disclose your Protected Health Information for purposes of healthcare treatment, payment and healthcare operations as described below.

For Treatment: We may use and disclose your Protected Health Information to provide, coordinate or manage your healthcare and any related services. Examples of how we will disclose information for treatment may include sharing information about you with: referring physicians, your primary care physician, a specialist, hospitals, ambulatory care centers, pharmacies or home health agencies.

For Payment: Your Protected Health Information will be used and disclosed as required, so that we can bill and receive payment for the treatment and services you receive from us. Examples of how we will disclose information for payment include: contacting your health plan to confirm your coverage or obtain precertification of a service, or we may provide information to any other healthcare provider who requests information necessary for them to collect payment.

For Healthcare Operations: We may use and disclose your Protected Health Information in performing business activities that we call "healthcare operations". This includes internal operations, such as for general administrative activities and to monitor the quality of care you receive at our facility. Examples include: quality of care assessments, training of medical staff, assessing certain services that we may want to offer in the future, evaluating the performance of our employees, licensing, or conducting or arranging other business activities. Other examples include: leaving messages on your answering machine; leaving messages at your place of employment or sending out recall notices. We may use or disclose your Protected Health Information when making calls to remind you of your appointment. We will use a sign-in sheet at the receptionist's desk where you will be asked to sign your name and the name of the provider you are seeing. We will also call you by name when you are in our waiting room.

Other Uses and Disclosures We May Make Without Your Written Authorization: Under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, we may use and disclose your Protected Health Information in which you do not have to give authorization. These situations include: those Required by Law, Public Health Risk Issues as required by Law, Communicable Diseases, Health Oversight Activities, reporting Victims of Abuse, Neglect or Domestic Violence, Legal Proceedings, Law Enforcement, Coroners, Medical Examiners, Funeral Directors, Organ/Tissue Donation Organizations, Research; Criminal Activity; Military Activity and National Security, Inmates/Law Enforcement Custody, and Worker's Compensation.

Any Other Use or Disclosure of Your Protected Health Information Requires Your Written Authorization: Will be made only with your consent, authorization or opportunity to object, unless required by law.

Your Rights Regarding Your Protected Health Information: You have the right to access your personal Protected Health Information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and Protected Health Information that is subject to law that prohibits access to Protected Health Information.

You Have the Right to Request Restrictions: You have the right to request a restriction on the way we use or disclose your Protected Health Information for treatment, payment or healthcare operations. You may make this request in writing, at any time. If we do agree to the restriction, we will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your emergency treatment.

You Have the Right to Request Confidential Communications: You have the right to request that we communicate with you concerning your health matter sin a certain manner or at a certain location. For example, you can request that we contact you only at a certain phone number or a specific address. We will accommodate your reasonable requests, but may deny the request if you are unable to provide us with appropriate methods of contacting you.

You Have the Right to Request that We Amend your Protected Health Information: If we deny your request, we will give you a written notice, including the reasons for the denial. You can submit a written statement disagreeing with this denial. Your letter of disagreement will be attached to your medical record.

You Have the Right to Request an Accounting of Certain Disclosures of Your Protected Health Information.

You Have the Right to Obtain a Paper Copy of This Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time by contacting our office in writing or by phone.

You May Issue a Complaint to our Privacy Officer (listed on the first page) or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

We Reserve the Right to Change the Terms of This Notice of Privacy Practices and to make the new provisions effective for all Protected Health Information we already have about you as well as any Protected Health Information we create or receive in the future. If we make any changes, we will:

a. Post the revised Notice in our office(s), which will contain the new effective date; and
b. Make copies of the revised Notice available to you upon request (either at our offices or through the contact person listed on the Notice.)

This notice was published and effective

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The practices listed above reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received or have been offered a copy of the Notice of Privacy Practices for the practices listed above.

_____

Name of Patient (Print)

_____

Signature of Patient or Responsible Party if Patient is a Minor

_____

Date