Glen Allen Pediatrics

Arkin/Goradia/Goodall

Patient Registration Form

Please Print Clearly and Complete All Blanks

CHILD'S FULL LEGAL NAME

1.____________________ **DOB** ____________ **M / F**

2.____________________ **DOB** ____________ **M / F**

3.____________________ **DOB** ____________ **M / F**

4.____________________ **DOB** ____________ **M / F**

CHILD'S HOME ADDRESS____________________

City____________ State________ Zip________

Preferred Method of Appointment Reminder: Call Home #__________ Call/Text Cell # __________

FATHER'S FULL NAME ____________________ DOB__________

Home Address ____________________ **Apt. No.**__________

City__________ State______ Zip______ SSN_____-_____-_____

Home Phone__________ Cell Phone __________ Work Phone __________

E-mail Address____________________

Preferred Method of Contact: (check one) ❒ Home ❒ Cell ❒ Work

MOTHERS FULL NAME ____________________ DOB__________

Home Address ____________________ **Apt. No.**__________

City__________ State______ Zip______ SSN_____-_____-_____

Home Phone__________ Cell Phone __________ Work Phone __________

E-mail Address____________________

Preferred Method of Contact: (check one) ❒ Home ❒ Cell ❒ Work

PRIMARY INSURANCE COMPANY ____________________

Policy or ID Number ____________ Group Number ____________

Subscriber/Policyholder Name ____________ DOB____________

SECONDARY INSURANCE COMPANY ____________________

Policy or ID Number ____________ Group Number ____________

Subscriber/Policyholder Name ____________ DOB____________

Address/Phone (if different from above)____________________

IN EMERGENCY NOTIFY (other than parents):

Name ________________ Home Phone____________

Relationship to Patient____________ Cell Phone____________

Referred to practice by____________________

The parent/guarantor is responsible for knowing the specifics of his/her insurance plan and following its procedures. We strongly advise checking with your insurance carrier prior to visting a Specialty Doctor, obtaining x-rays, hospital admissions and any other outside services. The patient/guarator is responsible for communicating any of the above special needs to office staff and is ultimately responsible for payment for any services rendered.

Please sign below signifying that you have read and understand the above statement and this office has permission to submit insurance claims on your behalf and has permission to release any information, including medical, to the above carrier. I agree that if I am unable to furnish my insurance card or proof of insurance at the time of service. I will be personally responsible for the balance in full until such information is provided. I understand that I am financially responsible for charges not covered by this authorization as well as any balance not paid by insurance. If my account is turned over to any attorney for collection, I will be responsible for attorney fees in the amount of thirty-five percent (35%) of the total debt plus court costs. Any outstanding balances are subject to service charges.

Signature of parent/guardian/patient over age 18 ________________ Date ____________

Glen Allen Pediatrics

Financial Policy

In order to reduce any misunderstanding between our patients (their parents and/or guardians) and our practice, we have adopted the following financial policy. Please read it and sign at the bottom. A copy will be provided to you upon request.

Patient Name(s) and Date of Birth:

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1. **Insurance.** We participate with most commercial insurance plans. Your health insurance policy is a contract between you and your insurance company. It is your responsibility to understand your policy coverage and requirements. Please contact your insurance company with any questions you have regarding your coverage. If your insurance company does not pay your claims within 45 days, the balance will automatically be billed to you. We are required to obtain a copy of your most current insurance card at each visit. If your plan requires a PCP, we must be listed as the PCP or you will be responsible for all charges. **If you do not have an up-to-date insurance card, and coverage cannot be verified, payment in full will be required. If your newborn has not been added to your insurance by the two month visit, payment in full will be required at the time of service.**
2. **Private Pay/Non-Participating Insurance.** If you are self-pay or if we do not participate with your insurance, payment in full will be due at the time of service unless prior arrangements have been made.
3. **Copayments and Deductibles.** All copayments must be paid at the time of service as required by your contract with your insurance company. If you are unable to pay your copayment at the time of service, a $15.00 service charge will be assessed. Deductibles will be billed and payment due upon receipt of your insurance company's EOB. We accept cash, check, money order, VISA, MasterCard, and Discover. You may keep your credit card information on file so that any deductibles, coinsurance, or non-covered charges may be charged to your credit card upon receipt of the insurance company's EOB. If payment is not received within 30 days of the statement date, a late fee will be assessed unless other arrangements have been made with our Billing Manager.
4. **Returned Check.** If your check is returned by the bank you will be assessed a $35.00 returned check fee.
5. **Missed Appointments/Late Cancellation.** It is your responsibility to contact our office if you are unable to keep an appointment. If you fail to do so, or give less than 24 hours notice, you will be charged a no-show/late cancellation fee. A fee of $50.00 will be assessed for any missed well (checkup) appointment, $25.00 for any sick appointment.
6. **Forms.** We will complete, free of charge, one form (school, sports, camp) at the time of your child's check-up visit. Additional forms or forms requested at other times will incur a charge of $10.00 each. There may be an additional charge for more complicated forms.

I have read and understand the above financial policies and agree to the terms.

______________________________________ ___________________________

Signature of Patient or Responsible Party Date

Glen Allen Pediatrics

Receipt of Notice of Privacy Practices

Our practice is committed to securing the privacy of your health information. Accordingly, we have provided you with a copy of our practice's Notice of Privacy Practices. You are not required to read this notice. However, we would like your acknowledgement that you have been notified that Glen Allen Pediatrics, LLC has such a Notice of Privacy Practices.

I ____, __________________________________

Print Name   Relationship to Patient

have reviewed a copy of Glen Allen Pediatrics, LLC's Notice of Privacy Practices.

Patient Name/DOB ____

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____ ___________________________

Signature of Patient/Parent/Guardian   Date

______ Patient/Parent/Guardian was given the opportunity to receive a copy of the Notice of Privacy Practices, but has refused to sign acknowledgement.

___________________________ (Initials)

Glen Allen Pediatrics employee

Glen Allen Pediatrics

804.282.4210
3990 Stillman Parkway
Glen Allen, VA 23060
P. 804.282.4210
F.804.282.4250

REQUEST FOR TRANSFER OF MEDICAL RECORDS

Name of Previous Pediatric Office: ____

Telephone Number: ____

Fax Number: ____

PATIENT'S NAME	DATE OF BIRTH
1. ____	____________________
2. ____	____________________
3. ____	____________________
4. ____	____________________

I, ____, parent/legal guardian of the above named, request the transfer of medical records to Glen Allen Pediatrics. Please send a complete copy of medical records (unless otherwise indicated) to:

Glen Allen Pediatrics
3990 Stillman Parkway
Glen Allen, VA 23060

Or fax to (804) 282-4250 with this as the cover sheet.

____ ______________________
Signature of Parent/Guardian Date

____
Date Faxed