Western Loudoun Pediatrics Registration Form

Child's Name	M/F	Date of Birth	Main Language	Ethnicity (optional)	Race (optional)	Choices for Race: 1-American Indian 2-Asian 3-Black/African American 4-More than one Race 5-Native Hawaiian 6-Other Pacific Islander 7-White
				Hispanic Not Hispanic		
				Hispanic Not Hispanic		
				Hispanic Not Hispanic		
				Hispanic Not Hispanic		

Primary Contact Parent

Name Date of Birth	Relationship to child Mother Father Step-parent Guardian Other
Address City State Zip	Resides with child ❒ Yes % of the time ❒ No
Cell phone Primary language	Occupation Work Phone
Level of Responsibility Joint Exclusive Financial Only Emergency Only	Email**(print clearly)**

Second Parent or Guardian

Name Date of Birth	Relationship to child Mother Father Step-parent Guardian Other
Address ❒ Same as above	Resides with child ❒ Yes % of the time ❒ No
Cell phone Primary language	Occupation Work Phone
Level of Responsibility Joint Exclusive Financial Only Emergency Only	Email**(print clearly)**

Insurance Information

Primary Insurance Company:	ID #
Policyholder Name:	Person responsible for payment:
Secondary Insurance Company:	ID #
Policyholder Name:	Person responsible for payment:

Authorized Persons and Emergency Contacts OTHER THAN PARENTS(Age 18+)

Name Relationship to Child Phone	☐ May bring to appointment and authorize treatment ☐ Emergency contact
Name Relationship to Child Phone	☐ May bring to appointment and authorize treatment ☐ Emergency contact

I state that I am the natural parent or legal guardian of the patient(s) listed above.

I authorize and consent to the exchange of medical data, including but not limited to medications, patient notes, consults, vaccinations, diagnostic tests and hospital records, between Western Loudoun Pediatrics and other healthcare entities.

I authorize and consent to receiving email and text notifications from Western Loudoun Pediatrics.

The information provided by me above is accurate and I understand that I must notify Western Loudoun Pediatrics in writing of any changes to the above.

Signature ______________________________ **Relationship to patient** ____________

Printed name ______________________________ **Date** ____________________

OFFICE AND FINANCIAL POLICY

Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

- ★ Our office sees patients **by appointment only**. We are unable to accommodate walk-in appointment requests.
- ★ **Appointments for additional children need to be made by phone prior to coming to the office.** We cannot add in a sibling during a patient's appointment. We can offer the next available appointment on the schedule.
- ★ If you are running late to your appointment, call the office to inform us. We will review the schedule and determine if you can be seen when you arrive or if you will need to reschedule. We cannot guarantee you will be seen if you arrive past your appointment time.
- ★ If you are unable to keep your appointment, you must cancel 24 hours in advance. There is a $50 charge for a no-show. This fee will need to be paid prior to scheduling future appointments. Repeated no-shows may result in the family being discharged from the practice.
- ★ Routine well child visits are for assessing childrens' growth and development. If you have concerns about chronic symptoms you will need to schedule a separate appointment so they can receive the full attention and time they deserve.
- ★ If your child has symptoms of illness upon arrival for a well child exam the visit no longer qualifies as a preventative encounter. We may need to change the appointment to a sick visit and reschedule the well visit.

Initial: ________________

Vaccines

- ★ We firmly believe in vaccines and follow the CDC's Immunization Schedules. We do not offer delayed or alternate vaccine schedules.

Initial: ________________

After-hours Nurse Calls

- ★ Our after hours emergency triage line is for urgent issues only. There is a $20 charge per call. This fee is waived for state Medicaid plans. For refills, appointment requests and other non urgent matters call the office during regular business hours.

Initial: ________________

Financial

- ★ We require you to notify us of any changes in insurance, address, phone number or emergency contact.
- ★ It is your responsibility to confirm we are a participating healthcare provider (in network) for your insurance plan.
- ★ Co-payments are due at the time of service. We accept VISA, MASTERCARD, DISCOVER and CASH.
- ★ Self pay patients are expected to pay in full for services at the time of the visit.
- ★ Deductibles and coinsurances are your responsibility and will be billed to you. Insurance coverage varies and any **charges not covered by insurance are the guarantor's responsibility.** Balances are due upon receipt. You may pay your balance by mail, phone or through your patient portal.
- ★ If any balance remains unpaid after 90 days you may incur a collection fee, referred to our collection agency and your family may be discharged from the practice.
- ★ There is a **$15 prepayment fee** for the review and completion of school/child care/FMLA/camp forms.

Initial: ________________

I have read and understand the above policies. I understand that failure to comply may result in discharge from the practice.

Patient Name(s): ____

Parent/Guardian Signature:____ **Date**____________________________

HIPAA NOTICE OF PRIVACY PRACTICES

Western Loudoun Pediatrics
17336 Pickwick Dr, Suite 100
Purcellville, VA 20132

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us, which we need to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care at Western Loudoun Pediatrics Inc. This notice tells you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- As required by law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National security and Intelligence activities
- Protective Service for the President and others

Your rights regarding Health Information about you:

- Rights to inspect and copy
- Right to amend
- Right to accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Complaints:

- If you believe that your privacy rights have been violated you may file a written complaint with us. You may also contact the Secretary of the United States Department of Health and Human Services.

I acknowledgement Receipt of this Notice:

Patient Name(s): ____

Patient/Parent Signature: ____ Date: _______________

PATIENT HISTORY

Patient Name: ____ Date of Birth: _____________________________

Medical History		Please provide details for any yes answers
Has your child had any allergic reactions to medications?	Y N	
Has your child had any allergic reactions to food or other items?	Y N	
Does your child take any medications on a daily basis?	Y N	
Does your child follow a special diet? (Vegetarian, gluten-free, etc.)	Y N	
Does your child have any medical conditions? (Asthma, seasonal allergies, heart problems, GER, developmental delay, etc.)	Y N	
Does your child see any specialists?	Y N	
Has your child had any serious injuries?	Y N	
Has your child had any surgeries?	Y N	
Has your child ever been hospitalized overnight?	Y N	
Are your child's immunizations up to date? Date of last well-child checkup________________	Y N	

Family and Social History	
What medical conditions do family members have? Who has them? (Ex. allergies, asthma, early heart disease, kidney problems, early unexpected death)	
What are the occupations of the adults living at home?	
Who lives at home?	
What types of animals or pets do you have?	
Does anyone at home smoke?	
Are there any guns in the home? If so, are they locked up?	