PATIENT REGISTRATION FORM

Registration Information- Please Print		Date:	PCC#:
Patient's Legal Name (First, Middle Initial, Last)		Mother's Maiden Name:	
Nick Name:	Gender: Male ☐ Female ☐	Date of Birth:	SSN:
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline		Preferred Language: ☐ English ☐ Korean ☐ Other:	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer not to answer			

List Additional Siblings			
Patient's Legal Name (First, Middle Initial, Last)		Mother's Maiden Name:	
Nick Name:	Gender: Male ☐ Female ☐	Date of Birth:	SSN:
Patient's Legal Name (First, Middle Initial, Last)		Mother's Maiden Name:	
Nick Name:	Gender: Male ☐ Female ☐	Date of Birth:	SSN:
Patient's Legal Name (First, Middle Initial, Last)		Mother's Maiden Name:	
Nick Name:	Gender: Male ☐ Female ☐	Date of Birth:	SSN:

Parents / Legal Guardian Information

☐ Mother ☐ Stepmother ☐ Legal Guardian

Full Name:		Date of Birth:	SSN:
Home Address:		City:	State/Zip:
Home Phone:	Cell Phone:	Email:	

☐ Father ☐ Stepfather ☐ Legal Guardian

Full Name:		Date of Birth:	SSN:
Home Address:		City:	State/Zip:
Home Phone:	Cell Phone:	Email:	

Additional Parental Information

Does the patient live with both biological parents? ☐ Yes ☐ No

If no, what is the patient's current living situation?

☐ Single-Parent Custody ☐ Joint Custody ☐ Foster Care ☐ Adoptive Family ☐ Other Family Members:_____

If the patient resides in more than one residence, we are required to know who has legal authority to authorize healthcare services for the patient.

Emergency contact person*(Someone other than Parents)

1.Name:	Relation to Patient:	Phone:
2.Name:	Relation to Patient:	Phone:

Patient Initial ___

Insurance Information

Primary Insurance Company Name:		Effective Date:
Name of Subscriber:	Subscriber's DOB:	Relation to Patient:
Policy ID #:	Group #:	Subscriber's SSN:
Name of the Guarantor: (Who the bills are sent to)		
Billing address:		

Communication Consent and Preference (Check **all** communication methods)

Contact Name:	Method: ☐ Phone ☐ Text ☐ Patient Portal _____ (Phone number) Email:

Patient Portal

Please provide an email address for patient portal. You can securely view and print your child's medical record and send us messages and requests via patient portal.

E-mail: _____

How did you hear about our practice? ☐ Friend/Family ☐ Referral ☐ Social Media ☐ Advertisement ☐ Other

CONSENT FOR TREATMENT

I, _____, parent or legal guardian of above listed patients, give consent to any medical care including but not limited to preventative care, urgent sick care, immunization, and emergency care to My Kid's Pediatrics and Adolescent Care for today and future visits.

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this physician/clinic to release any information required in the course of myself and/or dependent's examination or treatment. I further expressly agree & acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents.

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of this physician's clinic for medical benefits that may be otherwise payable to me for services rendered. I understand that I am financially responsible for the charges not covered by my insurance.

Signature: _____ Date: _____

NOTICES OF PRIVACY PRACTICES (HIPPA)

The U.S. Department of Health & Human Services has developed Notices of Privacy Practices for health care providers to communicate with their patients entitled, "Your Information. Your Rights. Our Responsibilities." This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

I hereby understand that this policy can be viewed on My Kid's Pediatrics and Adolescent Care website www.mykidspediatricians.com at any time and that it is available to me upon request from My Kids' staff.

Signature: _____ Date: _____

General Office Policies

Welcome to My Kid's Pediatrics and Adolescent Care. Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy allows us to have a good flow of communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, do not hesitate to ask a member of our staff.

Appointment

Please arrive on time. We will need to verify your insurance information, collect any necessary paperwork and co-pays.

Scheduling Appointments

- You can schedule an appointment by calling **703-865-KIDS (5437), or contacting us via patient portal.**
- You may be able to schedule same-day appointments for illness visits. Appointments are given on a first-come, first-serve basis.
- **Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a preventative visit.**

Missed Appointments

For missed appointment, there is a fee of $50.

- We understand that sometimes you cannot make it to your appointment. **Please call us by 12:00pm (Noon) the day before the appointment** to cancel or change your appointment. You will NOT be able to schedule any future appointments before clearing the missed appointment fee. Failure to call us by **12:00pm (Noon) the day before the appointment** equals a "No Show", and there will be a missed appointment fee charged to your account.

Late Cancellation

- Contacting us **after 12:00pm (Noon) the day before the appointment** is considered as a late cancellation; thus, a **missed appointment**.
- Please call us **by 12:00pm (Noon) the day before the appointment** to cancel or change your appointment.
- If you are unable to get a hold of us, please leave a voice mail, send us an e-mail, or message us through patient portal **by 12:00pm (Noon) the day before the appointment.**

Late Arrivals

For late arrival, there is a fee of $50.

- Arriving later than **15 minutes after your scheduled appointment** time is considered as late arrival.
- If you are late, you will be offered the next available appointment time, or we may need to reschedule your child's visit. Patients who arrive on time will be seen ahead of those who arrive late.
- While we will do all that is possible to accommodate the requests, the first-available appointment may or may not be on the day of the missed appointment.

Well Visit and Illness

- If your child is ill on their well child visit, the visit may be changed to an illness visit and you will need to reschedule their well child visit. This is to ensure we provide the best care to your child.
- Depending on your insurance policy, you may be responsible for co-pay.
- We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

After-hour Call Services

- Please call 911 for any life-threatening emergencies. You can refer to useful links on mykidspediatricians.com for common illness and Tylenol/Motrin dosing. For refills, appointment requests, and other non-urgent matters, you can send a message on patient portal or call the office during regular office hours. **Please limit after-hour calls to urgent issues and emergencies**.
- Please do the following when using after-hours call service:

When leaving a message, please speak slowly. Be sure to leave a callback number. Disable your call block feature. Follow the doctor's instructions.

Vaccine Policy

My Kid's Pediatrics follows the AAP and CDC guidelines and recommendations for vaccine preventable illnesses. We strongly believe in timely vaccinations as a protection against illnesses that can kill or debilitate an individual or necessitate repetitive antibiotic use. At this time to better serve our community and protect the most vulnerable patients, our office will not be taking new or established patients who refuse vaccinations.

Mask Policy for Unvaccinated Patient

All patients who are of under-immunized status, whether for medical or non-medical reasons, will be required to wear a mask in the waiting room. This is to protect the health and safety of our patients and staff.

- **Families who do not comply with the mask policy will be dismissed from our practice**.

Patient Initial ___

Referrals
Advance notice (7 business days) is needed for all non-urgent referrals. It is your responsibility to know if a selected specialist participates with your plan. Remember, we must get referrals approved before they are issued.
Additional Fees
• Many forms require the information to be based on an examination completed within the last 6-12 months or may require specific evaluations that were not performed at the routine physical examination (Ex. sport vitals, asthma/allergy treatment plans). Therefore an additional office visit may be required. • No form will be completed without a physical examination in our office within the past 12 months. Forms are completed on the basis of examinations conducted by the providers in the medical group only. Examinations performed by other health facilities will not be co-signed by our providers. • Forms will be released only *to parents and authorized delegat*e due to Health Insurance Portability and Accountability Act (HIPAA) regulations. Please refer to our financial policy for the form fees.
Transfer of Medical Records
• If you are transferring to another physician, we will provide a copy of patient's immunization record, growth chart, and most recent well child check-up free of charge. • There will be fees associated for any other medical records. • We do require at least 48 hours notice in order to process the medical records needed. • Please note, you have access to your child's medical records, lab results, immunization records and visit history via our patient portal at www.mykidschart.com/mykidspeds. • We only provide records of patients for visits that are performed here at My Kid's Pediatrics and Adolescent Care, including consultations from specialists. • For any previous records, you must request them directly from your previous doctor(s).
Prescription Refills
• For medication refills, please notify us **at least 5 business days prior to requiring a medication refill**. Please access My Kid's portal to request for a refill or contact us during regular business hours and plan accordingly. Please be aware that appointments may be needed for some medications, such as antibiotics or chronic illness medications.

I have read and understood this office policy and agree to comply and accept the responsibilities. I also understand and agree that the practice may amend such terms from time to time.

Parent/Guardian's Name (print): _____ Relationship to Patient(s): _____

Parent/Guardian's Signature: _____ Date: _____

The General Policies of My Kid's Pediatric and Adolescent Care, as well as our Financial Policies, are available on mykidspediatricians.com.

Patient Initial ___

Financial Policies

To reduce any confusion and misunderstanding between our patients and the office, we have adopted the following financial policies. If you have any questions, please do not hesitate to ask a member of our staff.

Health Insurance

• For every appointment, our office staff will verify your eligibility prior to or upon check-in. **Please make sure you bring your insurance card to every appointment** and notify us as soon as possible if your insurance changes.

• We participate with many different plans and cannot know the benefits of every patient's policy. Therefore, we recommend that you make every effort to understand your insurance coverage. If necessary, please contact your insurance company prior to receiving services in order to verify your coverage levels, copay, deductible, and coinsurance responsibilities.

• If the insurance company that you designate is incorrect, you will be responsible for any visit fees and must submit the charges to the correct plan.

Non-covered Services

• Please note that there are some services that your insurance may not cover.
• Such services can include: Vision tests, Hearing tests, Developmental screening tests, and In-office lab tests. These are important tests that are considered pediatric standards of care.
• If your insurance rejects the claim for services mentioned above, we will bill you at a discounted rate to ensure that you can continue to receive the highest standards of pediatric care.

Newborn

• Please note that your insurance company will allow up to 30 days to enroll your newborn to your insurance policy. **Our office will hold the insurance claims for your newborn for up to 30 days.**

• If your insurance rejects the claim for missed enrollment or for any other reasons, you are financially responsible for the charges not covered by your insurance. We strongly advise enrolling your newborn immediately after their birth and informing our office with the insurance information.

• Please see Self-pay Patients / Out-of-Network Insurance section of financial policies if the patient does not have active insurance coverage after one month of life or claim rejections.

Balances, Deductibles & Copayment

• Contract terms with health insurance companies hold us responsible to collect copayments at the time of service, and to bill for personal responsibilities assigned by the insurance company.
• It is your responsibility to pay all outstanding balances. *W*e are happy to set up a payment plan with you if you are unable to pay the balance in full at any time. Just make sure to set up a payment plan as soon as you receive the bill.
• If you participate in a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card on file.

Returned Checks

• If your payment by check is returned from the bank for insufficient funds, you will be charged a fee of $50. If more than one check is returned in any given period, we reserve the right to require all future payment by credit card or cash to prevent this situation from recurring.

Credits / Refunds

• Occasionally, there may be a credit on your account. By signing below, you authorize that any amount less than your copayment can be an offset against your next visit rather than refunded to you. Credits above your copayment amount will be refunded to you promptly.

Self-pay Patients / Out-of-Network Insurance

• If you do not have health insurance or if our office is considered out-of-network for your insurer, the payment is due at the time of service.
• Upon request, our office can provide a claim form for you to submit to your out-of-network insurer.
• Please note that we will not return or collect the difference between what you have already paid vs. reimbursement from your insurance.

Patient Initial ___

Guarantor
• Whoever accompanies the child to each visit is expected to pay the charges due for the service rendered that day, including copayments, coinsurance, deductibles, and etc. **Parental Divorce has no bearing on the responsibility for medical care as it affects third parties**. • The parent or guardian who signs the patient's paperwork is the individual who is responsible for all outstanding balances. • Due to confidentiality, we can only bill the person who signs the patient's paperwork. Therefore, if the person responsible for the medical bill changes, the new guarantor must complete a new set of paperwork. In these situations, please inform us as soon as possible.
Divorce Decrees
• This office is not a party to your divorce decree. **All copayments and coinsurance are due at the time of service and are the responsibility of the accompanying adult**. We will not bill another parent/guardian for the copayments or coinsurance due at time of service.
Form Fees
• No charge for up to two forms at the time of the well child exam. • $5.00 per form for any other additional forms. *(Ex. school, camp, sports forms, Family and Medical Leave Act forms, asthma medication forms, preauthorization/medication forms etc.). • **Advance notice of 7 business days**, especially for extensive medical records. • $5.00 (Will provid*e only* CD records) Immunization record, Most Recent Well-Child Check Up, Growth Chart (**Cost will increase depending on the volume of medical records)** • $10.00 per form for any forms brought in at any **other time** than Well-Child Check Up. • $35.00 for **"Rush Service"** forms that need to be completed within 48 hours. • We require ***7* business** day turnaround time for forms brought in **at any other time** than Well-Child Check Up. • **Payment is due when the forms are dropped off and/or on the day of the request.**

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to My Kid's Pediatrics and Adolescent Care for any services furnished to my dependent or ward and understand that failure to make payments timely may result in additional collection fees. I also understand and agree that the practice may amend such terms from time to time.

Parent/Guardian's Name (print): _____ Relationship to Patient(s): _____

Parent/Guardian's Signature: _____ Date: _____

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Patient Initial ___

Authorization to Release Medical Records / Information

Patient's Legal Name	Date of Birth
Patient's Legal Name	Date of Birth
Patient's Legal Name	Date of Birth
Patient's Legal Name	Date of Birth
Patient's Legal Name	Date of Birth
Release Records ☒ From ☐ To	**Release Records** ☐ From ☒ To
Name of Practice:	My Kid's Pediatrics and Adolescent Care 12011 Lee Jackson Memorial Hwy. Ste. 220 Fairfax, VA 22033 Tel: 703-865-5437 Fax: 703-865-5889

By initialing in the spaces below, I authorize the release of the following medical records

___ Clinician Office Chart Notes	___ Immunization History	___ Hospital Report
___ Diagnostic Imaging Reports (X-Rays)	___ Laboratory Reports	___ Other:

Purpose of Release ☐ Changing Healthcare Provider ☐ Consultation ☐ Legal ☒ PCP Review

The medical information authorized above ☒ **MAY** or ☐ **MAY NOT** be faxed. I understand there is a risk in faxing records and confidentiality cannot be guaranteed.

I request and authorize the above office or facility to release ALL of the selected medical records to the person or entity listed above. I understand that the information to be released may include, but is not limited to, the following conditions: drug abuse, alcohol abuse or alcoholism, sickle cell anemia, psychological or psychiatric conditions, AIDS or HIV status, and past medical history. I understand that if the person or entity that receives the information is not a healthcare provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations.

I certify that this request has been made voluntarily and I can refuse and/or revoke this authorization in writing at any time, except to the extent that an action has already been taken to comply with it.

I understand this authorization will expire, without my express revocation, either one year after the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first.

Parent/Guardian's Name (print): _____ Relationship to Patient(s): _____

Parent/Guardian's Signature: _____ Date: _____