NEW RIVER VALLEY PEDIATRICS

PRIVACY ACKNOWLEDGEMENT: *I understand the New River Valley Pediatrics' Notice of Privacy Practice provides me with detailed information on how my child's protected health information may be used and disclosed. I acknowledge that New River Valley Pediatrics' Notice of Privacy Practice will be made available to me upon request.*

DEEMED CONSENT: *I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the the guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or Hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that, by law, I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.*

MEDICATION CONSENT: *I voluntarily consent to any and all health care treatment and CLIA waived procedures provided by New River Valley Pediatrics and its associated physicians and other personnel. I authorize the facility to contact healthcare providers from whom I have received treatment to obtain medical information and/or records including, but not limited to, commercial pharmacies for verification of medications.*

ASSIGNMENT OF BENEFITS/PROMISE OF PAYMENT: *Authorization is hereby given to release to my insurance company(s) such information that may be necessary for the completion of my child's clinical insurance claims. I understand I am financially responsible for charges not covered by insurance (co-pays, co-insurance, deductibles, non-covered services) and assign any insurance benefits to New River Valley Pediatrics. Co-pays are due at the time of service. Any co-pays not paid at the time of service are subject to a $10.00 late fee.*

CONSUMER CONTRACT: *You agree, in order for us to service your account or to collect any amounts you may owe us, we may contact you by telephone at any telephone number associated with your child's account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail addresses you provide to use.* ***Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing device, as applicable.*** *I have read this disclosure and agree that your collection agency of choice may contact me as described above. If an account is forwarded to our outside collection agency it is subject to additional fees up to 25% of the amount sent to collections. This is to cover the fee charged by the collection agency and costs to our practice for maintaining accounts in collections.*

New River Valley Pediatrics treats all patients and families ethically with respectful, compassionate care. I understand that, if at any time, my behavior or language is inappropriate or disrespectful to any staff or other individuals, I will be subject to immediate dismissal from the practice.

By signing below, I am agreeing and acknowledging to the above.

Responsible Party/Parent Signature_____

Printed Name_____

Relationship to Patient_____

Mailing Address_____
Street City State Zip Code

Date_____

Revised: 3/28/19

NEW RIVER VALLEY PEDIATRICS
REGISTRATION FORM

(Please Print Legibly and Complete Entire Form in Black Ink Only)

Primary Physician:

SECTION 1: PATIENT INFORMATION		
Patient's Full Name:	DOB:	Sex:
Patient's Street Address:		
City:	State:	Zip:
Race: (check one) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Declined	Preferred Language:	
Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined		
Preferred Pharmacy Name:	Location:	Phone #:

SECTION 2: APPOINTMENT CONFIRMATION	
Please send a text to:	Please send an e-mail to:

SECTION 3: MESSAGES		
May we leave messages concerning labs, x-rays & appointments, etc?	☐ YES	☐ NO

SECTION 4: PARENTAL / GUARDIAN INFORMATION

BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Name:_____	Name:_____
DOB: _____ SS#_____	DOB: _____ SS#_____
Is the above the guardian of this child? ____Yes ____No	Is the above the guardian of this child? ____Yes ____No
If yes, please complete bottom portion; if no go to Section 5	If yes, please complete bottom portion; if no go to Section 5
Mailing Address: If same as patient, check here ☐	Mailing Address: If same as patient, check here ☐
Street Address:_____	Street Address:_____
City_____State_____Zip_____	City_____State_____Zip_____
Primary Phone #: _____ H W C	Primary Phone #: _____ H W C
Secondary Phone #: _____ H W C	Secondary Phone #: _____ H W C
Employer_____	Employer_____

SECTION 5: GUARDIAN CONTACT INFORMATION

If you answered NO to: Are you the guardian of this child in Section 4, please complete this section
If you answered YES to: Are you the guardian of this child in Section 4, please skip to Section 6

[1]Name:	DOB:	Relationship to patient:
Does this patient live with you ☐ Yes ☐ No		
If answer is no – Address:		
Phone #:	email address:	
Custody information:		
[2]Name:		Relationship to patient
Does this patient live with you ☐ Yes ☐ No		
If answer is no – Address:		
Phone #:	email address:	
Custody information:		

(Please complete information on the back)

SECTION 6: MEMBERS LIVING IN HOUSEHOLD YOUNGER THAN 18					
Name	DOB	Relationship to Patient	Name	DOB	Relationship to Patient
1)			4)		
2)			5)		
3)			6)		

SECTION 7: MEMBERS LIVING IN HOUSEHOLD OLDER THAN 18					
Name	DOB	Relationship to Patient	Name	DOB	Relationship to Patient
1)			4)		
2)			5)		
3)			6)		

SECTION 8: EMERGENCY CONTACTS (OTHER THAN PARENTS)		
[1]Name:		Relationship to patient
Phone #:		
The above may:	☐ accompany child for office visits ☐ call for labs, x-rays, etc.	☐ call for appointment information for sick care ☐ pick up prescriptions
[2]Name:		Relationship to patient
Phone #:		
The above may:	☐ accompany child for office visits ☐ call for labs, x-rays, etc.	☐ call for appointment information for sick care ☐ pick up prescriptions

SECTION 9: INSURANCE INFORMATION		
Company:	Policyholder:	DOB:
Address of Policyholder:		

SECTION 10: BILLING INFORMATION				
Who should receive billing statements:				
Relationship to Patient:		Phone #:		
Mailing Address:				
City:		State:		Zip:
Is this person financially responsible for any other children in our practice: ☐ Yes ☐ No If the answer is YES, please list the name and birthdate for all children				
Name:	DOB:	Name:		DOB:
Name:	DOB:	Name:		DOB:
Name:	DOB:	Name:		DOB:

SECTION 11: GUARDIAN SIGNATURE	
Printed Name of Guardian:	Relationship:
Signature of Guardian:	Date:

NRV PEDIATRICS OFFICE USE ONLY		
Date:	Reviewed By:	Entered By: