Reston Pediatrics

☐ New ☐ Existing

PATIENT REGISTRATION

Please Print

Patient Name (First,Last) ☐ Male ☐ Female		Date of Birth
Phone Number - Home ( )	Drug Allergies	
Street Address		
City	State	Zip Code

Parent or Legal Guardian Information

Parent/Legal Guardian of Minor (First,Last)	Date of Birth	Relationship to Minor
Phone Numbers - Home ( ) Cell ( ) Work ( )		
Street Address (if different from above)		Email Address
City	State	Zip Code
Employer Name		Job Title
Parent/Legal Guardian of Minor (First,Last)	Date of Birth	Relationship to Minor
Phone Numbers - Home ( ) Cell ( ) Work ( )		
Street Address (if different from above)		Email Address
Employer Name		Job Title
City	State	Zip Code

Emergency Contact Information

Emergency Contact Other Than Parent/Legal Guardian (First,Last)	Relationship to Patient
Phone Numbers - Home ( ) Cell ( ) Work ( )	

ASSIGNMENT AND RELEASE

I, the undersigned, certify that the information I have provided is correct and do hereby authorize Reston Pediatric Associates, Ltd. and/or its physicians (hereafter referred to as Reston Pediatrics) to apply for benefits from my insurance company to Reston Pediatrics. If applicable, I further request payment of government benefits be assigned to Reston Pediatrics. I permit a copy of this authorization to be used in place of the original on all insurance claim submissions whether manual, electronic or telephonic.

I further authorize Reston Pediatrics to release any and all of my child's/children's/self's medical records and/or other records and information; (1) needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to Reston Pediatrics; (2) to any hospital, lab, doctor, or other healthcare provider and grant permission for any hospital, lab, or other healthcare provider to release their medical records of my child/children/self to Reston Pediatrics.

Records will be provided to either parent upon written request and without notice to the other, unless there is legal documentation presented to our office showing the parent bringing the child for treatment has sole legal and physical custody, or that there is a temination of parental rights, or restricted access to medical records.

Additionally, I acknowledge that I am hereby informed in accordance with the Code of Virginia Section 32.1, that if the provisions of health care services exposes any health care worked to the patient's body fluids in a manner that may transmit immunodeficiency virus or HIV or Hepatitis, that the patient shall be deemed to have consented to testing for the infections and to release the test results to the person(s) exposed.

Print Name_____

Address (if different from above)_____

City_____ **State**_____ **Zip**_____ **Phone Number ( )**

_____ **X**_____

Date **Signature of Insured/Parent/Legal Guardian/Self**

INSURANCE

☐ **Self Pay**	I do not have insurance coverage or I have insurance that Reston Pediatrics does not accept. I acknowledge that all services provided are payable in full at the time of service.
Insurance Information	All information must be completed. If incomplete, this account will be considered self pay and payment in full is due at time of service. As a courtesy, secondary insurance will be billed but only if the primary and secondary insurances are coordinated. The secondary insurance must be presented at the time of service.

Primary Insurance Company			Policy/Identification Number
Insurance Network, if applicable			Group Number
Insurance Address			Insurance phone number for eligibility/verification
City	State	Zip Code	Insurance Co-Payment/Co-Insurance

Policyholder/Subscribers' Name	SSN	Date of Birth
Street Address		
City	State	Zip Code
Employer Name		Job Title/Position
Phone Numbers - Home ( )	Cell ( )	Work ( )
Do you have Secondary Insurance? ☐ Yes ☐ No		

Copies of the insurance cards for each child is required. The insurance card must list a RPA physician if a primary care physician is required. Responsible party must provide one form of picture identification.

FINANCIAL POLICY

I accept full financial responsibility for all medical services rendered to my children.
I agree to pay all insurance co-payments, deductibles, and co-insurance under the terms of my health insurance plan and pay any service not covered by my plan.
Co-payments are due on the date services are rendered. A $30.00 billing fee will be added to your account if co-pay is not made at the time of service.
I understand that in the event that I default on my payments the doctor-patient relationship may be terminated. In the event of default of my financial obligations, I agree to pay all relevant costs associated with collection actions taken by Reston Pediatric Associates.
I accept full responsibility for assigning Reston Pediatrics as the PCP on my child(ren)'s health insurance.
I authorize that all insurance benefits due and payable for medical services rendered be paid directly to Reston Pediatrics
I authorize Reston Pediatrics to disclose medical record to my child's insurance company.
I am responsible for charges accrued by my child(ren) under the age of eighteen whether accompanied or in the presence of a parent or caregiver.
I understand that Reston Pediatrics is HIPAA compliant and will protect my child(ren)'s personal information.

ADDITIONAL CHARGES

There is a $30.00 fee for all returned checks.

MISSED APPOINTMENT/LATE CANCELLATIONS

Cancellations are requested 24 hours prior to the appointment, and 2 hours for same day sick visits. We will charge a $50.00 fee for missed appointments or same day cancellations.

Print Name_____

Address (if different from above)_____

City_____ **State**_____ **Zip**_____ **Phone Number ( )**

_____ **X**_____

Date **Signature of Insured/Parent/Legal Guardian/Self**