Southside Pediatric CENTER

34-F Medical Park Boulevard
Petersburg, Virginia 23805
(804) 520-8135
Fax (804) 520-8092

PATIENT REGISTRATION FORM

Child's Name	Sex	Birth Date	SS#
_____	( )	_____	_____
_____	( )	_____	_____
_____	( )	_____	_____
_____	( )	_____	_____

Mother's Name _____ Date of Birth ____/____/____ SS#_____

Home Address _____
Street City State Zip

Home Phone # _____ Work Phone #_____

Mother's Employer _____ Mother's Occupation_____

Employer's Address _____
Street City State Zip

Father's Name _____ Date of Birth ____/____/____ SS#_____

Home Address _____
Street City State Zip

Home Phone # _____ Work Phone #_____

Father's Employer _____ Father's Occupation_____

Employer's Address _____
Street City State Zip

Former Pediatrician?_____ Phone #_____

Whom may we thank for referring you to us? _____

Whom may we contact in case of emergency?_____

Insurance Company _____ **Policy Holder**_____

Contract ID# _____ **Group #** _____

Address of Insurance Co. _____ **Phone #**_____

I give permission to _____ , to bring my children in for office visits, if I am unable to do so. I also understand that I will need to provide this person with the funds to pay office charges for these visits.

_____ _____
Guardian Signature Date

Please read each of the items below before signing. Without your signature, we cannot see your children.

I AUTHORIZE Southside Pediatric to render medical care to my child/children. I authorize payment from my insurance carrier (if applicable) to Southside Pediatric for incurred charges. I also authorize release of medical information to my insurance carrier. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information above and have completed the above answers. I certify the information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

_____ _____
Signature Date

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WE WELCOME YOU . . .

We are board certified specialists in the provision of health care to infants, children, and adolescents. Everyone in this practice operates as a team member. As such, we act as advocates on your child's behalf. By providing ongoing primary care for your child through our group, you are ensuring the best care possible.

ABOUT FINANCIAL ARRANGEMENTS & MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your understanding of our payment policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE PROVIDED. We accept cash, checks, MasterCard or Visa. We will be happy to process claims with those insurance companies with which we participate, but you will be expected to pay any co-payments and/or percentages of lab fees at time of service. For all other insurance companies, you are responsible for all fees at time of service and must file for reimbursement from your insurance company.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of claims with those companies with which we participate is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If someone else is presumed liable for your bill, such as a divorced spouse, we will provide you with any necessary information to assist you with your claim. However, we look to the party receiving services for payment, and cannot be expected to wait for the conclusion of court cases or insurance disputes. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly prior to your office visit for assistance in the management of your account.

Should a check be returned to us for insufficient funds a $25.00 service charge will be applied to your account. Balances older than 30 days may be subject to additional collection fees. If it becomes necessary to refer your account to an agency or attorney for collection, you will be responsible for all fees that may be incurred, up to 1/3 (one-third) of your unpaid balance. If collection attempts by our billing office on your account prove to be unsuccessful then you will be dismissed from the practice and your account will be turned over to an outside source. Charges may also be made for broken appointments, especially those without 24 hours notice. A $25.00 no show fee will be applied to each child's account after the second occurrence.

We will gladly discuss your charges prior to office visits and any questions relating to your insurance. You must realize, however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area referred to by insurance companies as UCR - usual, customary, and reasonable.
3. Not all services are a covered benefit in all contracts. It is your responsibility to know what services are covered by your policy. Should your insurance require services to be provided by another provider for various reasons it is your responsibility to make us aware which facility this is, i.e. lab procedures, x-ray and DME (durable medical equipment).

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

By signing below I certify that I have read and understand the above information.

_____ SIGNATURE

_____ DATE

Southside Pediatric Center

Guarantor's Agreement

In accordance with provisions of Section 32.1 - 45.1 of Code of Virginia (whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to bodily fluids of a patient in a manner which may according to the current guidelines of the Center of Disease Control, transmit Human Immunodeficiency Virus or Hepatitis B or C Viruses), the patient whose bodily fluids were involved in the exposure shall be deemed to have consented to testing for infections with Human Immunodeficiency Virus and Hepatitis B or C.

If there is an exposure, and the patient's test is positive, the attending physician will notify the patient, any person exposed, and the VIRGINIA HEALTH DEPARTMENT. Appropriate counseling will be offered.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its content.

Print Name: _____

Sign Name: _____

Date: _____

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I, _____ give my permission for the following person's to bring my child/children to Southside Pediatric Center for treatment.

Name of Child/Children	Authorized Person/Relationship

I, _____ give Southside Pediatric Center permission to disclose health information on my child/children to the following persons.

Name of Child/Children	Authorized Person/Relationship

Print Guardian Name _____ Date _____

Sign Guardian Name _____ Date _____

Witness Signature _____ Date _____

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Consent for Treatment

As parent or legal guardian (circle one) for _____ ,
I give permission for Southside Pediatric Center to authorize any and all medical treatment my child may need.

This consent is valid from _____ to _____.

Signature of parent or guardian _____ Date _____

Southside Pediatric Center

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
MARY C ARRIETA, M.D., F.A.A.P

Patients full name

Date of Birth

Street Address

Social Security Number

City, State, Zip Code

Phone Number

At the request of the individual, I _____, do
(Patient Name)

Authorize Dr. Mary C Arrieta to (circle one) Receive Send medical records.

__PROGRESS NOTES __PATHOLOGY REPORTS __ALL RECORDS
__LAB REPORTS __EKG/EEG/CARDIAC CATH __OTHER
__HOSPITAL NOTES __RADIOLOGY REPORTS

Information released from or to: _____
Name of Physician, Hospital, Agency, Etc.

Fax Number

Street Address

Phone Number

City, State, Zip Code

I HEREBY AUTHORIZE DISCLOSE OF HEALTH INFORMATION FOR THE PATIENT NAMES LISTED ABOVE. THE AUTHORIZATION IS VALID FOR 12 MOS FROM DATE OF SIGNATURE. I UNDERSTAND THAT I MAY CANCEL THIS REQUEST WITH WRITTEN NOTIFICATION BUT THAT IT WILL NOT AFFECT ANY INFORMATION RELEASED PRIOR TO NOTIFICATION OF CANCELLATION. I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED MAY BE SUBJECT TO RE-DISCLOSURE BY THAT PERSON OR CLASS OF PERSON OR CLASS OF PERSONS OR FACILITY RECEIVING IT, AND WOULD NO LONGER BE PROTECTED BY FEDERAL REGULATIONS. I UNDERSTAND THAT THE MEDICAL PROVIDER TO WHOM THIS IS AUTHORIZED IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME WHETHER OR NOT I SIGN THE AUTHORIZATION.

Patient/Guardian/POA

Date

NOTE: THERE WILL BE A CHARGE FOR RECORDS IN ACCORDANCE WITH THE VA CODE 8.01-413. $.50 (PER PAGE UP TO PAGE 50) ADDITIONAL $.25 PER PAGE (FROM PAGE 51 AND UP) + ACTUAL POSTAGE (IF APPLICABLE).