Richmond
Pediatric
Associates, Inc.

PATIENT REGISTRATION

Patient Name_____ Date of Birth:_____ Sex:_____

Patient Address_____

Race_____ Ethnicity: Hispanic/Latino ☐Yes ☐No Primary Language_____

Parent I's Name:(M or F (circle one)) _____ Parent I's Date of Birth_____

Parent I's Address: _____

Parent I's Home#_____ Parent I's Cell #_____

Parent I's Work#_____ Parent I's Employer_____

Parent I's Email:_____ Parent I's SSN_____

Parent II's Name:(M or F (circle one)) _____ Date of Birth_____

Parent II's Address_____

Parent II's Home #_____ Parent II's Cell #_____

Parent II's Work #_____ Parent II's Employer_____

Parent II's Email_____ Parent II's SSN_____

Pharmacy Name_____ Pharmacy Address/Phone_____

Preferred method of Communication (please circle one) Home Phone Cell Phone Web Portal Message

I allow detailed messages, including lab results, to be left at the above ☐ Yes ☐ No

Sibling's names and dates of birth_____

Emergency Contact Name and Phone #(other than listed above):_____

Do you allow us to release your child's immunization record to their school or daycare upon their request? ☐Yes ☐ No

How did you hear about us? ☐RPA Website? ☐Advertisement? ☐ Another Patient? If so, who?_____

INSURANCE INFORMATION

Primary Insurance Company_____ Effective Date_____

I.D. Number_____ Group Number_____

Policyholder Name_____ Policyholder SSN_____ Policyholder DOB_____

I hereby authorize the above named Physicians to release the information to the Insurance Company named herein. I herby authorize payment directly to the above named Physicians and benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event that my account must be turned over to an attorney for collection, I will be responsible for attorney's fees, court costs and interest.

Signature_____ Date_____

RICHMOND PEDIATRIC ASSOCIATES, PC
DISCLOSURES OF HEALTH INFORMATION AND MEDICAL TREATMENT AUTHORIZATION FOR A MINOR

I, _____, the parent/legal guardian of the following child(ren):

Please Print Name

_____ (Print Child(ren)'s Name and Date of Birth)

_____

_____

_____

Understand that disclosures may be made to family and friends related to the patient's health or as needed for payment of health care services. I understand that only information relevant to current treatment will be disclosed.

I agree that the following persons may seek medical treatment for, and receive health information about, my child(ren) in my absence. I authorize Richmond Pediatric Associates, Inc. to provide such treatment, including immunizations, in my absence.

This temporary authority shall begin on_____, and shall remain effective until terminated by the undersigned.

I understand that any persons so authorized to seek medical treatment and/or receive health information must be over age 18.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

_____ _____

Parent/Guardian Signature Parent/Guardian Printed Name

_____

Date

Richmond Pediatric Associates, PC

HIPAA Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy upon your request. A current version of our Notice is always posted in our offices as well as our website.

_____ (Initial) I have received a copy of the Richmond Pediatrics' Notice of Privacy Practices, OR

_____ (Initial) I was offered a copy of the Richmond Pediatrics' Notice of Privacy Practices but deferred keeping a paper copy.

I have had the opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to Richmond Pediatrics if I do not understand any information contained in the Notice of Privacy Practices.

_____
Patient Name (or Patient Signature if patient is 18 or older)

_____
Patient Name

_____
Patient Name

_____
Patient Name

_____
Signature of Authorized Representative of Patient

_____
Printed Name of Authorized Representative

_____
Relationship to Patient

_____
Date

FOR OFFICE USE ONLY:
Authorized Representative refused signing and/or completing form:_____
Staff Signature

RICHMOND PEDIATRIC ASSOCIATES
New Patient Questionnaire

DATE_____
Patient Name_____ DOB_____
Patient's Nickname_____
Parent I's Name_____ Age_____ Cell Phone #_____
Parent II's Name_____ Age_____ Cell Phone #_____
If adults in household work outside the home, what childcare arrangements are made for the child? _____

_____

A. PREGNANCY AND BIRTH

1. Parent II's age at Birth_____
2. Did mother have any illness during pregnancy? Yes No
3. Did she take any medications other than vitamins and iron? Yes No
4. Was the Baby on time? Yes No
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breath? Yes No
7. Did the baby have any trouble in the hospital? (Jaundice, infections, other?) Yes No

What kind?_____

B. PAST MEDICAL HISTORY

1. Where has your child gone for check-ups until now?_____
2. Date of last checkup_____
3. Date of last dental checkup_____
4. Has your child had allergic reactions to any medications, foods, insect bites? Yes No
   Which ones? _____
5. Has your child had any major reactions to any immunizations? Yes No
   Which ones? _____
6. Any hospitalizations other than for birth? Yes No
   For what?_____
7. Any series injuries? Yes No
   What kind? _____
8. Any medications taken regularly? Yes No

Which ones? _____

C. FAMILY HISTORY

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts, or uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others_____
3. List the age, sex, and general health of brothers and sisters_____

_____

D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there a severe colic or any unusual feeding problem during the first three months? Yes No
4. Do any foods disagree with him/her? Yes No
5. For the first 6 months, is he/she (was he/she) breastfed or bottle fed? _____
6. If still on formula, which one do you use?_____
7. Does he/she take vitamins? Yes No

FORM COMPLETED BY_____

E. REVIEW OF SYSTEMS:

F.

G.

1. Has your child had frequent ear infections? Yes No
2. Any eye problems? Yes No
3. Has he/she had any problems with teeth? Yes No
4. Does he/she have frequent colds or sore throats? Yes No
5. Is there asthma, Pneumonia or recurrent cough? Yes No
6. Does he/she have a heart murmur or any heart problems? Yes No
7. Any problems with urination? Yes No
8. Any problems with diarrhea or constipation? Yes No
9. Have there been any convulsions or other problems with the nervous system? Yes No
10. Any eczema, hives or other skin conditions? Yes No
11. Has your child ever been anemic? Yes No
12. Please list any other medical problems_____

_____

H. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone?_____
3. Did he/she say any words by the time he/she was 1 ½ years old? Yes No
4. How did this child compare to other his or her age?

_____

5. Does he/she have any trouble sleeping? Yes No
6. What grade is he/she in? Yes No
7. Has he/she had any trouble in school? Yes No
8. Does he/she get along with other children? Yes No
9. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others_____

_____

I. SAFETY/ENVIRONMENT:

1. Do you live in a private house apartment, mobile home other? (Circle)
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Does your child always use a car seat or seat belt when riding in a car? Yes No
4. Is there a working smoke alarm on each floor of your house? Yes No
5. Are there any smokers in your household? Yes No
6. Are there any problems with the condition of your home? (peeling paint, insects, rats or mice.) Yes No
7. Does your child always wear a helmet when riding his/her bicycle? Yes No
8. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No

PLEASE USE OTHER SIDE FOR ADDITIONAL INFORMATION

Financial Policy
Richmond Pediatric Associates, Inc.
9900 Independence Park Dr., Suite 100, Richmond, VA 23233 (804) 747-1750
7521 Right Flank Rd., Mechanicsville, VA 23116 (804) 559-0447

This is an agreement between Richmond Pediatric Associates, as creditor and _____, as the patient guardian. In this agreement, the words 'you', 'your,' and 'yours', refer to the Patient Guardian. The word 'account' refers to the financial ledger established to which charges and payments are made. The words 'we', 'us' and 'our' refers to Richmond Pediatric Associates.

PAYMENT is due at the time of your visit. We accept cash, personal check and debit/credit card for any copayment, balance on account, co-insurance, deductible, or non-covered service. The balance on your statement is due upon receipt and past due if not paid within 30 days. Payments are accepted over the phone, by mail or by logging onto our patient portal, Richmond Pediatric Associates under the Pay My Bill tab. For your convenience, we do offer a credit card on file program which allows you to authorize payments for balances on your account.

- If you do not have active insurance, you will be considered self-pay. Payment will be due at the time of check-in.
- If you have active insurance that is not provided within 90 days of services, balances not paid by insurance due to untimely filing will be considered self-pay.
- If you have active insurance, you will be responsible for all co-pays, deductibles, or balances on your account at the time of service.
- Richmond Pediatrics charges an extra fee for weekend medical services.
- There is a returned check fee of $25.00.

COPAYMENTS are due at the time services are rendered. This is a contractual obligation required by your insurance company.

DEDUCTIBLES. If your insurance plan is a deductible plan, Richmond Pediatric Associates will collect **$50** towards your deductible at the time of service.

INSURANCE. Your insurance policy is a contract between you and your insurance carrier. It is your responsibility to know and to understand your child's policy. If your child is covered by more than one insurance policy, the insurance companies require that you notify us of all insurance policies.

NEWBORNS. You have up to 30 days to add your child to an insurance policy. If your child is not added to an active policy after 30 days, you will be considered self-pay until the newborn is added.

MISSED APPOINTMENTS. After one (1) No Show for a pre-scheduled appointment, you will receive a warning letter. After a second No Show, you will receive another letter and a $40.00 charge will be added to your account. Insurance policies will not pay for this charge. Appointments made the same day must be cancelled within one hour of the appointment. If you do not show up for an appointment that you have scheduled on the same day, you will automatically be charged a No-Show fee.

WELL CHILD CHECKS. Most insurance plans will cover Well Child visits at 100%. Copays and deductibles are not collected at the time of service for a Well Child visit. There are certain services recommended by the AAP performed at your child's well child check that **may not be covered** under your insurance policy and are sometimes left to patient responsibility as a **NON-COVERED** service. Some services include but are not limited to **fluoride topical varnish, vision, hearing and depression screenings**.

PAST DUE ACCOUNTS. If your account is past due, we will take the necessary steps to collect the balance. If, we refer your account out to a collection agency, you agree to pay all of the collection costs which are incurred. A **15%** collection fee is added to accounts turned over to the collection agency. If, your account is referred to an outside attorney, you will be responsible for paying all attorney fees and court costs in addition to any outstanding balance.

RESPONSIBLE PARTY. We expect payment from the parent/guardian who brings the child in for services. We do not interfere with payment responsibility between parents/guardians which may be waiting for the conclusion of court cases.

1st Patient Name/DOB_____ **2nd Patient Name DOB**_____

3rd Patient Name/DOB_____ **4th Patient Name/DOB**_____

Responsible Party Name_____

Responsible Party Signature_____ **Date**_____