RESTON TOWN CENTER PEDIATRICS
Patient Registration Rights & Responsibilities Privacy Form

PATIENT INFORMATION (Please print) **New Patient** _____

How did you hear about us ? _____ **Patient ID #** _____

Patient Name (Last) _____ (First) _____ (Middle) _____

Primary e-mail address _____

Address _____ City _____

State, Zip Code _____ / _____ Sex M/F _____ Social Security # _____

Birth date _____ Home Phone _____ **Siblings** Name's _____, _____, _____, _____

Mother's Name _____ Father's Name _____

Mother's SS # _____ Date Of Birth _____ Father's SS # _____ Date Of Birth _____

Mother's Work # _____ Father's Work # _____

Mother's Cell # _____ Father's Cell # _____

EMERGENCY CONTACT _____ **RELATIONSHIP** _____ **PHONE #** _____ **CELL #** _____

PRIMARY INSURANCE

Name of Insurance Company _____ Policy Holder _____

Insurance Company Address _____, State _____, Zip _____ Ins. Co. Phone # _____

Patient Relationship to Policy Holder _____ Policy Number _____ Group Number _____

Policy Holder's Employer _____ Phone Number _____

Employer Address _____ City, State, Zip _____

Policy Holder/Guarantor SS # _____ Birth Date _____ Sex _____

PATIENT RIGHTS AND RESPONSIBILITIES.

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of medically accepted laboratory tests, all of which the judgment of the attending or the assigned designees, may be considered medically necessary or advisable.

I fully understand that this consent is given in advance of any diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. I authorize any individual I verbally designate, to bring my child to be seen and treated at Reston Town Center Pediatrics. This consent will remain in full force until revoked in writing.

I hereby authorize Reston Town Center Pediatrics to release medical information to any physician or insurance company that may be pertinent to my case I hereby authorize payment directly to Reston Town Center Pediatrics of benefits otherwise payable to me. I hereby, authorize release of my medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided. I understand that I am financially responsible for charges not covered by this authorization. I understand in the event that my account is turned over to a collection agency I will be responsible for the additional 33 1/3% collection fee. A photocopy of this authorization shall be considered as valid as the original. "Further, I acknowledge that I am indebted for past due charges and I understand that I am financially responsible for those charges also."

I AUTHORIZE Reston Town Center Pediatrics to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Reston Town Center Pediatrics.

In accordance with the provisions of Sections 32.1-45.1 of the code of Virginia, (whenever any healthcare provider, or any person employed by or under the direction and control of a health care provider, is exposed to body fluids of a patient in a manner which may, according to the current guidelines of the Centers of Disease Control, transmit human immunodeficiency virus), the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus.

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 and appropriate counseling will be offered..

I have reviewed and understand my PATIENTS RIGHTS AND RESPONSIBILITIES. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its policy. I have received a copy of the RTCP NOTICE OF PRIVACY PRACTICES. It is posted in all patient waiting rooms, on our website, and is available upon request at any time.

PLEASE COMPLETE REGISTRATION ON THE BACK OF THIS FORM