# Pediatric Associates of Richmond, Inc.

**Child/Children Information:**

| Last Name | First Name | MI (Nickname) | Date of Birth | SS# | Sex |
|---|---|---|---|---|---|
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| | | | | | |
| | | | | | |

StreetAddress:_____City_____ Zip:_____

****Check here if the information below applies to all children listed above. If not, please put child's initials next to appropriate responses.****

| Race | Ethnicity | Language |
|---|---|---|
| o Black or African American | o Hispanic or Latino | o English |
| o American Indian or Alaska Native | o Not Hispanic or Latino | o Other _____ |
| o Asian | o Unknown | |
| o Hawaiian or Other Pacific Islander | | |
| o Other Race | | |
| o White | | |

**Please provide phone number contact information to be used for updates and reminders**

**Primary Contact Phone #:_____ 2nd Phone #:_____ 3rd Phone #:_____**

**Optional ** Email Address:_____**

**Father's Information:**

| Last Name | First Name | MI | Date of Birth | SS# | Marital Status |
|---|---|---|---|---|---|
| | | | | | |

StreetAddress:_____,City_____Zip:_____Home #:_____

Employer:_____Occupation:_____ Work#:_____ Cell #:_____

**Mother's Information**:

| Last Name | First Name | MI | Date of Birth | SS# | Marital Status |
|---|---|---|---|---|---|
| | | | | | |

StreetAddress:_____,City_____Zip:_____Home #:_____

Employer:_____Occupation:_____ Work#:_____ Cell #:_____

**Emergency Contact (Other than Parent) Information:**

| Last Name | First Name | MI | Address | Phone # | Relationship to child |
|---|---|---|---|---|---|
| | | | | | |

**Authorized to seek Treatment**: - In addition to the emergency contact listed above the following individuals may bring my child/children to Pediatric Associates of Richmond, Inc. for treatment:

| Last Name | First Name | MI | Address (optional) | Phone # | Relationship to child |
|---|---|---|---|---|---|
| | | | | | |

Pediatric Associates of Richmond participates with the Virginia Immunization Information System (VIIS). The VIIS is an online database that stores a historical listing of immunizations given to patients in the state of Virginia. The VIIS can be accessed by authorized parties to obtain this information in the case of a missing shot, shots given at school or any other health department clinic. By default in the state of Virginia, your child is opted-in, meaning when we enter a shot into our health record the information is then transmitted to the database.

_____ **YES,** I authorize P.A.R.to electronically transmit my child(s) immunization history to the Virginia Immunization Information System (VIIS)

_____ **NO,** I would like to opt-out of having my child(s) immunization history transmitted to the Virginia Immunization Information System

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Pediatric Associates of Richmond uses an EHR (Electronic Health Record) called Pulse Systems. Within our EHR we have the ability to check your external prescription (RX) history, meaning we can pull into our system the other prescriptions that you may have had filled at another doctor's office helping to build a better health record for your child. As a patient, you have the right to either opt in or opt out of this service.

_____ **YES,** I authorize Pediatric Associates of Richmond to electronically retrieve my child(s) external RX history into their EHR, Pulse System

_____ **NO,** I would like to opt-out of having my child(s) external RX history imported into P.A.R.'s medical record

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Fees incurred are payable when services are rendered and are the sole responsibility of the parent/and or guardian. I understand that my insurance coverage is a contract between me and the insurance company and it is my responsibility to know my insurance benefits. I understand that regardless of any insurance coverage I may have, I am responsible for payment for all children on my account. I understand that co-payments are due at the time of service and it is my responsibility to pay any co-payment, co-insurance, deductible or service not covered by my insurance. I understand that full payment is expected at the time of service for uninsured patients and non-covered services. I understand a self-pay discount is only offered to uninsured patients or those patients that are not seeking reimbursement, providing full payment is received at the time of service. I agree in the event that my account must be turned over to an attorney for collection, I will be responsible for attorney fees, court costs and interest. I hereby authorize my insurance benefits be assigned to Pediatric Associates of Richmond, Inc. I authorize Pediatric Associates of Richmond, Inc. to furnish all information regarding my child's medical history, diagnosis and treatment to my insurance company. I authorize Pediatric Associates of Richmond, Inc. to furnish such medical information deemed necessary during the course of my child's treatment to any individual authorized to consent to my child's treatment and to any other person who presents with my child for treatment in my absence.

Our **Notice of Privacy Practices** provides information about how we may use and disclose PHI (Protected Health Information) about you, your child/children. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

I, _____ (Please print parent/guardian name) have received a copy of the Pediatric Associates of Richmond's Notice of Privacy Practices.

I understand by signing below I have read, agreed to the policies listed, that I accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients and that all information listed is correct.

| _____ | _____ | _____ |
|---|---|---|
| Parent / Guardian Signature | Please Print Name | Date: |