Pediatric Associates of Richmond, Inc.

Patient/Adult Information:

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

StreetAddress:_____City_____ Zip:_____

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

Please provide your phone number to be used for updates and reminders

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

Email Address:_____

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION:

I authorize P.A.R. and its agents to release/discuss my protected health information to the following individuals:

****You will find our 'Notice of Privacy Practice' posted on our website, www.parpeds.com, under 'Forms'.**

Name:	Relationship	Cell Number	Portal Access	Email
_____	_____	_____	YES or NO	_____
_____	_____	_____	YES or NO	_____

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, you are 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 immunization history to the Virginia Immunization Information System (VIIS)

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

Pediatric Associates of Richmond uses an EHR (Electronic Health Record) called E-Clinical Works. 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..

_____ **YES,** I authorize Pediatric Associates of Richmond to electronically retrieve my external RX history into their EHR, ECW System

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

Fees incurred are payable when services are rendered and are the sole responsibility of the patient. 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 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 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 treatment to any individual authorized to consent to my treatment.

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 the patient and that all information listed is correct.

X_____

Signature Please Print Name Date

HIPAA Written Acknowledgement

Our **Notice of Privacy Practices** provides information about how we may use and disclose PHI (Protected Health Information) about you. I,_____ acknowledge the September 11, 2013 Notice of Privacy Practices is posted on our website and a copy is available in-office. I am signing this form as acknowledgement of the HIPAA notification for myself, or the stated patient for which I am the responsible party:

X_____

Signature Please Print Name Date