ADM Parham Pediatrics

1770 N Parham Rd., Ste 100
Henrico, VA 23229
T: 804-964-1600/F: 804-964-1604

PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Sex: _____ Marital Status: _____

Mailing Address: _____ City: _____

State: _____ Zip: _____ Employer: _____ Work Phone: _____

Cell Phone _____ Emergency Contact # : _____

INSURANCE INFORMATION

Primary Ins. Name: _____

Subscriber's Name: _____

Subscriber's D.O.B.: _____

I.D. #: _____

Group/Plan #: _____

Secondary Ins. Name: _____

Subscriber's Name: _____

Subscriber's D.O.B.: _____

I.D. #: _____

Group/Plan #: _____

We charge a $35.00 fee for failure to keep a weekday appointment, and a $50.00 fee for failure to keep a Saturday appointment. There is a $25.00 service charge added to your account for all returned checks. We charge a $25.00 fee if your account is assigned to a Collection Agency in addition to reasonable attorney's fees and all collection costs.

Please remember that insurance is a method of reimbursing the patient for services provided by Dr. Samaan and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, co-pays, or any other balance not paid for by your insurance within a 90 day period.

I AGREE TO THE ASSIGNMENT AND FINANCIAL RESPONSIBILITIES OF THIS FORM.

Signature (Patient or responsible party, if under 18): _____

Date: _____ Relationship: SELF PARENT OTHER_____

IF PATIENT IS NOT PERSON SIGNING THE FORM, PLEASE COMPLETE THE FOLLOWING:

Responsible Party Name: _____ Social Security #: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Cell: _____ Work Phone: _____

Employer: _____ Preferred Contact Number: HOME / CELL / Work (circle one)

Email: ----------

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient……
Address……
Phone Number……
Email……
Birthdate……
Social Security Number……
Other Aliases……

Name of Guardian or Legal Representative……
Address……
Phone Number……
E-mail……

I hereby authorize the following health care professional to release (Check one)
☐ all health information about me/My child ☐ my medical records as described on the following page:
To **ADM Parham Pediatrics**

Person/Organization to Release Information……
Street Address……
City…… State…… Zip Code……
Phone Number…… Fax Number……

The following health information that relates to service beginning from _____ [Date] to _____ [Date], may be released: (Check one)

☐ Entire medical record (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers)

Only the following: (Check all that apply)
☐ Patient histories ☐ Referrals ☐ Consults ☐ Billing records ☐ Films
☐ Office notes (except psychotherapy notes) ☐ Insurance records
☐ Test results ☐ Records sent by other health care provide
☐ Radiology studies
☐ Other: _____

Reason for request:

☐ Change of doctor
☐ Individual request
☐ Workers' compensation
☐ Specialist referral
☐ Insurance purposes
☐ Continued treatment
☐ Legal investigation
☐ Other: _____

_____

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____	_____	_____
Patient's Signature	Patient's Name	Date
_____	_____	_____
Guardian or Legal Representative's Signature	Guardian or Legal Representative's Name	Date

ADM Parham Pediatrics

A Division of Aloha Dcotora Medicine, LLC

Assignments and Authorizations

Patient Name: _____ Date of Birth: _ _ /_ _ / _ _ _ _

My signature below attests that I am the
- ☐ **Biological/Adoptive Parent**
- ☐ **Legal Guardian; or**
- ☐ **Foster Parent**

for the patient named above and my agreement of the below terms.

In order to protect the welfare of the patient, if any court orders/decrees/letters/contracts authorizing medical treatment exist regarding custodial/parental/guardian rights, etc., please be aware that we must maintain a copy of these documents in the patient's file.

I understand that I may be subject to legal ramifications if I purposely provide false or inaccurate information to ADM Parham Pediatrics. This release expires one (1) year from the date of signature; unless I choose to revoke this agreement (termination of the authorization must be received in writing).

On behalf of my minor child or other patient named above,

CONSENT TO TREAT

I hereby give my permission to ADM Parham Pediatrics (referred to as "ADM" in this form) for the evaluation and treatment of the presented medical condition (herein referred to as "health care services"). I am requesting that health care services be provided to my minor child or the patient named above at ADM. I voluntarily consent to all treatment and health care services that the caregivers at ADM consider to be necessary for the patient named above. These services may include diagnostic, therapeutic, imaging, and laboratory services, including blood testing, such as HIV testing. If I want any HIV testing to be performed anonymously, I will tell the ADM caregiver. ADM complies with all laws allowing minors to consent for treatment without parental consent. I am aware that the practice of medicine is not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

FINANCIAL RESPONSIBILITY

Subject to applicable Virginia law and the terms and conditions of any applicable contract between ADM and a third-party payer, and in consideration of all health care services rendered or about to be rendered to the above-named patient, I agree to be financially responsible and obligated to pay ADM for any balance not paid under the "Assignment of Benefits" paragraph below. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to the above-named patient, I agree to be financially responsible and obligated to pay ADM for the patient balances due.

ASSIGNMENT OF BENEFIT In consideration of all health care services rendered or about to be rendered to the above-named patient, I hereby assign to ADM all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding ADM's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by ADM to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in

advance whether the services provided are covered by insurance or other third-party payer. I understand that my current insurance must be on file with ADM for my insurance to be billed and as such I will be asked to present my insurance card at each visit to verify my insurance coverage. If I do not provide ADM with accurate insurance information, I will be considered a self-pay patient and obligated to pay all fees associated with services rendered.

CONSENT TO RETRIEVE MEDICAL INFORMATION

As a patient of ADM, I authorize ADM to retrieve and use my minor child or other above-named patient's medical and medication history, including electronic records, from other providers, past and current.

NOTICE OF PRIVACY PRACTICES

I have received a copy of the ADM Notice of Privacy Practices. The Notice of Privacy Practices explains how ADM may use and disclose confidential health information that identifies me (or the above-named patient). I consent to let ADM use and disclose health information about me (or the above-named patient) as described in the Notice of Privacy Practices. In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by ADM, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent ADM or provide assistance to ADM for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above named patient's) health care, including for substance use, psychiatric care, or HIV, if applicable. I can revoke my consent in writing at any time except to the extent that ADM has already relied on my consent. I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to ADM or updated at a later time, text messages and/or telephone calls or other communications using live, artificial or prerecorded voices, automatic telephone dialing systems, or any other computer-aided technologies from ADM and its affiliates, clinical providers, and business associates, along with any billing services, collection agencies, agents, or other third parties who may act on their behalf. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered, including marketing messages/calls. I understand this consent to communications is not required to receive services from ADM or any of the other authorized callers and that data usage and other charges may apply. I may revoke this consent to these communications at any time.

FOR BIOLOGICAL/ADOPTIVE PARENTS ONLY

You may list in the space provided below, individuals who are given permission to consent for treatment for the patient listed above and have the same access to the patient's medical records, including the right to disclose the contents to others:

Authorized Individuals:	Relationship to Patient:
_____	_____
_____	_____

FOR MINOR PATIENTS 16 YEARS OF AGE OR OLDER

☐ I authorize the minor patient referenced above to seek care and treatment, including vaccinations, without a parent/ guardian present (except for sports or school physicals).

_____	_____
Patient/Legal Guardian Signature	Relationship to Patient
_____	_____
Telephone Number	Date
_____	_____
Witness Signature	Date

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HIPAA Acknowledgment and Consent

I, _____, understand that I have certain rights to privacy regarding my child/ my health records and information. By signing this acknowledgment and consent, I am acknowledging that I have been provided and reviewed a copy of ADM Parham Pediatrics' HIPAA Notice of Privacy Practices and consent to the use and disclosure of my child's records in accordance with that Notice. I understand and acknowledge that ADM Parham Pediatrics reserves the right to change and amend the terms and conditions of the Notice and that I may request a current copy of the Notice at any time.

I understand that I may revoke this acknowledgment and consent, in writing, at any time. Any use or disclosure of my health records or information that occurred prior to the date of any written revocation will not affected.

_____ _____

Signature Date

If applicable, Legal Representatives sign and acknowledge the following below:
By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof that I am legally authorized to act on the Patient's behalf with respect to this acknowledgment and consent form.

Signature: _____ Date: _____

Printed Name of Legal Representative: _____