AKSHAR PEDIATRICS

7474 Limestone Dr, Gainesville VA 20155 | (P) 703-721-7218 | (F) 703-721-7219

PATIENT REGISTRATION FORM

Patient's Name: ____DOB: _________________ Sex: ___________ SSN/ID: _________________

Known Allergies to Medication/s: ____

Address (Street/City/State/Zip): ____

Home Phone: ____________________________ Mobile Phone: ________________________ Email Address: _______________________________

Name & Address (if different from patient) of the Person Responsible for Payment: (*Please provide a valid ID for office copy)*

Name: ____ Relationship to Patient: _______________________________________

DOB: _________________ SSN: ____________________ Address:____

Home Phone: ____________________________ Mobile Phone: ________________________ Email Address:_______________________________

Work Phone: _____________________________ Occupation: _____________________ Employer: ____

Name of Spouse: ____ Relationship to Patient: _______________________________________

DOB: _________________ SSN: _________________ Address:____

Home Phone: ____________________________ Mobile Phone: ________________________ Email Address:_______________________________

Work Phone: _____________________________ Occupation: _____________________ Employer: ____

(REQUIRED) *Ethnicity:* ___________________________ *Race:* _____________________________

Medical Insurance Policy /Holder Information: (*Please provide insurance card/s for official record)*

Insurance Name: ______________________________ Policy #: ______________________________ Group #: ________________________________

Subscriber's Name: ____________________________________ Subscriber's ID: ________________________ Employer: ______________________

Secondary/Other Insurances (if yes please provide info): ____

Brothers and Sisters:	**Date of Birth**	**Sex**	**Known Allergies to Medication**
1. ______________________	______________	__________	______________________________
2. ______________________	______________	__________	______________________________
3. ______________________	______________	__________	______________________________
4. ______________________	______________	__________	______________________________
5. ______________________	______________	__________	______________________________

Preferred Pharmacy: ____

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I hereby authorize the release of any Medical Information necessary to process any claims with any insurance company. A copy of this authorization and assignment may be used in place of the original. I understand that I am financially responsible for charges not covered be my health insurance plan.

Signature: ____Name: ____

Referred by: ______________________________________Date: ____

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PATIENT REGISTRATION FORM

TREATMENT AUTHORIZATION: Authorization is hereby granted for my child/children to have examinations, immunizations, or routine screening procedures as recommended by the providers at Akshar Pediatrics LLC. The authorization shall be continuous unless revoked by your office, the parents or guardian. I also authorize Akshar Pediatrics LLC to initiate any medical treatment required in emergency situations.

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of medical/surgical benefits to Akshar Pediatrics LLC for services rendered by them in person or under their supervision I further Authorize Akshar Pediatrics LLC to release my medical or incidental information that may be necessary for processing of medical claims or applications for financial benefits. A photocopy of this assignment shall be valid as the original. This authorization may be revoked by either my insurance carrier or me at any time in writing.

PAYMENT POLICY: I understand and agree that, (regardless of my insurance status): I am ultimately and financially responsible for the balance of my child's/children's account for all professional services rendered including services not covered by my insurance company.

I have read all the above information and certify that the information provided by me to Akshar Pediatrics LLC is true and current to the best of my knowledge. I will notify this office of any changes in child's/children's health status or the above information.

Signature of Parent/Guardian: ____

Name of Parent/Guardian: ______________________________ **Date:** ________________

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NOTICE OF PRIVACY PRACTICES

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION:

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plane for future care or treatment. This Information, often referred to as your health or medical record, serves as a basis for planning your care or treatment, a mean of communication among the many professionals who contribute to your care, a legal document describing the care you received, a means by which you or a third-party payer can verify that services billed were actually provided. Understanding what is in your record and how your health information is used helps you to ensure accuracy, and better understand who, what, when, where and why others may access your health information makes more Informed decisions when authorizing discloser to others.

YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of Akshar Pediatrics LLC, the information belongs to you. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a copy of your health record for a fee. You also have the right to be scheduled by an appointment. You may obtain an accounting of disclosures of your health information, request communications, of your health information by alternative means or at alternative locations, revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES:

This organization is required to maintain the privacy of your health Information, provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health Information by alternative means or at alternative locations. We reserve the right to change our practice and make new provisions effective for all protected health information we maintain. Should our information practice change, we will mail a revised notice to the address provided to us.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact the office at (703) 721-7218. If you believe your privacy rights have been violated, you can file a complaint with our practice, contact the office at the above number. All complaints must be in writing. You will not be penalized for filing a complaint.

DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS:

We will use your health information for treatment and for payment. We will also use it as needed for business associates such as other physicians, labs, and billing companies. To protect your health information, however, we require the business associate/s to appropriately safeguard your Information. Health professionals, using their best judgment may disclose to a family member, other relative, close friend, or any other person you identify; health information relevant to that person's involvement in your care or payment related to your care. We will also provide your health Information as required by federal, state, or local laws. Any authorization you provide to us regarding the use and disclosure of health-information may be revoked at any time in writing. Please note, we are required to retain records of your care.

A more detailed version of the Notice of Privacy Practice is available for inspection in the office.

______________________________ ______________

Patient's (Parent/Guardian) Signature **Date**

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STATEMENT OF OFFICE POLICIES

The following polices have been adopted to provide better pediatric care to our patients. It is important to follow these policies to ensure smooth service and a respectful, nurturing office environment that meets your needs.

1. A valid insurance card must be presented at the time of service. Otherwise, your office visit must be paid for as fee-for-service at the time of your visit.
2. Co-payments will be paid at the time of sign-in.
3. Our office will submit claims to all the insurance plans that we participate with. Any resubmissions of insurance claims can be arranged if needed. Any insurance disputes must be settled within 120 days. Any unpaid balance must be paid within 30 days of receipt of statement from our office.
4. If the patient's insurance company deems an office visit, vaccine, or any other service as a non-covered service and denies payment, then the patient's financially responsible person will be responsible for the full cost of the services rendered. Subsequent filing for reimbursement or balance owed will become the responsibility of the financially responsible person, once the denial occurs.
5. Any outstanding balance will be turned over to the collection agency and an additional 30% will be added to the unpaid balance.
6. Minimum 72-hour notice must be provided to the office to obtain referrals.
7. School forms require a minimum of 48 hours to be completed and ready for pick-up. Forms can be mailed only if a self-addressed and stamped envelope is provided. We will not fax any school forms.
8. Faxing of documents to the office is discouraged.
9. A written request is necessary to transfer medical records to another office and can be done within two weeks from the time of request.
10. There is a fee for copying medical records. Please check with us for more information about the fee.
11. A fee will be charged for no-show appointments. Appointments must be cancelled at least 48 hours in advance to avoid the no-show fee. Please check with us for more information about the fee.
12. There is a $45.00 charge for all returned checks, in addition to the check amount Checks will NOT be accepted from those whose check was previously returned unpaid from the bank.

I acknowledge that I have read and understand the Statement of Office Policies.

______________________________ ______________________

Signature of parent/guardian **Date**

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Printed name of parent/guardian