Southeastern Virginia Health System
Pediatric Registration

Child's Information

Name_____
(Last) (First) (Middle Initial)

Previous Name_____

Address_____

_____
(City) (State) (Zip)

Contact Information – Please help us to reach you regarding appointments, medications, and your test results by completing all known information.

Home Phone_____ Cell Phone_____

Work Phone_____ No Phone. Leave Message at #_____

Email: _____

Responsible Party Self☐ Another Person☐ (complete below)

Date of Birth_____/_____/_____
(Month) (Day) (Year)

_____
(Last) (First) (Middle Initial)

Relationship to patient: _____ Responsible Party Social Security #_____

Employer Name_____

Employment Status: Full-Time☐ Part-time☐ Not Employed☐ Self-Employed☐ Retired☐
Active Military Duty☐ Unknown☐

Child's Information

Primary Care Provider (PCP) _____

Referring Provider_____

Date of Birth_____/_____/_____ Sex: Male ____ Female ____
(Month) (Day) (Year)

Social Security #_____/____/_____

Emergency Contact_____
(Name) (Phone Number)

Relationship to patient _____

Insurance Information

Primary Insurance: _____

Address: _____

Subscriber #: _____ Co-Pay $:_____

Insured Name:_____

Patient Relationship to Insured: _____

Group #:_____ Employer/ Group Name:_____

Demographic Information

Race: _____ Ethnicity:_____

Language: English☐ Spanish☐ French☐ Vietnamese☐ Other☐(Specify:)_____

Veteran: Yes☐ No☐

Pharmacy Preference

Name of Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone #: _____

Survey Questions

How did you hear about us? Friends/Family☐ TV☐ Radio ☐ Other (Specify:) _____

Government guidelines require community health centers to survey their patients for the following information. While not required to respond, your participation will help us continue serving this area. All information is confidential and will not be shared with other entities.

How many individuals live in your home? _____
What is your estimated annual household income? $_____

Southeastern Virginia Health System (SEVHS)

Patient Name_____

Social Security #_____**DOB**_____

Sign your initials next to each section:

_____**CONSENT FOR TREATMENT**: I authorize the employees, agents, and staff of Southeastern Virginia Health System to perform and hereby consent to such medical treatment and examinations, including diagnostic procedures or behavioral health evaluations, as may in the opinion of the patient's physician to be necessary.

_____**NO GUARANTEE:** I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of any procedures, treatments, or examinations.

_____**FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible for all charges, whether or not paid by insurance. Southeastern Virginia Health System does not participate in **every** insurance plan. I understand that I am responsible for verifying that my Provider is a participating provider with my insurance plan. Payment is expected at time of service.

_____**RELEASE OF INFORMATION:** I authorize Southeastern Virginia Health System to release any and all patient medical and billing information to any physician involved in my treatment; to any health care facility to which I/the patient is discharged or transferred for treatment, billing, quality assurance, collection, or defense of litigation or anticipated litigation; and to any insurance company, review organization, or other entity, which is directly or indirectly responsible for payment or review of services provided by Southeastern Virginia Health System. I consent to the use and disclosure of my protected health information to carry out treatment, payment, or health care operations by Southeastern Virginia Health System.

_____**DEEMED CONSENT FOR BLOOD TESTING:** I understand that under Virginia Law, if a health care provider, a person employed by, under the direction of, or control of a healthcare provider, is directly exposed to body fluids of a patient, which may transmit viruses causing HIV or Hepatitis B or C, the patient will be deemed to have consented to testing for HIV or Hepatitis B or C, and to the release of such test results to the person who was exposed. (Exposure could occur due to an accidental needle stick.) A patient who tests positive will be afforded the opportunity for individual face-to-face disclosure of test results and appropriate counseling.

_____**SLIDING FEE SCALE:** Qualifying for our sliding fee scale is based on your family income and family size may result in lower charges. You are required to report any income and family size changes to us as this may impact the amount you are expected to pay. We will review and update your information annually. Eligibility cannot be determined until we receive all requested information from you. If it is determined that you are not eligible for a sliding fee and you have incurred charges, you will be expected to pay the balance due. We will assist you by arranging a payment plan if needed. You will be asked to pay a minimum fee for your first visit until the sliding fee eligibility process is complete. The remaining cost of the first and subsequent visits will be based on the outcome of this determination. If you do not pay for services at the time they are rendered, your balance must be paid in full within sixty (60) days.

_____**MEDICARE LIFE-TIME/MEDICAID SIGNATURE AUTHORIZATION AND ASSIGNMENT:** I request that payment of authorized Medicare/Medicaid benefits be made on my/the patient's behalf for any services furnished by or in the practice, including physician services. I authorize any holder of medical or other information about me, to release to Southeastern Virginia Health System for Medicare and Medicaid Services, the Virginia Department of Medical Assistance Services and their agents, any information needed to determine these benefits or benefits for related services. I assign the benefits payable for physician and other medical services to the physician or organization furnishing the services and authorize such physician or organization to submit claim to Medicare and/or Medicaid for payment. I understand that I/the patient am/is responsible for any deductibles, co-payments, and any applicable percentage of remaining charges.

____**CERTIFICATION AND ACKNOWLEDGEMENT:** I certify that all foregoing information and all information supplied by me, as part of the registration process, is correct. I also acknowledge receipt of Southeastern Virginia Health System's Notice of Privacy Practices (HIPAA).

Patient or Parent/Legal Guardian Date

Relationship to Patient Witness Signature