



**PATIENT NAME:**

**INSURANCE**

- I AUTHORIZE THE PHYSICIANS OF NOVA PEDIATRICS, LTD. TO APPLY FOR BENEFITS ON MY OR MY CHILD'S / CHILDREN'S BEHALF FOR COVERED SERVICES RENDERED.
- I CERTIFY THAT THE INFORMATION I HAVE REPORTED REGARDING MY INSURANCE COVERAGE IS CORRECT. I FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM TO MY INSURANCE CARRIER.
- I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO NOVA PEDIATRICS, LTD. FOR SERVICES RENDERED. A COPY OF THE AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL. EITHER MY INSURANCE CARRIER OR I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

**FINANCIAL RESPONSIBILITY**

- I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY INCLUDING BUT NOT LIMITED TO: CO-PAYMENTS, NON-COVERED CHARGES AND DEDUCTIBLES. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY COLLECTION AGENCY OR ATTORNEY FEES IF MY ACCOUNT BECOMES DELINQUENT (AFTER 60 DAYS).

**RELEASE OF MEDICAL RECORDS, IMMUNIZATION HISTORY AND CHILD LOCATOR INFORMATION**

I AUTHORIZE NOVA PEDIATRICS TO RELEASE ANY MEDICAL RECORDS, IMMUNIZATION HISTORY, AND / OR CHILD LOCATOR INFORMATION OF MY CHILD / CHILDREN AS LISTED ON THE REGISTRATION FORM UPON MY WRITTEN OR VERBAL REQUEST TO THE FOLLOWING PERSONS: ANY LICENSED PHYSICIAN, LICENSED HEALTH CARE FACILITY, LOCAL OR DISTRICT HEALTH DEPARTMENT, THE DEPARTMENT OF HEALTH AND / OR ANY EDUCATION FACILITY. THE INFORMATION RELEASED MAY INCLUDE BUT IS NOT LIMITED TO: NAME OF PATIENT, DATE OF BIRTH, SOCIAL SECURITY NUMBER, PARENT NAME(S), TELEPHONE NUMBER, ADDRESS, AND ANY OTHER RECORDS OF TREATMENT, EXAMINATION AND/OR DIAGNOSIS. FURTHERMORE, I UNDERSTAND THAT THE INFORMATION MAY BE RELEASED BY FORWARDING A PHOTOCOPY THROUGH THE U.S. POSTAL SERVICE OR BY CONFIDENTIAL FACSIMILE.

- CONVERSELY, I AUTHORIZE ANY OF THE ABOVE LISTED PERSONS TO RELEASE ANY MEDICAL INFORMATION NECESSARY FOR MY CHILD'S (CHILDREN'S) MEDICAL TREATMENT TO THE DOCTORS OF NOVA PEDIATRICS, LTD.

**DEEMED CONSENT**

- I UNDERSTAND THAT THE LAWS OF VIRGINIA PROVIDE THAT IF ANY EMPLOYEE OF NOVA PEDIATRICS, LTD. IS DIRECTLY EXPOSED TO MY CHILD'S BODY FLUIDS IN ANY MANNER WHICH MAY, ACCORDING TO THE CURRENT GUIDELINES FOR THE CENTER OF DISEASE CONTROL, TRANSMIT THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) OR HEPATITIS B OR C VIRUSES, THAT I AM DEEMED BY LAW TO HAVE CONSENTED TO THE TESTING OF MY CHILD FOR INFECTION WITH HIV OR HEPATITIS B OR C VIRUSES AS WELL AS TO THE RELEASE OF THESE TEST RESULTS TO THE PERSON WHO IS EXPOSED TO THE BODY FLUIDS.

**OFFICE POLICIES**

- I UNDERSTAND THAT A CHARGE WILL BE ADDED TO MY ACCOUNT FOR RETURNED CHECKS. THE CHARGE WILL BE DETERMINED BY OUR CHECK PROCESSING COMPANY AND THE AMOUNT OF THE CHARGE WILL BE DISPLAYED IN THE WAITING ROOM.
- I UNDERSTAND THAT A CHARGE OF \$5.00 WILL BE ADDED TO MY ACCOUNT IF I FAIL TO PAY A CO-PAYMENT WITHIN FIVE (5) BUSINESS DAYS FROM THE DATE SERVICES ARE RENDERED.
- I UNDERSTAND THAT THERE WILL BE A CHARGE OF \$10.00 FOR ALL FORMS REQUESTED.
- I UNDERSTAND THAT THERE WILL BE A CHARGE OF \$15.00 FOR ALL AFTER HOURS TRIAGE CALLS.
- I UNDERSTAND THAT I MUST GIVE AT LEAST 24 HOURS NOTICE IF I NEED TO CANCEL AN APPOINTMENT TO AVOID A POSSIBLE CHARGE TO MY ACCOUNT. IT IS ALSO THE POLICY OF THE PRACTICE TO DISMISS PATIENTS WHO FAIL TO APPEAR MORE THAN TWO (2) TIMES FOR A SCHEDULED APPOINTMENT.
- I UNDERSTAND THAT THERE WILL BE A CHARGE FOR COPIES OF MY CHILD'S (CHILDREN'S) RECORDS AS ALLOWED BY THE VIRGINIA STATE LAW AND THAT NOVA PEDIATRICS, LTD. HAS UP TO 15 DAYS FROM THE DATE OF MY REQUEST TO PROVIDE THE COPIES.

**SIGNATURE OF PARENT/GUARDIAN:**

**DATE:**