



Mountain Ridge Pediatrics

Child's First Name	Child's Last Name	Date of Birth	Gender
		/ /	M F
		/ /	M F
		/ /	M F
		/ /	M F

<p><b>Legal Guardian 1:</b>  Name: _____  Date of Birth: _____  Address: _____  City: _____ State: ____ Zip: _____  Home Phone #: (____) _____  Cell Phone #: (____) _____  Work Phone #: (____) _____  Email Address: _____  Social Security Number: _____  Relationship to Patient: _____  Marital Status: Married __ Single __  Separated __ Divorced __ Widowed __  Employer: _____  Employer Address: _____  City: _____ State: ____ Zip: _____</p>	<p><b>Legal Guardian 2:</b>  Name: _____  Date of Birth: _____  Address: _____  City: _____ State: ____ Zip: _____  Home Phone #: (____) _____  Cell Phone #: (____) _____  Work Phone #: (____) _____  Email Address: _____  Social Security Number: _____  Relationship to Patient: _____  Marital Status: Married __ Single __  Separated __ Divorced __ Widowed __  Employer: _____  Employer Address: _____  City: _____ State: ____ Zip: _____</p>
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Has Custody (Circle One)?    Both    Father    Mother    Other: \_\_\_\_\_  
Child Lives With (Circle One)?    Both    Father    Mother    Other: \_\_\_\_\_  
Which Parent Will Bring in Patient(s) Most Often (Circle One):    Both    Father    Mother    Other:

**Emergency Contact (Other Than Parent):**

Name: \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_  
Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**INSURANCE INFORMATION – A copy of your insurance card(s) will be requested at every visit.**

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Insurance Effective Date: _____	Insurance Effective Date: _____
ID #: _____	ID #: _____
Group #: _____	Group #: _____
Subscriber's Name: _____	Subscriber's Name: _____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____

I certify that the information I have entered above is correct and that as the Parent/Guardian/Guarantor I have read, understand, and fully accept the Conditions of Registration as stated on the back of this document. In cases of divorce or separation, unless otherwise specified by a court order, both parents will be permitted to bring the child(ren) into the office and have full access to your child(ren)'s medical records.

\_\_\_\_\_  
Patient's Signature or Parent/Guardian (if minor)

\_\_\_\_\_  
Date

**PAYMENT IS DUE AT TIME OF SERVICE**



## Mountain Ridge Pediatrics

### CONDITIONS OF REGISTRATION

1. **CONSENT TO MEDICAL CARE:** I understand that I have the right and responsibility to take part in making decisions regarding my child(ren)'s health care and plan for treatment. I authorize the physicians of Mountain Ridge Pediatrics and their nursing staff to perform medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the condition(s) that have brought about my seeking medical care for my child(ren) at Mountain Ridge Pediatrics.
2. **RELEASE OF MEDICAL RECORD INFORMATION:** I authorize Mountain Ridge Pediatrics to release any and all of my minor child(ren)'s medical records and/or other information and records required by my insurance company, who provide insurance benefits on my child(ren)'s behalf, needed to determine benefits and to process insurance claims and secure payment of benefits to Mountain Ridge Pediatrics.
3. **HIV/HEPATITIS B & C TESTING:** I acknowledge that I am hereby informed in accordance with Virginia law, any patient whose body exposes a healthcare worker in a manner which may transmit immunodeficiency virus (HIV) or Hepatitis B or C viruses, that the patient shall be deemed to have consented to HIV/HEPATITIS B & C TESTING and for the release of the test results to the person who was exposed.
4. **NO SHOW POLICY:** Here at Mountain Ridge Pediatrics, we are committed to the timely healthcare of all of our patients. Failure to keep appointments without notifying our office interferes with your child(ren)'s healthcare, as well as our ability to accommodate other children. We ask that you give our office 24-hour cancellation notice for all pre-scheduled appointments. I understand that failure to provide Mountain Ridge Pediatrics with adequate cancellation notice is considered a "no-show" and will result in a \$25 fee. After two no show fees we unfortunately will need to dismiss you/your family from the practice.
5. **ALTERNATIVE VACCINE SCHEDULE:** The American Academy of Pediatrics and your insurance company recommend a routine immunization schedule that Mountain Ridge Pediatrics adheres to. If I elect to follow an alternate vaccine schedule, my insurance company may charge additional fees. I further understand that these additional fees will become my responsibility.
6. **AFTER HOURS CONCERNS:** A physician is available to answer emergency questions after office hours. Non-emergent questions should be handled during regular weekday office hours. I understand that all telehealth services (the provision of healthcare remotely by means of telecommunications technology) made to the physician on-call after hours are billable charges and will be billed accordingly based on the physician's discretion. I further understand that if this fee is not covered by commercial insurance carriers it is my responsibility.
7. **CORRECT INFORMATION:** The undersigned certifies that he/she has provided correct information in this Patient Registration Form. The undersigned certifies that he/she has read, fully understands, and accepts the above information, terms and conditions, and is the patient's parent or legal guardian, duly authorized to execute the above and to accept the terms.

\_\_\_\_\_  
Patient's Signature or Parent/Guardian (if minor)

\_\_\_\_\_  
Date

Account # \_\_\_\_\_



## Mountain Ridge Pediatrics

### AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

I/We designate,

\_\_\_\_\_  
(Name, address, telephone number)

\_\_\_\_\_  
(Name, address, telephone number)

\_\_\_\_\_  
(Name, address, telephone number)

the approval to obtain, in my/our absence, medical care for my/our child(ren). I/We realize and request that confidential health information be shared with this/these individual(s) for my/our children listed below:

\_\_\_\_\_  
(Child's name, Birthdate)

\_\_\_\_\_  
(Child's name, Birthdate)

\_\_\_\_\_  
(Child's name, Birthdate)

Access to certain health information may be restricted. I wish to limit access to my child's medical information as described below (If none, state "NONE"):

I wish to restrict this authorization to the following dates (If none, state "NONE"):

**This consent will be considered valid unless revoked in writing. This consent may be revoked in writing at any time. Please understand that we are unable to take back any disclosures previously permitted.**

\_\_\_\_\_  
Patient's Signature or Parent/Guardian (if minor)

\_\_\_\_\_  
Date

Account # \_\_\_\_\_



## Mountain Ridge Pediatrics

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that Mountain Ridge Pediatrics has given you a copy of its Notice of Privacy Practices (HIPAA) to read and review. Additionally, you have had the opportunity to ask any questions about this notice and all of your questions have been answered.

\_\_\_\_\_  
Patient's Signature or Parent/Guardian (if minor)

\_\_\_\_\_  
Date

### PATIENT RECORD OF DISCLOSURES

HIPAA privacy rule gives the individual the right to request a restriction on uses and disclosures of their protected health information (PHI). Please indicate below your preferred communication means below.

**I wish to be contacted in the following manner (check all that apply):**

**Home Telephone**

- OK to leave message with detailed info
- Leave message with call-back number only

**Cell Phone**

- OK to leave message with detailed info
- OK to text message a call-back number
- Leave message with call-back number only

**Work Telephone**

- OK to leave message with detailed info
- Leave message with call-back number only

**Written Communication**

- OK to mail to my home address
- OK to mail to my work address

**FAX Communication**

- OK to fax to this number:  
\_\_\_\_\_

**E-mail**

- OK to E-mail appointment reminders
- OK to E-mail receipts

\_\_\_\_\_  
Patient's Signature or Parent/Guardian (if minor)

\_\_\_\_\_  
Date

Account # \_\_\_\_\_



## FINANCIAL POLICY

Thank you for choosing Mountain Ridge Pediatrics. We are committed to providing the best care possible. This goal is best achieved by letting you know in advance of our financial policy, which is an agreement between the doctors of the practice and the child's parent or guardian or a patient 18 years and older. Your clear understanding of the financial policy agreement is important to our professional relationship. Please read this carefully and if you have questions please do not hesitate to ask. We require a signature to document that you have read and understand these policies.

### **INSURANCE**

- Current insurance card(s) must be presented at check in for every visit. If the insurance company that you designate is incorrect, you will be responsible for payment.
- We will not bill another insurance carrier supplied at a later date, if it is past the timely filing period for that insurance company. If a child is insured by more than one insurance company, our office needs to have all insurance companies' names on file.
- According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co-Payments are due at time of service. There will be a \$10 fee added to any co-payment not paid at the time of visit.
- If you have a deductible plan and have not reached your deductible for the year we will collect 50% of the office charge at the time of visit.
- If a sibling is added to an appointment, they will have a separate charge and co-payment collected if required by insurance.
- If your insurance company does not cover a service, the amount must be paid in full within 30 days of denial from the insurance company. If not insured, the amount must be paid in full within 30 days from date of service.
- If you have no insurance, payment for the visit is to be paid at the time of service. A 30% discount is given when the visit is paid in full on the day of the appointment.
- Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to understand your benefit plan, including needs for referral or authorization for specialty care, vaccine coverage, lab tests and other services that may be required. Please note: physicians follow accepted national guidelines when determining your charges. They must code based upon which services were provided and cannot take into account particular health plan benefits.
- We are not currently accepting new Medicaid patients. If you are an established patient and have been switched to Medicaid please call our office ASAP. We are also not in network with all Medicaid plans and do not always have an open Medicaid panel. This may result in dismissal from our practice.

### **BILLING**

- Mountain Ridge Pediatrics will bill you accordingly for any medical advice you seek. This includes but is not limited to Office Visits, Car Visits, Telemedicine Services, Phone Calls, Portal Message Communication, and Text Message Communication.
- We provide you with an itemized statement each month when there is a balance due. We accept cash, checks, MasterCard, Visa, Discover, and American Express.
- We will charge your account a \$50.00 non-sufficient funds charge if your check is returned to us for insufficient funds and you will no longer be allowed to pay by check. This balance must then be paid within 30 days.

- We understand the difficulties involved in divorce and court orders, however, Mountain Ridge Pediatrics will not participate in disputes between custodial and noncustodial parents. We will refer to the responsible party, who signs the financial policy, for reimbursement of any amounts owed to our clinic.
- Balances are due within 30 days of the first statement, unless prior arrangements have been made with the billing department. Please call if you have questions about your outstanding bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
- Registrars will be collecting payments at check in on all accounts with balances that are more than 30 days past due.
- A \$5 late fee will be added to your account(s) for every statement sent after the initial notification of balance. If you are unable to pay a balance in full please inquire about a payment plan.
- Should your account remain outstanding for more than 90 days, a final letter will be issued. Balances not paid in full within the 10 days of the date on the final request letter may be forwarded to a collection agency.
- In the event of default of your financial obligations, you agree to pay all costs associated with collection, including but not limited to thirty-five (35) percent agency fees, and to pay any necessary and reasonable attorney fees, up to and including thirty-three (33) percent but not less than \$200.00 for the collection of my account, whether or not suit is filed.
- If your account is forwarded to a collection agency, or you fail to make payments in accordance with the payment policies, your family will be dismissed from the clinic. In order to allow you time to find a new source of medical care, the physicians will continue to see your child on an emergency basis only for the next 30 days, providing visits are paid in full at the time of service.
- If an appointment is missed a \$25.00 no show fee will be charged to your account. After the second no show you will be charged a \$50.00 no show fee. After the third no show you will be charged a \$50 now show fee and dismissed from Mountain Ridge Pediatrics.
- Due to insurance contracts, additional charges may need to be applied to Well Visits for the following reasons, but not limited to: excessive time spent with the provider, discussing topics outside the normal well criteria, mental health concerns, illness concerns, or behavioral problems.
- Our office will now be charging for the following services to include but are not limited to: after hours calls, texts, and pictures; FMLA and disability paperwork, forms requested outside of the visit, certified letters, mailing of forms, and medical records.

**FINANCIAL AGREEMENT**

We must emphasize that as pediatric providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know the benefits your insurance plan provides for you.

The undersigned agrees with the terms and conditions listed in the financial policy. By refusing to sign this financial policy, I agree to pay in full at the time of service.

I certify that the information I have given to Mountain Ridge Pediatrics is accurate. I hereby authorize Mountain Ridge Pediatrics to provide my insurance company any information they may request concerning the patient's present illness or injury. I hereby assign to Mountain Ridge Pediatrics all benefits for service rendered.

\_\_\_\_\_  
Patient's Signature or Parent/Guardian (if minor)

\_\_\_\_\_  
Date

Account(s) #: \_\_\_\_\_