



Physicians to Children, Inc.

21 Highland Avenue, Suite 100 • Roanoke, VA 24013

Telephone (540) 344.9213 • Facsimile (540) 345.7559

REGISTRATION FORM

Patient Name: _____
Last First Middle

Date of Birth: _____ Male: _____ Female: _____ SSN: _____

Address: _____
Street/PO Box Apt # City/State Zip

Home Phone: _____ Day Phone: _____

Child lives with: Father Mother Guardian Email: _____

Father Name: _____ DOB: _____ SSN: _____

Address: (If different from patient) _____

Phone: _____

Employer: _____ Employer or Daytime phone: _____

Mother Name: _____ DOB: _____ SSN: _____

Address: (If different from patient) _____

Phone: _____

Employer: _____ Employer or Daytime phone: _____

Guardian: _____ DOB: _____ SSN: _____

Address: (If different from patient) _____

Phone: _____

Employer: _____ Employer or Daytime phone: _____

Emergency-Contact: _____ **Phone:** _____ **Relationship:** _____

INSURANCE INFORMATION: (We will need to scan your insurance card. Please give your cards to registration).

Primary Coverage Anthem Medicaid/Va Premier Other _____

Secondary Coverage Anthem Medicaid/Va Premier Other _____



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PARENTAL CONSENT FOR MEDICAL TREATMENT: In my absence, I designate the following person(s) to make any medical or surgical decisions or to participate in the treatment of my child. Information about my child may be disclosed to the following person(s) to the extent of that person's involvement with my child's care or payment for care:

- 1. _____
Name Relationship to Patient
- 2. _____
Name Relationship to Patient
- 3. _____
Name Relationship to Patient

I furthermore authorize the medical staff at Physicians to Children, Inc. to carry out any medical procedures and treatments that are deemed appropriate. *This consent will stay in effect from the date signed until the parent/guardian revokes the consent in writing.

PRIVACY ACKNOWLEDGEMENT: I acknowledge that the Physicians to Children's Notice of Privacy Practice, Dated April 14, 2003 has been made available to me. I understand the Notice of Privacy Practice provides me with detailed information how my protected health information may be used and disclosed.

Patient's Name: _____ DOB: _____

Signature: _____ Date: _____

If this acknowledgement is signed by a parent, guardian, or personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____
(Please Print)

Relationship to Individual: _____

This acknowledgement could not be signed due to: _____

Date: _____ Signature: _____

DEEMED CONSENT: Virginia State law provides that when a healthcare worker is exposed to the body fluids or another person in a manner which may transmit human immunodeficiency virus (HIV – the virus that causes AIDS), such as an accidental needle stick, the patient shall be deemed to have consented to testing for HIV and to the release of the results to the exposed person and the local health department.

ASSIGNMENT OF BENEFITS: By signing below, I assign to Physicians to Children, Inc. any and all rights to receive payment pursuant to any insurance policy, and any recoveries upon any claim for injuries which are payable on account for the services rendered to the patient. I understand that I am financially responsible for all charges incurred for services rendered whether or not they should be paid for by insurance or by someone else. Should legal action be initiated as a result of nonpayment of any charges incurred with Physicians to Children, Inc., then I agree that the proper location of such actions will be the City of Roanoke and in addition to charges due, I agree to pay court costs and to pay attorney's fees up to an amount equal to 30% of the unpaid charges on that account.

VIRGINIA LAW GOVERNS: I agree that any dispute, cause of action, or any disagreement of any nature relating in any way to this consent or the treatment, diagnosis, administration of drugs or procedures, or any other interactions between the doctors, nurse practitioners, and employees of Physicians to Children, Inc. and me shall be governed by and construed in accordance with the laws of the Commonwealth of Virginia, but without regard to its or any other state's principles of conflicts of laws, and shall be binding upon me and my heirs, and personal representative. In the event this consent is signed by a parent or personal representative of the patient, this choice of law provision binds both the patient and personal representative.

By signing below I am agreeing to the above (Consent to Treat, Deemed Consent, Assignment of Benefits, and Virginia Law Governs):

Signature: _____ Date: _____

WHY DID YOU CHOOSE PHYSICIANS TO CHILDREN?

- Parent was former patient
- Sibling is patient
- Referred by other doctor's office (who) _____
- Hospital
- Internet search
- Phone book
- PTC's reputation
- Other _____