Children First, Inc. Indira Sinha, M.D., 17618 Main Street, Dumfries, VA 22026 703-441-8998 Fax 703-445-8568 childrenfirstdumfries@gmail.com

PATIENT'S INFORMATION

Patient's last name: _____First name _____Middle name_____

Gender: Male/ Female Age: _____ D.O.B.: _____ Race: _____ Ethnicity: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home phone #: _____ Cell phone #: _____ Work #: _____

Father's name:_____ SSN: _____ DOB: _____

Mother's name:_____ SSN: _____ DOB: _____

Legal guardian's name _____

E-mail address _____ Can we communicate with you via e-mail, electronic or web portal? (https://childrenfirstdumfries.com) Yes ____No_____ Pharmacy name & location _____

INSURANCE INFORMATION

Do you have insurance coverage for your child(ren) ? Yes ___NO___ **If your child is covered by more than one insurance, you must provide the ID for each insurance in order to file his/her claims. Failure to provide all the information, will result in claims rejection and possibly becoming full responsible for the services.**

Insurance name: _____Policy type HMO, PPO, MC_____

Policy Holder's Name: _____

Address if different from above: _____

Home phone #: _____ Work phone #: _____

Employer: _____

SSN: _____ DOB: _____ Gender: Male or Female

Secondary Insurance Name: _____Policy type HMO PPO, prime_____

Policy holder's name_____ DOB _____SS # _____

Policy #: _____ Group #: _____

Ins. Phone #: _____ Address: _____

Patient/ Parent is responsible for all insurance deductibles and for non covered services.

Please notify this office if you change or cancel your insurance plan. Co-pay is due at the time of service.

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name:_____ Relationship: _____ Phone #: _____

In the event that you need some one else to bring your child for medical attention, name a person who is fully authorized to bring, receive or make medical decisions about you child.

Name:_____ Relationship: _____ Phone#:_____

Please note that no patient under the age of 18 years can be seen without his/her parent or legal guardian.

MEDICAL RECORDS:

No medical records can be disclosed to an individual other than the parent or legal guardian, unless proper written authorization and identification is obtained. For all children under foster care, social services, child protection services, legal documentation must be presented before services are rendered.

A copy of your child immunization record is required for all new patients.

Release & Assignment:

The information that I have provided is correct and to best of my knowledge. I understand that it will be held in strict confidence and it is my responsibility to inform this office of any changes in my child's medical status. I certify that my child is covered by the insurance provided above a assigned directly to Dr. Indira Sinha all insurance benefits for services rendered. I understand that I am responsible for providing all insurance information for all charges whether or not paid by my insurance. I authorize insurance submission whether manual or electronic. I know that if I have a HMO policy, I must select Dr. Indira Sinha as my child's PCP or accept full responsibility for the balance.

Signature: _____ Relationship to the patient: _____ Date: _____

Consent to Medical Care: By my signature or electronic signature below, I warrant that I am the parent or legal guardian of the registered child(ren) named on this patient's registration. I hereby request and authorize the physician and other health care providers of Children First, Inc ("The Practice") and their professional staff to perform any medical diagnostic procedure, surgical care, labs, drug injection, x-rays or other studies which in their professional judgment is deemed necessary to diagnose or treat the condition(s)that have brought about my seeking medical care services for my child(ren) at the offices of Children First. I understand that the practice of medicine is not an exact science, that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by Children First physicians and staff. As part of my/child health care, Children First Inc. originates, generates and maintains medical paper or electronic records describing my child's health history, symptoms, examination, test results, diagnosis, treatment, and any plan for future care or treatment.

HIV/hepatitis B or C testing: I acknowledge that I am informed in accordance with Section 21.1-45.1of the code of Virginia,,1950, as amended , that if the provision of healthcare services to the registered patient(s) exposes any health care provider to the patient's body fluids in a manner which may transmi mmunodeficiency virus or HIV or Hepatitis B or C viruses, then patient shall be deemed to have consented to testing for infection with HIVor Hepatitis B or C viruses and to the release of such test results to the person(s) exposed, as provided by law.

Privacy policy acknowledgement: I acknowledge that I have been provided with a copy of HIPAA ***Notice of Privacy Practice*** for children First, which provides a more complete description of information uses and disclosures. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by revoking or refusing to sign this consent, this organization may refuse to treat me/my child as permitted by section 164.506 of the Code of Federal Regulation. I further understand that Children First Inc. serves the right to change their notice and practices and prior to implementation, in accordance with Section 164.20 of the Code of Federal Regulations. I wish to have the following restriction to the use or disclosure of my protected health information (PHI):_____

Release of medical record information: I hereby authorize Children First to disclose all or any part of the content of my child's medical record. I understand that as part of this organization's treatment, payment, or health care operation, it may become necessary to disclose my protected health information to another entity, such as my insurance carrier, third party payers, collection agency, lawyers, schools, other healthcare practitioner, specialists, etc. including disclosures via fax, e-mail or mail carrier. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or otherwise may not serve the interest of the registered patient or myself.

Assignment of insurance benefits: I hereby authorize and request my insurance company to pay directly to Children First Inc. insurance benefits otherwise payable to me. I understand my insurance carrier may have annual deductibles, coinsurance, waiting periods, exclusions limitations, or pay less than the actual bill service. I agree to be responsible for payments of all services rendered to my child, dependent, or my behalf.

Children under 18 year must have a parent or legal guardian present: Children under the age of 18 cannot legally consent to their own treatment. Treatment can only be approved by a parent or legal guardian. If you cannot attend their appointment and must send your child alone, or with and older sibling or nanny, please aware that they do not have legal authority to provide a "consent to treatment" for your child. You must send a SIGNED LETTER of authorization with them. Or give us a written pre-authorization naming the person you approve in advance to consent to treatment on your behalf.

Patient's Responsibility:

Missed appointments. I understand it's the policy of this practice that I must give a minimum of twenty four hours notice if it becomes necessary for me cancel an appointment. In the event that 24 hours notice is not given; I understand that I will be billed $25.00 for any missed appointment.

Return Check: Please note that there is a $40.00 charge for any returned check.

STD/Pregnancy test results and care are disclosed and discussed with the patient only, even if he /she is under 18 years. This is due to HIPAA regulations.

Web portal access: if you would to access to your child's medical information, you must first set up an account with our front desk. Please note that the record is read only format. If you constantly forget your pass word, there is a $5.00 charge to re-set your account.

Shot/medical records: No medical information/ record will be disclosed without prior written authorization from parent or legal guardian. A copy of shots records can be provided free of charges at patient's request. Additional medical copies or copy of medical record: can be provided with a $ 15 processing fee + 0.25 cent per page.

Important: It is the patient's responsibility to maintain their account current. If you have new insurance, address, phone number, etc, you must provide us with that information. Any insurance claim denied due to: no referral, not active at the time of service, missing information, etc, you will be billed for it. If you have a HMO or MC insurance plan, you must select Dr. Sinha as your primary doctor before you receive medical service. If you forget to pay your co-payment, you will be billed for it + a $10.00 billing fee will be added to your account.

Lab Results: Please note that we do not call our patients with normal test results, abnormal tests results will be notified as soon as possible and will be discussed with patient in the office.

Referrals: Should you need a referral, you must give us 72 hours notice to call your insurance, get authorization for the service you will receive, and generate a referral. Referrals for MRI, CT scan EEG, minor surgeries, outpatient services, must be authorized at least 10 days in advanced. For security and privacy reasons, we do not fax referrals, medical records, prescriptions or any other medical document unless a life-threatening emergency occurs.

Forms: We charge $ 5.00.00 and up to fill out forms. (Depending on the complexity of the form) and takes up to 5 days to complete them. Forms without patient's name and DOB on it, will not be fill out. Sport physical forms, page 1 & 2 must be complete by patient before you we fill it out the rest. WE DO NOT FAX BACK FORMS.

Reimbursements: If you pay for an office visit due to insurance issues, and would to be reimbursed for the visit, you will need to file your own claim to your insurance company. We will provide you with the procedure and diagnosis codes. If you are seeking reimbursement from our office, you must bring an original receipt or proof of payment in order to get reimbursed.

Financial agreement & guarantee: A accept full and complete financial responsibility for all medical services rendered to my child/ren and agree to any and all insurance co-pays, deductible, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered "non-covered" service under the terms of my medical insurance plan. I further acknowledge, understand, and agree that in the event that I fail to make such payment in accordance with the payment policies of Children First, Inc, or in the event of default of my financial obligation to pay for services rendered, this practice may terminate the "doctor-patient" relationship with the registered patient(s) in accordance with the code of Virginia. Furthermore, in the event of my default of my financial obligation, should my account be turned to TRANSWORLD SYSTEMS (collection agency) for non-payment, I agree to pay associated cost. I understand that in the event the patient(s) are not covered by a medical insurance plan, I will be required to make full payment at the time of the visit. I understand that I also have the option to make a payment arrangement or plan prior to receiving care.

Late payment charges: If I do not pay the entire amount or make partial payment within 25 days of the monthly billing date, a late payment charge of 1.5% will added to the balance each month. I realize that failure to keep my account current may result on being unable to receive additional treatment/ service except for emergencies or where there is a pre-payment for additional services**.** In the case of default of payment, I agree to pay collection cost and reasonable attorney and court fees incurred on attempting to collect on this amount or any future amount balance**.**

_____	_____	_____
Name of person completing this form	Parent or legal guardian's signature	Date