# Patient Registration Form

Please fill out and email to **help@acornpeds.com**

Acorn Pediatrics
2610-B Gaskins Rd
Richmond, VA 23238
P: 804-548-4700
F: 804-548-4788
help@acornpeds.com

**Child #1**

Full Name: _____ Preferred Name: _____

DOB: _____ Gender Identity (m/f/other): _____

**Child #2**

Full Name: _____ Preferred Name: _____

DOB: _____ Gender Identity (m/f/other): _____

**Child #3**

Full Name: _____ Preferred Name: _____

DOB: _____ Gender Identity (m/f/other): _____

**Child #4**

Full Name: _____ Preferred Name: _____

DOB: _____ Gender Identity (m/f/other): _____

Home address of the patient(s):

_____
(Street) (City/State/Zip)

Who does the child live with (check all that apply):
- ☐ Both parents
- ☐ One parent (please specify) _____
- ☐ Other (please specify) _____

Preferred Pharmacy: _____
(Name)

_____
(Street) (Zip Code)

**Parent/Legal Guardian #1:**

Name: _____ Relationship to Patient: _____

DOB: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Best ways to reach me (check all that apply): Home: ☐ Cell: ☐ Work: ☐ Email: ☐

Acorn Pediatrics may leave messages with protected health information such as lab results on my (check all that apply): Home: ☐ Cell: ☐ Text: ☐ Email: ☐

If you do not live with the patient, please list your address:

_____

(Street) (City/State/Zip)

**Parent/Legal Guardian #2**:

Name: _____ Relationship to Patient: _____

DOB: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Best ways to reach me (check all that apply): Home: ☐ Cell: ☐ Work: ☐ Email: ☐

ACORN PEDIATRICS may leave messages with protected health information such as lab results on my (check all that apply): Home: ☐ Cell: ☐ Text: ☐ Email: ☐

If you do not live with the patient, please list your address:

_____

(Street) (City/State/Zip)

Who has legal custody? _____

If applicable, please fill out this section:

If there are any legal restrictions that prevent the non-custodial parent from obtaining protected health information or from consenting to medical treatment for the patient, please give a brief explanation and provide a copy the legal paperwork detailing these restrictions:

_____

_____

## Billing and Insurance Coverage Information

Who should receive billing statements? _____
(Name and phone number)

Billing address (if different from current address):

_____

Insurance Policyholder's Name: _____

Policyholder's DOB: _____ Relationship to Patient: _____

**Please email pictures of the front and back of the insurance card with this form to help@acornpeds.com.**

If you are unable to do so, fill out the information below:

Name of Insurance Company: _____

Insurance Group number: _____

Insurance Member ID: _____

If available:

Phone number (customer service or for providers): _____

Claims address (if available): _____
(PO BOX) (ZIP CODE)

**Thank you! Almost done!**

# Patient Consent, Release of Information and Financial Responsibility Form

Acorn Pediatrics
2610-B Gaskins Rd
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P: 804-548-4700
F: 804-548-4788
help@acornpeds.com

By signing this Patient Consent, Release of Information and Financial Responsibility Form ("Form"), I acknowledge and understand the following:

**1. 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) provided for and named in the Patient Registration. I hereby request and authorize the physician and other health care providers of Acorn Pediatrics and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions(s) that have brought about my seeking medical care services for my child(ren) at Acorn Pediatrics. I understand that the practice of medicine is not an exact science, and 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 the physicians and professional staff of Acorn Pediatrics.

**2. RELEASE OF MEDICAL RECORD INFORMATION**. I hereby authorize Acorn Pediatrics to disclose all or any part or the contents of the medical record of the patients provided for and named in the Patient Registration to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with the Health Insurance Portability and Accountability Act (HIPAA). 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 which otherwise may not serve the interests of the registered patient(s) or myself.

**3. ASSIGNMENT OF INSURANCE BENEFITS**: I hereby request and authorize that any and all insurance benefits due and payable for medical services rendered to the patients(s) be paid directly to Acorn Pediatrics.

**4. POLICY ACKNOWLEDGMENT**: I acknowledge that I have read the Notice of Privacy Practice for Acorn Pediatrics and been given the option to receive a copy of it.

**5. FINANCIAL AGREEMENT AND GUARANTEE:** I accept full and complete financial responsibility for all medical services rendered to the registered patient(s) and agree to any and all insurance co-payments, deductibles, 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 a "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 payments in accordance with the payment policies of Acorn Pediatrics, or in the event of default of my financial obligation to pay for services rendered, Acorn Pediatrics 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 over to anexternal collection agency for non-payment, I agree to pay any associated collection costs.
I understand that Acorn Pediatrics may not take my insurance, and I agree to pay any and all fees associated with services rendered at the time of the visit unless I've made prior arrangements with Acorn Pediatrics. In the event the patient(s) are not covered by a medical insurance plan, I will be required to pay any and all fees associated with services rendered at the time of the visit unless I've made prior arrangements with Acorn Pediatrics. I understand that this balance must be paid in full at or before the next visit.

**6. CORRECT INFORMATION:** The undersigned certifies that he/she has provided correct information to Acorn Pediatrics for Patient Registration and understands that any false statements or concealment of material fact may be prosecuted under applicable federal and state laws. The undersigned further certifies that he/she (i) has read, fully understands, and accepts the above information, terms and conditions; (ii) agrees that his/her consent and agreement to the terms and conditions will remain in effect until he/she notifies Acorn Pediatrics in writing that he/she has revoked consent; (iii) is the patient's parent or legal guardian, duly authorized to execute the above and to accept its terms; and (iv) all signature requirements are fulfilled with his/her electronic signature typed or otherwise.

Print Patient(s) Names: _____

Relationship to Patient: _____

Date: _____

Parent or Legal Guardian Signature: _____
*(your electronic signature can be typed)*

Print Parent or Legal Guardian Name: _____

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# Authorization and Financial Policy for Storing Credit Cards

Acorn Pediatrics requests a valid credit card be kept on file. This helps to avoid billing-related fees, streamline the check-in process, and reduce environmental impact (less paper!).

1. After you fill out this form, your credit card information is electronically encrypted and only the last four digits are visible to our staff.

2. After each visit, we bill your insurance carrier for all charges related to the visit as usual.

3. When we receive an explanation of benefits (EOB) from your insurance, we will send you a statement for any balance due.

4. Your signature will authorize your credit card to be used after 30 days from the issue date of the statement.

5. If we attempt to use your card and it is declined or has expired, we will contact you to update your credit card information.

6. Maintaining a credit card does not restrict your right to appeal any charge made to your credit card. If you believe that we have charged your card in error, please contact our office. If a mistake has been made, we will quickly reverse the charges.

*The undersigned agrees to provide their credit card information to Acorn Pediatrics for the purpose of payment for medical care received at Acorn Pediatrics. The undersigned also certifies that they (i) have read, fully understand, and accept the above information, terms and conditions; (ii) agree that their consent and agreement to the terms and conditions will remain in effect until they notify Acorn Pediatrics in writing that they have revoked consent; (iii) are the authorized user of the credit card listed below; and (iv) all signature requirements are fulfilled with his/her electronic signature typed or otherwise.*

_____ _____
Signature of Authorized User *(your electronic signature can be typed)* Date

_____ _____
Print Name as it appears on your Credit Card Best Contact Number of Cardholder

I, _____, authorize Acorn Pediatrics to charge overdue patient-responsible balances on my account to the following credit card:

Credit Card #: _____ Expiration date (mm/yy): _____

Security code/CCV: _____ Card type: ◯ Mastercard ◯ Visa ◯ Discover ◯ Amex