WEST END PEDIATRICS, P.C.

Amelia Holder Colley, M.D., F.A.A.P.
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WEBSITE

rev 04-2012 18+

Patients 18+yrs must complete and sign

LAST NAME **FIRST** **MIDDLE** **(Nickname)** **Date of Birth** **Sex** **Allergies?/Specify**

_____

Address: Street/PO Box _____

City/State/Zip Code _____

Home Phone _____ Cell Phone _____

I prefer to be reminded of future appointments by: ____ voice mail (home / cell) *circle one*

____ text message

Preferred Pharmacy / Location: _____ Phone _____

_____ Referred to practice by _____

EMERGENCY Contact **relationship** **phone number** (optional)

BILLING INFORMATION

Who is responsible for charges not covered by insurance? _____

Address where statement should be sent _____

Home Phone _____ Cell Phone _____ Work Phone _____

Relationship to patient _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policyholder _____ Policyholder _____

Policyholder Address _____ Policyholder Address _____

_____ _____

Relationship To Patient_____ Copay Amt $ _____ Relationship To Patient _____ Copay Amt $_____

Employer _____ Employer _____

Ins ID # _____ Group # _____ Ins ID# _____ Group # _____

Policyholder's Date of Birth _____ Policyholder's Date of Birth _____

I hereby authorize the above named physicians to release the information requested to the insurance company named hereon. I hereby assign payment directly to the above named physicians of benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. I agree that in the event my account must be turned over to an attorney for collection, that I will be responsible for attorney's fees, court cost and interest. *PLEASE SIGN BELOW & CONTINUE ON BACK…*

X_____

Signature of Patient (18+yrs) or Legal Representative Date

WEST END PEDIATRICS, P.C.
9606 Patterson Avenue
Richmond, VA 23229

DEEMED CONSENT FORM
REQUIRED

I understand, that the laws of Virginia require that if my physician or any person employed by my physician(s) is directly exposed to my body fluids that may transmit the Human Immunodeficiency Virus (HIV) or Hepatitis B or C viruses according to the current guidelines for the Center for Disease Control, that I consent to be tested for infection with HIV or Hepatitis B or C viruses. I further understand that by law I consent to the release of these test results to the person(s) who is exposed to my body fluids.

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DISCLOSURES TO FAMILY / FRIENDS
(not including schools, camps, etc.)

Please list all persons (ex. parents, grandparents, friend) who may receive my health information (18 yrs +). (ex. scheduling, medical advice, treatment, prescriptions, medical forms, medical records and billing information.) These individuals may be asked to present identification.

NAME **RELATIONSHIP** **PHONE #** **If any restrictions, list below:**

_____

_____

_____

_____

This authorization will remain in effect until further written notice by patient / legal representative to:

Privacy Officer, West End Pediatrics, P.C., 9606 Patterson Avenue, Richmond, VA 23229

I understand that once information is released by West End Pediatrics, P.C., the information may be subject to redisclosure by the party receiving the information and may no longer be protected by federal or state law.

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WRITTEN ACKNOWLEDGEMENT: Our Notice of Privacy Practices provides information about how we may use and disclose PHI about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. I have received a copy of the West End Pediatrics, PC's Notice of Privacy Practices. I have had an opportunity to read the notice and understand that I may ask questions if I do not understand any information contained in the Notice of Privacy Practices.

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I certify the above information is correct:

X_____X_____ _____
Signature of Patient (18+yrs) or Legal Representative Date (office use – initial) Date

X_____
Please Print Name