Registration Form

Please fill out the form completely and include all children on form

Child's Name: _____ Date of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Child's Name: _____ Date of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Child's Name: _____ Date of Birth: _____ Gender: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Parent/Guardian Name: _____ Date of Birth: _____ Gender: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone # _____

Parent/Guardian Name: _____ Date of Birth: _____ Gender: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone # _____

INSURANCE INFORMATION

Name of Insurance: _____ Effective Date: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____

Do you consent to send/receive health information regarding your child via our secure patient portal? (please check one) ❑ Yes ❑ No

If yes, please provide the email address below that you would like linked to your account:

_____

Revised 7/22/2026

***All communication containing Protected Health Information (PHI) should be transmitted to or from Commonwealth Pediatrics via our secure patient portal. Any communication not transmitted to Commonwealth Pediatrics through the portal poses a risk of being accessed inappropriately. To protect patient privacy, Commonwealth Pediatrics will not respond to any communication containing PHI not submitted through our secure portal.*

Permission To Disclose Protected Heath Information (PHI)

Patient(s) Name: ______________________________ Date of Birth: ______________

Name: ______________________________ Date of Birth: ______________

Name: ______________________________ Date of Birth: ______________

Commonwealth Pediatrics is dedicated to protecting the privacy of our patients. Except where required by law, Commonwealth Pediatrics will NOT authorize treatment, disclose, or discuss any information regarding your child's health or financial status with anyone other than the parent or legal guardian, unless otherwise listed in the chart below. ***Please consider adding certain people such as grandparents, aunts, uncles, siblings over the age of 18, babysitters, or 'other care providers' that may need to seek treatment or advice in your absence.***

Name	***Relationship To Patient***	***Phone***	***Permission To Do The Following:*** *(check all that apply)*
		____________ OK to leave detailed message? ❑ YES ❑ NO	❑ Bring in for an appointment ❑ Seek medical advice ❑ Obtain lab/procedure results ❑ Pick up medication ❑ Discuss financial/insurance info
		____________ OK to leave detailed message? ❑ YES ❑ NO	❑ Bring in for an appointment ❑ Seek medical advice ❑ Obtain lab/procedure results ❑ Pick up medication ❑ Discuss financial/insurance info
		____________ OK to leave detailed message? ❑ YES ❑ NO	❑ Bring in for an appointment ❑ Seek medical advice ❑ Obtain lab/procedure results ❑ Pick up medication ❑ Discuss financial/insurance info

As a parent or legal guardian do you consent to receive a detailed message regarding your child's care or account in the event a member of our staff is unable to reach you? (please check one) ❑ YES ❑ NO

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disclosed, but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

By signing below, I give permission for the person(s) listed in the table to receive the indicated protected health information about my child. I understand that this form is legally binding, and I have the right to refuse co sign this authorization and my child's treatment will not be conditioned on signing. The information is released at the parent/legal guardian, or at the time the child reaches 18 years of age.

Signature of Parent/Guardian: ______________________________ Date: ______________

Printed Name: ______________________________ Relationship to Patient: ______________

PLEASE READ EACH OF THE ITEMS BELOW BEFORE SIGNING.

WITHOUT YOUR SIGNATURE, WE CANNOT SEE YOUR CHILDREN.

I AUTHORIZE Commonwealth Pediatrics to render medical care to my child/children. I authorize payment from my insurance carrier (if applicable) to Commonwealth Pediatrics for incurred charges. I also authorize release of medical information to my insurance carrier.

I UNDERSTAND AND AGREE that, (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information above and have completed the above answers; I certify that this information is true and correct to the best of my knowledge. I will notify you immediately of any change in the above information.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient:_____

Notice of Deemed Consent

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

Commonwealth Pediatrics is required by § 32.1-45.1 of Code of Virginia (1950), as amended, to give you the following notice:

1. If any Commonwealth Pediatrics health care professional, worker or employee should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for infection with human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you the results of the test. Under VA. Code § 32.1-45.1 (4), you are deemed to have consent to release of the test results to the person exposed.

2. If you should be directly exposed to blood or bodily fluids of a Commonwealth Pediatrics health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with the human immunodeficiency virus (the "AIDS" virus), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

I certify that I have read and fully understand that this consent will remain in effect if my dependent or I receive care from Commonwealth Pediatrics or until I withdraw it.

_____

Parent or Patient/Legal Guardian Name

_____

Parent or Patient/Legal Guardian Signature

_____

Date

HIPAA Consent Form

(Health Insurance Portability and Accountability Act of 1995)

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our NPP before signing this consent. As provided in our NPP, the terms or our NPP may change, in accordance with changes in Federal regulations. A current copy is attached to this form and may also be viewed by visiting our website, www.commonwealthpeds.com.

You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

If you have any questions, you may contact our Privacy Officer at (804) 320-1353.

Print Name: _____ Signature: _____

Child Name: _____ Date: _____

Child Name: _____ Date: _____

Child Name: _____ Date: _____

Assignment of Benefits / Guarantorship of Account

We must emphasize that as medical care providers, our relationship is with your child and not your insurance company. While the filing of claims is a courtesy that we extend to you, you are responsible from the date of service is rendered. If we do not participate with your insurance company, you are responsible for all fees at the time of service and must file for reimbursement from your insurance company. For your convenience we accept cash, check, and credit (American Express, Discover, MasterCard, and Visa). **Commonwealth Pediatrics will hold the person signing this form fully financially responsible for all balances due regardless of the insured party, unless a signed court order is provided proving financial responsibility lies elsewhere.**

We will provide you with any information you require to assist you with your claim. We look to the party receiving the services for payment and cannot be expected to wait for the conclusion of court cases or insurance disputes. We realize that temporary financial problems may affect timely payment of your account. We encourage you to contact us promptly prior to your office visit for assistance in management of your account if any problems arise.

Should a check be returned to us for insufficient funds a $25.00 service charge will be applied to your account. Balances older than 60 days may be subject to a hold on account prohibiting certain types of appointments from being scheduled unless the balance is resolved or arrangements are established. If collection attempts by our office on your account prove to be unsuccessful, then you will be dismissed from the practice and your account will be turned over to and outside source that will report to the credit bureau. Charges may also arise from broken appointments, especially those within 24 hours notice.

We will gladly discuss charges prior to your office visit and any question relating to your insurance. Please realize that:

- Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
- Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area referred to by insurance companies as **UCR-usual, customary, and reasonable.**
- Not all services are a covered benefit in all contracts. It is your responsibility to know what services are covered by your policy. Please contact your insurance company to go over the medical coverage for your child/children. This includes how many well child checks (check-ups) your child is allowed per year (birth to 12 months, 2-3 years, and annual visits after 5 years). Check with the insurance company to make sure that vaccinations are a covered benefit with their policy. If the child goes over the amount of allowed well child check-ups or receives vaccinations that are not considered a covered benefit, we will expect payment in full for these services. Should your insurance require services to be rendered by another provider it is your responsibility to notify us of the provider and facility used (e.g. lab procedures, x-ray, and durable medical equipment).

ADDITIONAL CHARGES DURING WELL CHILD CHECK-UPS: Sometimes a child is ill on the day his/her physical is scheduled. When this happens, our physicians recommend that you bring your child in to be seen and treated for the illness, and reschedule the check-up for a date and time when your child is feeling better.

Sometimes, if your child has a simple illness such as an earache, sore throat, or fever, treatment for the illness and the check-up can occur at the same visit. Please be aware that these are considered two separate visits and are required to be charged as such. This may result in an additional copay or application of your deductible for a visit that would otherwise have been considered preventative. Please notify the receptionist of your child's illness and of your choice to be seen for both visits together or to reschedule the check-up portion. Thank you for your cooperation.

By my signature, I attest that I have read and understood the above policy.

Parent/Guardian/Guarantor Signature: _____

Relationship to Patient:_____ Date: _____

New Patient Packet

A Welcome...

Welcome to our practice. We are board certified specialists in the provision of health care to infants, children, and adolescents. Everyone in this practice operates as a team member. As such, we act as advocates on your child's behalf. By providing on-going primary care for your child through our group, you are ensuring the best care possible. We look forward to participating in your child's health care. To better serve you, all visits are by appointment only. Please be on time in order to help keep us on schedule. If you are late, you may be asked to reschedule. We require 24 hours notice of cancellation of appointments. There will be a service charge for missed appointments without proper notice. When calling our office, be sure to provide the name of your child and the type of visit needed. Please have the scheduler repeat to you all of the appointment information at the end of your conversation to confirm that it is correct. If you have more than one child that needs to be seen, let the scheduler know so that an appropriate amount of time is allowed. If your child is sick, we ask that you call as early as possible in the morning for an appointment. Appointments can be made or canceled after 7:15 a.m. Please try to make your next checkup and/or follow-up appointment while you are still in the office.

Telephone Calls...

If you are calling with a true medical emergency, please call 911. We have centralized scheduling; all appointments can be made by calling (804) 320-1353 and then selecting option 2. Daily sick appointments are made after 7:15 a.m. If you would like to reach a doctor, or need medical advice, please leave a message on the medical advice line. We will need the following information when you leave any message: the child's name, date of birth, nature of your call and a telephone number where you can be reached. All calls are returned in order of medical necessity.

Referrals...

It is your responsibility to know specifics of your insurance policy. Please be sure to take proper steps when seeking care outside of our office. We require 72 hours notice when acquiring a referral or authorization number. Your insurance company does not allow us to back date any referral or pre-certification.

Emergencies...

For all true medical emergencies please call 911. During our office hours, if your call is urgent, please state the nature of your call immediately and you will be connected with our medical advice staff. If you have an emergency situation after hours, in the evening, on a weekend or on a holiday, a nurse may be reached either by calling (804) 320-1353 or (804) 739-8166. You will hear a recorded message with instructions on how to contact the on-call nurse. We do ask that after hours calls are limited to **emergency and urgent care situations only.** The nurse will return your call as soon as possible. **All after hours in-office visits are rendered at our Chippenham/ Old Jahnke Road Office location only.**

LANGUAGE LINE: Commonwealth Pediatrics offers the use of language phone line for those who speak a language other than English. We also offer interpreters for the deaf (interpreter visits require a two-day advance notice).

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you!

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY COMMONWEALTH PEDIATRICS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Rights:

When it comes to your health information you have certain rights. This section explains your rights**. Upon written request:**

- Ask to see or get an electronic or paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost-based fee. We will provide this information as soon as possible but no later than 15 working days of the request, a 30-day extension may be granted, and you will be notified.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it affects your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer, we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list of the past six years for the request. One request per year will be provided free of charge. For additional requests, we will charge a reasonable, cost-based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, 7023 Old Jahnke Road, Richmond VA 23225, (804) 320-1353, commonpedsleadership@commonwealthpeds.com
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

Our Responsibilities:

The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy.
- Not to use or share your information other than what is described in this notice unless you communicate approval in writing. If you initially provide approval and then change your mind, please let us know in writing.

Your Choices:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

- In these cases, you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses And Disclosure:

We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: We may share your health information with an outside doctor for a referral. We will also provide your health care providers with copies of various reports to assist them with your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

SUD Treatment Information: If we receive or maintain information about you from a substance use disorder treatment program covered by 42 CFR Part 2 (a "Part 2 Program"), we may use and disclose that information for treatment, payment, or health care operations if you have provided a general consent allowing the Part 2 Program to do so. If we receive your Part 2 Program record through a specific consent you provide to us or another party, we will use and disclose it only as permitted by that consent.

Part 2 Program records are protected by federal law, and any further disclosure is prohibited unless allowed by 42 CFR Part 2. We will not use or disclose your Part 2 Program record, or testimony about it, in any civil, criminal, administrative, or legislative proceeding against you unless you authorize it or a court orders it after providing you notice.

Please note that after health information has been disclosed, it may be redisclosed by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA).

Other ways we can use or share your health information – We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law:** We will share information about you whether state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.

Address workers' compensation, law enforcement, and other government requests:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

Changes To This Notice:

We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available on request, in our office and on our website.

Suzanne Greth
President
sgreths@commonwealthpeds.com
(804) 320-1353