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Children's Medical Associates of Northern Virginia, P.C.

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Pediatric and Adolescent Medicine

PATIENT INFORMATION

Father's Name:		SS#:	DOB
Address:		Occupation:	
City:	State:	ZIP:	Employer:
Home Phone: ()		Address:	
Work Phone: ()		City:	State: ZIP:
Cell Phone: ()			
Mother's Name:		SS#:	DOB
Address:		Occupation:	
City:	State:	ZIP:	Employer:
Home Phone: ()		Address:	
Work Phone: ()		City:	State: ZIP:
Cell Phone: ()			

Child / Children's Name(s)	Birth Date	Sex	Allergies	Account Number
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

Copy of Insurance Card

FOR OFFICE USE ONLY

Billing

Verification of Benefits

FOR OFFICE USE ONLY

I hereby certify that all the information above is true. I also certify that I have been presented with a copy of Children's Medical Associates of Northern Virginia's Notice of Privacy Practice. I authorize CMA to leave me a message, or voice mail, regarding my child(ren)'s personal health information on any phone number listed above in Patient Information.

Signature _____

Date _____

Relationship to Child(ren) _____



Children's Medical Associates of Northern Virginia, P.C.

STATEMENT OF RESPONSIBILITY

We, at Children's Medical Associates, are pleased that you have chosen us to provide pediatric care for your children and are looking forward to serving you. Please read, sign and date this form to acknowledge your understanding of our future relationship.

Health Insurance

We will file to all insurance companies with which we participate and will assign benefits otherwise payable to CMA, will attempt to contact them prior to your visit to determine your benefits, co-pays, deductible and co-insurance, and will collect these amounts at the time of your visit. Failure to provide us with a copy of your current insurance card, failure to list us as your PCP, if required to do so, the inability of our staff to determine eligibility prior to your visit, and/or any service not deemed covered by your insurance company will be deemed your financial responsibility and legal obligation. Insurance is not designed to cover all medical costs incurred by you, or your children. If you have any questions about what your health care plan will or will not cover, you need to contact them directly.

Referrals

If your child needs to be seen by a specialist and your insurance requires referrals, it is your responsibility to obtain the referral and to keep track of expiration dates and number of visits authorized. The specialist's name and provider number is needed for a referral, and it takes 5 days to generate a referral. Referrals cannot be dated retroactively.

Payment Methods

Payment is due at the time of service. We accept cash, check, Visa, MasterCard, and the Discover card. Co-pays not made at the time of service will generate a \$10 billing fee. Patients whose co-insurance is based upon a percentage of charges, or who has an unmet deductible, are required to pay a reasonable estimate at the time of the service. Additionally, we must charge your account \$25 per returned check. If you cannot meet your stated financial obligations, please contact our bookkeeping office to make alternative arrangements. If there comes a time when we find it necessary to send your account to a collection agency, then it is the policy of this office to discharge your family from the practice.

Missed Visits

If you cannot keep an appointment in our office, we require 24 hours notice for cancellation. Should you find it unavoidable to late cancel your appointment, or miss your appointment entirely, then your account will be assessed a \$50 fee.

Record Transfer

Transfer of medical records requires a signed HIPAA approved authorization by parent or by patient if over age eighteen. All medical records are scanned and mailed by HealthPort Corporation under HIPAA directives. They will charge a nominal fee for this service as allowed by law.

Other Services

For the benefit and convenience of our patients and parents, CMA provides other services to include in-house laboratory, forms and letters, and family flu vaccines, which are not covered by your medical insurance and will be your responsibility to pay at the time you request, and utilize, these services. For more details on these services, please ask our staff.

Authorizations

I authorize the release of any and all of my or my minor child(ren)'s information, including financial information, confidential health information, and medical records as required by my(our) insurance carriers or its designated review agents, including, if applicable my employer, in order to file claims, appeal claims and assign benefits; to the Social Security administration; the Health Care Financing Administration; authorized chart reviewers; any federal or state agency in order to comply with federal or state law; to any doctor, hospital, laboratory or ancillary healthcare provider for the payment of benefits, and as required for medical treatment.

Copy of Signature

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and benefit assignments, for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

Certification

By signing below I certify that I have read and understand the Statement of Responsibility, have had the opportunity to ask questions, have them answered and accept the above conditions and terms. I further certify that I am the parent, guardian, other family member of the patient, duly authorized representative, or the patient.

Signature _____ Print Name _____

Relationship to patient _____ Date _____

HIPAA

By my signature below, I am acknowledging that I have been presented with a copy of Children's Medical Associates of Northern Virginia's Notice of Privacy Practice.

Signature _____ Date _____

Relationship to patient _____