ALEXANDRIA
6303 Little River Tpk., #300
Alexandria, VA 22312
(703) 914-8989
Fax (703) 914-5494

cma

CHILDREN'S MEDICAL ASSOCIATES OF NORTHERN VIRGINIA, P.C.

FAIRFAX
10615 Braddock Road, #200
Fairfax, VA 22032
(703) 691-4700
Fax (703) 691-4791

PARENT INFORMATION

Mother / Father / Guardian: (*Circle One*)

Last Name:	First Name:	DOB:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:
Employer:		
Employer Address:		
Occupation:	Work Phone:	Social Security Number:

PARENT INFORMATION

Mother / Father / Guardian: (*Circle One*)

Last Name:	First Name:	DOB:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Email Address:
Employer:		
Employer Address:		
Occupation:	Work Phone:	Social Security Number:

HEALTH INFORMATION PREFERENCES

Which parent would prefer to manage the CMA Patient Portal account for the family? Name_____

How would you like to receive the Patient Portal invitation? Please initial one choice: by email_____ OR by text_____ OR not at all_____

Would you like to receive appointment reminders by text message? Please initial one choice: Yes, OK to text_____ OR No, do not text_____

CMA has permission to leave a voicemail regarding my child(ren)'s health on any phone number listed above. Please initial: Yes_____ OR No_____

	NAME OF CHILD	BIRTH DATE	SEX	ALLERGIES	ACCOUNT NUMBER
1.					
2.					
3.					
4.					

BY SIGNING,

I hereby certify that all the information above is true.

I acknowledge that the CMA **Notice of Privacy Practices** is available for me to read online at www.cmanva.com or available in paper form upon request. A copy is also located in each waiting room.

Signature: _____ Print Name: _____

Relationship to Child(ren): _____ Date: _____

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STATEMENT OF RESPONSIBILITY

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

IN-OFFICE GUIDELINES:

Per OSHA mandates, we must prohibit food or drink in our office clinical areas. Additionally, in order to protect your privacy, and the privacy of others, photography, video recording, and audio recording are strictly prohibited. Thank you for your understanding.

HEALTH INSURANCE:

We will file to all insurance companies with which we participate, and will assign benefits otherwise payable to CMA, 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), or 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 child(ren). If you have any questions about what your health plan will or will not cover, you need to contact your insurance company directly.

REFERRALS:

If your child needs to be seen by a specialist, and your insurance company requires a referral be obtained, then it is your responsibility to obtain the referral, to ensure the specialist is in network with your insurance plan, and to keep track of expiration dates and number of visits authorized. The specialist's name and provider number is needed. It takes 5 business days to generate a referral, and they cannot be dated retroactively.

PAYMENT METHODS:

Payment is due at the time of your visit. We accept cash, check, Visa, MasterCard, and the Discover card. Co-pays not made at the time of service will generate a $10.00 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 service. There will be a $25.00 charge to your account per returned check. If you cannot meet your stated financial obligations, please contact our bookkeeping office to make alternative arrangements. If the balance on your account remains unpaid and is your responsibility, then we will be forced to turn the account over to a collection agency and will be unable to continue to see your children in our practice.

MISSED APPOINTMENTS:

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 $50.00 fee.

AFTER HOURS VISITS:

We strive to be available when you need us, and offer visits after our regularly scheduled office hours. Weekend, holiday, and most weekday evening appointments are reserved for sick patients, seen on a same day, as needed basis. There is a charge for this service. We will file this to your insurance company but cannot guarantee that they will cover it.

RECORD TRANSFER:

Transfer of medical records requires a signed HIPAA approved authorization by parent, or patient if over age eighteen. All medical records are scanned and mailed by GRM Corporation under HIPAA directives. They will charge a 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, family flu vaccines, and forms and letters, 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 about 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 carrier(s) 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 Centers for Medicare and Medicaid Services; authorized chart reviewers; any federal or state agency in order to comply with federal or state law; collection agency; 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 this Statement of Responsibility, have had the opportunity to ask questions, have them answered, and accept the above terms and conditions. I further certify that I am the parent, guardian, other family member of the patient, duly authorized representative of the patient, or the patient.

Signature _____ Print Name _____

Relationship to Patient _____ Date _____