Boulevard Center Pediatrics, Inc.

"Where your children are the center of our attention."

CONDITIONS OF REGISTRATION FORM

THE PRACTICE
Boulevard Center Pediatrics, Inc. and/or its physicians, employees, agents or assignee will hereafter be referred to as "The Practice."

CONSENT FOR TREATMENT
I(we) understand that only the signatories to this document are authorized to act as a personal representative of the identified patient(s) and these are the only individuals able to secure medical treatment and services on the patient's behalf (unless a signed court order specifies otherwise.) I further understand that it is the policy of The Practice that all minor children (those under the age of 18 years) must be accompanied by a parent or legal guardian or signed documentation by the legal guardian permitting another adult acting on behalf of the legal guardian, in order to receive medical services or treatment, as indicated on the Registration Form.
The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren.)
HIV/Hepatitis B & C Viruses Testing Notification: In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/Hepatitis B & C Testing. In all other cases, the patient shall have the right to informed consent or refusal for HIV/Hepatitis B & C Testing.

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS
I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Ac and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION
I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Health Care Financing Administration, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having records copied.

REFERRALS AND AUTHORIZATION
I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from The Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify The Practice prior to going, if possible, or within 24 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible any that any of these aforementioned actions do not guarantee that my insurance company will pay for my(our) child(ren)'s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I(we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT
I agree that payment in full is due at time of treatment. I the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by my children, including but not limited to anyone whom I am a legal guarantor/custodian for, stepchildren, and extended family members. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreement with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the insurance subscriber/policy holder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or confirmation. I understand that I am responsible for and agree to pay the assessed $20.00 Emergency Walk In Fee in addition to the office visit if I arrive without a scheduled appointment, which may not be covered by my insurance company. I understand that I am responsible for an agree to pay a $25.00 Missed Appointment Fee for all scheduled appointments that I was more than 15 minutes late for or that were not cancelled with at least 24 hours advance notice, which is not billable to any insurance company. I understand that I am responsible for and agree to pay a $20.00 "Emergency After Hours Fee" for

all after hours calls to the covering provider. These after hours calls are considered an emergency and will be charged to the member's account on the date the services were rendered. The after hours calls are not covered by any insurance company or policy and are the member's responsibility. I understand that I am responsible for an agree to pay a $10.00 administrative fee for each form I request to be completed, which is not billable to any insurance company. I understand that I am responsible for the entire balance on my child's account; including co-payments, co-insurance, deductibles, termination of coverage, not adding a dependant to insurance plan , non-payment at time of service and/or any other reason. I understand and agree that I am expected to pay all balances within 30 days of services being rendered. I understand and agree that if for any reason my personal check is returned for any reason, including insufficient funds in my account, I will be assessed and responsible for a $50.00 Returned Check Fee in addition to ALL original fees for services. Interest of 1.5% per month, eighteen percent per annum, will be charged on all accounts over 30 days. If the balance is not paid within 30 days of it agreed upon payment arrangements on my (our) account are not made, I authorize the practice to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureau of my(our) delinquencies. I understand this will affect my(our) credit rating. If this account is placed for collection, I agree to have my(our) information , including all demographics sent to the collection agency/attorney(s.) I authorize them to utilize my(our) information for collection of debt purposes. I agree to pay all collection fees, plus court costs and minimum interest in the amount of 1.5% per month, beginning 30 days after the monies have become due or expenses have been incurred. Any expenses incurred by such collection actions, including maximum allowed interest, shall become an additional liability for which I(we) assume full responsibility. The Practice is required to report all services rendered , including those that occur outside of normal business hours to your insurance carrier should you choose to utilize insurance for services rendered. I understand that I am responsible for an agree to pay all balances rendered patient responsibility by my insurance carrier. I further understand that the future medical care and treatment by this practice may be denied if the account falls more than 60 days past due.

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 for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CHILDREN'S IQ NETWORK
I understand that this practice uses Electronic Medical Records provided by EClinicalWorks hosted by Children's National Medical Center. My signature below indicates that I have reviewed a copy of the Children's IQ Network (CIQN) Information Sheet. I understand that patient information will be stored electronically in The practice's Electronic Records Medical Records (remote server) which is also available to other providers in the CIQN Network. I also understand that I have the right to not share (opt out) health information with other providers within CIQN. I agree to CIQN's use of de-identified health information about myself or my child(ren) for appropriately reviewed and approved research and quality improvement activities.

CERTIFICATION
I certify that the information I have reported with regard to my(our) insurance coverage is correct and should be honored by my(our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing as the parent/legal guardian and fully accept the terms therein.

ACKNOWLEDGEMENT OF PRIVACY POLICY
I understand that The Practice, as allowed by law, will release or disclose health information, for the purposes of treatment, payment and other healthcare purposes. I understand that this office has a "Notice of Privacy Practices" which explains in detail the policies and practices of The Practice relating to mine or my child(ren)'s protected health information. I acknowledge that I have been given an opportunity to review a copy of this "Notice of Privacy Practices" as required by the Health Insurance and Portability and Accountability Act of 1996.

I have reviewed the Conditions of the Registration Form and Office Policies and agree to abide by all such policies. I further understand and agree that changes in office policies may occur without notice. Any such future changes in policies will be made available to review on our website www.boulevardcenterpediatrics.com and on the Patient Portal.

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Mother/Legal Guardian Signature **Date**

______________________________ ______________

Father/Legal Guardian Signature **Date**

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OFFICE POLICIES

Appointments:

- All patients under 18 years of age MUST BE ACCOMPANIED BY AN ADULT FOR ALL VISITS, specifically a parent. Legal Guardians must provide court appointed and signed documents in order to bring a patient to the office for their appointment. Individuals other than parent/legal guardian need to provide written and signed consent from the parent/legal guardian.

- All visits are by APPOINTMENT ONLY. There is a $20 Emergency Walk In Fee. We will try our best to accommodate your child in the schedule based on the severity of illness.

- If you arrive more than 15 minutes late for your appointment, it may be rescheduled. There is a $25 No Show Fee for Missed Appointments. Our office requires a minimum of 24 hours notice to cancel or reschedule an appointment. Failure to do so will result in the No Show Fee being assessed. Repeated No Shows will result in a discharge from the practice which will apply to the patient's siblings of the same family. Our office will notify your insurance company about the discharge from our practice.

Office Visits

- All children need Well Visits at 2 Weeks, 1 Month, 2 Months, 4 Months, 6 Months, 9 Months, 12 Months, 15 Months, 18 Months, 2 Years, 30 Months, 3 Years and every year afterwards as per the American Academy of Pediatric (AAP) guidelines. Our office strongly believes in the safety and effectiveness of vaccinations and therefore follows the guidelines for immunizations as per the AAP. **Our office does not accept patients whose caregivers refuse essential primary vaccines for non medical reasons.**

- Our office does not provide second opinions and urgent care services for patients who get primary care from other pediatricians in the area. If we find such occurrences, we may ask you to leave our practice.

After Hours Calls

- Please always call our office at (703) 670-0300 to get the on call physician information. There is a $20 Fee for Phone Consultations. You can leave a message for a non urgent matter on the office line, your call will be returned the following business day. You may also utilize your insurance company's nurse line for acute needs.

- Every Friday afternoon, the on call physician changes to a local pediatrician in the area (our office shares its weekend calls with them.) Please always call the office to be connected with the current on call physician.

Forms:

- School Excuse: Free, please notify the front desk at the end of your appointment that you will require one. Our office does not fax in school notes.

- There is a turnaround time of 48 Hours for all Form completion:

  - School Entrance/Sports Physical Forms: $10 Fee, a corresponding visit is required (per the parameters of the form.)

  - FMLA Forms: $25 Fee, a corresponding visit is required for completion

  - Tax/Immigration Forms: Minimum $25 Fee, depending on complexity and time spent.

  - Referrals: Free for non HMO insurances, however a corresponding visit is required. HMO Insurances: Free, however turnaround time is minimum 72 hours to coordinate with your insurance company. It is your responsibility to ensure you have your referral with you when you go to a specialist.

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Medical Records:

- There is a $15 Fee for all Medical Record Requests made to our office. This includes a request from the parent or from another physician's office. If you are transferring your child to another practice, the fee will need to be paid in order for the records to be faxed over. Records will be available within 15 days of payment.

- Medical Record Requests must be made in writing with the signature of the parent/legal guardian. Our office provides these forms. Medical Records will be available to the parent/legal guardian only. Written consent is required if anyone other than them will be picking up. If records are to be mailed, there is a $8 Postage Fee plus a $25 Hard Copy Fee. If records exceed 30 pages, records will be burned to a CD.

- Electronic Medical Records: Your child's medical record is available to you via the Patient Portal. Please collect your username and password from the receptionist. There is no charge for the access of this service at present. This may change in the future at the sole discretion of the practice.

Financial Policies:

- A valid insurance card must be present at every visit in order to verify coverage. If we are not able to determine active coverage, you will be asked to pay in full for the visit. Please ensure this information is given to us in advance of your appointment as it takes a considerable amount to time to verify coverage with an insurance company. It is your responsibility to know the parameters of your insurance policy. Information given to us is just an estimate and subject to the rules and policies of your plan.

- It is your responsibility to disclose all active insurance policies at the time of the visit and to maintain active coverage on your insurance. The practice will not be liable for any actions by any insurance company for incomplete/incorrect/falsified information provided by you.

- If you have more than 1 insurance, please note the commercial insurance will ALWAYS be considered primary. Medicaid will be considered secondary. Our office DOES NOT bill secondary insurance.

- All co-payments, deductibles, co-insurance and fees are due at the time of service. Our office accepts Cash, Credit Card (Visa, MasterCard and Discover) and Bank Issued Checks. There is a $50 Bounced Check Fee. We do not accept Personal Checks. Based on your insurance policy, office procedures may require additional payment which will be due at the time of service.

- Balances must be paid within 30 days. Balances over 30 days will be subject to interest accrual. Balances over 60 days with no payment will result in the account being sent to collections/attorney's actions and will be assessed additional charges. Accounts over 60 days with no payment will also result in a discharge from our practice.

We thank you for your adherence to our Office Policies.

I have reviewed the Conditions of the Registration Form and Office Policies and agree to abide by all such policies. I further understand and agree that changes in office policies may occur without notice. Any such future changes in policies will be made available to review on our website www.boulevardcenterpediatrics.com and on the Patient Portal.

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Mother/Legal Guardian Signature **Date**

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Father/Legal Guardian Signature **Date**