NOVA
PEDIATRICS, LTD.

WELCOME!

Welcome to NOVA Pediatrics. We are honored that you have chosen us for the care of your children.

The practice was founded in 1961 by Ira Seiler, M.D. We have two locations: 6120 Brandon Ave, Ste. 308, Springfield, VA 22150 and 1483 Old Bridge Road, Ste. 201 Woodbridge, VA 22192.

We have an exceptional staff, which includes eight pediatricians, all certified by the American Board of Pediatrics and three Nurse Practitioners. In addition, we have highly qualified and experienced employees in nursing, the business office, and management.

We have provided this letter to help you better understand our practice so we may better serve you.

OFFICE HOURS:

- Both offices are open 5 days a week. Each office is open alternate Saturday mornings.
- Our after-hours triage service provides emergency care whenever the office is closed. There is a consultation fee of $25.00 per call.

TELEPHONE and COMMUNICATIONS:

- Our staff answers the phone from 8 a.m. to 5:30 p.m. Monday - Friday and from 8 a.m. to 12:30 noon on Saturday. If your child is ill, a nurse is available via the telephone to give medical advice and to determine if your child needs to be seen that day. Your message may also be left on the voicemail and a nurse will return your call as soon as possible.

- After hours, our nursing triage service will help you in a medical emergency. Call the office number, and you will be transferred to the triage system. One of our doctors is always on call. The nurse will consult with the doctor as needed and send us a report in the morning.

- Please remember that general medical questions, prescription refills, and other non-urgent matters should be taken care of during regular office hours or by leaving a message on the non-emergency line. Non- urgent after hours calls will be returned on the following business day.

APPOINTMENTS:

- All patients are seen by appointment, sick children are usually seen the same day. We advise you to call as early in the day as possible if your child is ill. Physical exams are scheduled in advance.

- As a courtesy, reminder calls are made 24-48 hours prior to the appointment.

- It is the patient's responsibility to keep appointments for his or her child. We understand that there are occasional circumstances that might keep you from the appointment. When this happens, we request 24 hours of advanced notice in order to avoid a late cancellation/no show fee.

- It is our policy to charge the patient a $50 fee for an office visit if 24- hour cancellation notice is not given. It is also our policy to dismiss the patient from the practice who cancels more than two appointments without 24-hour cancellation.

ALLERGY INJECTIONS:

- Allergy injections are typically given Monday – Friday 9a.m. – 11a.m. and 1p.m. – 4p.m. Appointments are highly recommended to minimize wait times. Allergy injections are also given Saturday 9:00-11:00 at the office scheduled to be open. If you are a member of a managed care plan, you are required to pay your copay at the time of service.

PRESCRIPTIONS REFILLS:

- Please make every effort to request refills or medication before you run out. Your child may be required to see the doctor before we issue a refill. Please allow one to two days for us to notify the pharmacy. Please allow 3-4 days for controlled substances such as Ritalin. There is also a $10.00 prescription refill fee for all prescriptions not refilled at your scheduled appointment. There is also a $10.00 fee to call prescriptions into the pharmacy as a courtesy after your appointment.

INSURANCES WE ARE IN NETWORK WITH:

AETNA HMO/PPO
BLUE CROSS/ BLUE SHIELD (CAREFIRST BC/BC, BLUE CHOICE, ANTHEM, ANTHEM HEALTHKEEPERS, CAPITAL CARE)
CIGNA HMO/PPO
FIRST HEALTH/PHCS/MULTIPLAN
GREAT WEST
ONE NET
SOUTHERN HEALTH/COVENTRY
TRICARE STANDARD/PRIME
UNITED HEALTH; MAMSI (MAMSI LIFE & HEALTH; MDIPA; OPTIMUM CHOICE)

INSURANCE RULES TO BE AWARE OF:

- Your plan requires that you present your insurance card at the time of service and it is your responsibility to notify the office of any changes to your policy including policy/group #'s, copays, coverage, or participants on the plan.
- Although we will assist you, it is ultimately your responsibility to be aware of the extent of your coverage, limitations, and exclusions before the time of service. This includes well child care and immunizations.
- If you have a co-pay your plan's contract requires us to collect this at the time of service. Deductibles are due upon receipt of the patient statement.
- Most of our managed care plans have limited our ability to perform lab tests on site. If your child needs a lab test, we will provide you with necessary documents and instructions to have this test done at an outside lab. The results will be sent to us, and we will notify you.
- With the exception of a medical emergency, referrals will be prepared within 3-5 business days of a request. Referrals have expiration dates, so be sure that your appointment with the specialist is within your referral expiration period. It is the patient's responsibility to request a referral, if one is required, prior to your appointment with the specialist.
- Referrals may be picked up in our office or mailed. We will not fax referrals. We are not permitted to issue retroactive referrals. Please contact our receptionist if you have any questions.

FINANCIAL RESPONSIBILITY:

- We will file our charges with your primary insurance carrier if we contract with the plan. In order to file, we need a current copy of the child's insurance card. In most cases, we do not file to secondary insurance.
- If your insurance plan requires you to have a Primary Care Physician (PCP) & we are not listed as your PCP, you will need to contact your insurance company and change the PCP to one of our doctors prior to being seen.
- If you do not have a card and cannot produce valid insurance coverage that we can verify, or if your child is not covered under any insurance, you will be responsible to pay in full at the time of service.

LIST OF ADDITIONAL FEES:

- $5.00 charge if the copay is not paid at the time of service.
- $50.00 returned check fee.
- $50.00 no show fee for not showing up for a scheduled appointment and/or an appointment not canceled within 24 hours.
- $25.00 after hours triage call.
- $10.00 fee per form for all forms filled out. All forms require 48-72 hours for completion. (There are some forms which require additional fees such as FMLA forms.)
- $10.00 fee for personalized patient letter requests.
- $10.00 RX refill or call-in fee.

IF YOU HAVE ANY QUESTIONS PLEASE DON'T HESITATE TO CALL US AT THE NUMBERS BELOW.

6120 BRANDON AVE. STE. 308
SPRINGFIELD, VA 22150
OFFICE 703.451.3333

WWW.NOVAPEDS.COM

1483 OLD BRIDGE ROAD, STE. 201
WOODBRIDGE, VA 22192
OFFICE 703.491.2141

NOVA
PEDIATRICS AND YOUNG ADULT MEDICINE

Registration 0 – 17 years old
Today's Date: _____

Patient (child's) Information (Please Print)
Full Legal Name: _____ Nick Name: _____
D.O.B: _____/_____/_____ Sex: M / F Social Security #: _____
Home Address _____
City, State, Zip _____
Home #: _____ Cell #: _____ Email Address: _____

Sibling Information
Full Name: _____ D.O.B.: _____/_____/_____ Sex: M / F
Full Name: _____ D.O.B.: _____/_____/_____ Sex: M / F
Full Name: _____ D.O.B: _____/_____/_____ Sex: M / F
Full Name: _____ D.O.B.: _____/_____/_____ Sex: M / F
Full Name: _____ D.O.B.: _____/_____/_____ Sex: M / F
Full Name: _____ D.O.B.: _____/_____/_____ Sex: M / F

As a service to our clients, we provide courtesy appointment reminder calls and other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Check who the child primarily lives with: ___ Father ___ Mother __ Step Mom __ Step Dad ___ Other _____
Full Name: _____ D.O.B _____/_____/_____
Home Address: _____
City, State, Zip: _____
Social Security #: _____ Employer: _____
Home #: _____ Cell#: _____ Work #: _____ Ext: ____
Is this person financially responsible for the account? Y / N

Other parent / Guardian: ____ Father ____ Mother ____ Step Mom ____ Step Dad _____ Other _____
Full Name: _____ D.O.B _____/_____/_____
Home Address: _____
City, State, Zip: _____
Social Security #: _____ Employer: _____
Home #: _____ Cell #: _____ Work #: _____ Ext ____
Is this person financially responsible for the account? Y / N If not fill out financially responsible section below.

Please check the Preferred Number to call: ___ Home ___ Cell ___ Work
Number: _____
Please check the Best Time to call: ___Morning ____Afternoon ____Evening

Financially Responsible: _____ Father _____ Mother _____ Other _____
Full Name: _____ D.O.B _____/_____/_____
Home Address: _____
City, State, Zip: _____
Home #: _____ Cell#: _____ Work #: _____ Ext ____

NOVA
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Registration 0 – 17 years old

Consent to Email and Text:

____ (Initials) I consent to receiving text messages regarding appointment reminders, feedback, general health information, and account information to the above listed cell numbers.

____ (Initials) I consent to receiving emails regarding appointment reminders, feedback, general health information, and account information to the above listed email addresses. **We can only send emails to one email address so please provide the one you want emails going to. Email Address:** _____

Y / N I would also like to be signed up for NOVA Pediatrics' Patient Portal. Please ask the front desk for more information regarding the Patient Portal and to get your password and login.

Primary Insurance Information (Please provide card to scan) Effective Date _____/_____/_____

Insurance Company Name _____ Copay Amount _____

Policy # / ID _____ Group # _____

Policy Holder's Full Name _____ D.O.B._____/_____/_____ Sex: M / F

Social Security # _____ Relationship to Patient __ Parent __ other (explain) _____

Type of Insurance: _____HMO _____PPO _____Medicaid/HLK Plus/FAMIS PCP _____

Secondary Insurance Information (Please provide card to scan) Effective Date _____/_____/_____

Insurance Company Name _____ Copay Amount _____

Policy # / ID _____ Group # _____

Policy Holder's Full Name _____ D.O.B. _____/_____/_____ Sex: M / F

Social Security # _____ Relationship to Patient __ Parent __ Other (explain) _____

Type of Insurance: _____HMO _____PPO _____Medicaid/HLK Plus/FAMIS PCP _____

We would like to thank the person or persons for referring you to us: (circle all that apply)

Insurance / Internet / Publications / Community Event / Physician / NOVA Employee
Friend or Family Member / Babies R US

Name: _____ Specialty (if applicable):_____

Address: _____

Name of OB/GYN: _____

Hospital baby born at: _____

Pharmacy Information:

Name of Pharmacy: _____ Phone #: _____

Address: _____ Fax #: _____

NOVA
PEDIATRICS AND YOUNG ADULT MEDICINE

Registration 0 – 17 years old

Permission to Treat

Family or friends that you give permission to bring your children in to be treated by NOVA Pediatrics in your absence and permission to receive medical information.

Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____
Name _____ Relationship _____ Phone # _____

This authorization will remain in effect until the office is notified in writing.

_____ **Initials:** I was offered/received a copy of the FINANCIAL RESPONSIBILITY POLICY.

_____ **Initials:** I was offered/received a copy of the PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI).

_____ **Initials:** I authorize NOVA Pediatrics to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. MY INITIALS CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ **Initials:** I hereby authorize NOVA Pediatrics to accept assignment and apply for benefits on my behalf for covered services rendered to my child/dependent. I request payment from my insurance company(s) listed on my patient demographics form be made payable to NOVA Pediatrics. I understand and agree that I am financially responsible for any charges not covered by my insurance carrier for this visit. This includes, but is not limited to, co-insurances, co-payments, deductibles and charges not covered by my insurance carrier (for instance, some immunizations, labs and procedures). The parent/guardian is also responsible for services not covered if NOVA Pediatrics has not been listed as the Primary Care Provider (PCP) with the insurance company and on the patient's insurance identification card.

I understand that policies vary among insurance carriers and it is the parent/guardian's responsibility to know which benefits are covered or not covered by the insurance program in which I participate. There may be additional charges for disease-related matters addressed during a well-child checkup. I also understand and agree that if my insurance carrier notifies NOVA Pediatrics that my child is not covered, has no well-child coverage, or has exceeded well-child coverage, I will be financially responsible for the entire charge and will pay promptly upon receipt of the statement. I understand copayments are due at the time of service and a fee will be assessed if it is not paid. If NOVA Pediatrics does not participate with my insurance plan, I will pay the charges for this service in full at the time of the visit.

I certify that the information I have reported with regard to my insurance coverage is correct and my demographics and insurance information is up to date and I further authorize the release of any information concerning my child, to my child's insurance company in order to determine insurance benefits to which I may be entitled.

NOVA
PEDIATRICS AND YOUNG ADULT MEDICINE

Registration 0 – 17 years old

_____ **Initials:** Patient's Rights/Data Sharing: As NOVA Pediatrics is a member of the Children's IQ Network, some of your child's clinical information may be shared with other providers in the network on a need to know basis. The Children's IQ Network® connects Children's National hospital, emergency department, community health centers, independent health care practitioners, regional immunization registries and commercial laboratories. Health data pertaining to you or your child is shared between authorized health care providers within the Children's IQ Network® to ensure that accurate and complete information is available to make your care or the care of your child safer, more efficient, and less costly. I understand that patient information will still be stored electronically for my provider's records, and that an electronic health summary will be available to other providers through the Children's IQ Network. I also understand that I have the right to not share (opt out) health information with other providers within the Children's IQ Network.

_____ **Initials: Release of Medical Records, Immunization History, and Child Locator Information**
I authorize NOVA Pediatrics to release and/or send medical information/records with regard to my child's health condition to other consultants and/or referring physicians, licensed healthcare facility, local or district health department, the department of health, and /or any education facility as appropriate. NOVA Pediatrics will share immunization and child locator information with other physicians, hospital, and health department for purposes of ensuring that he/she receives age appropriate immunizations. The information released may include but is not limited to: name of patient, date of birth, social security number, parents name(s), telephone number, address, and any other records of treatment, examination, and /or diagnosis. Furthermore, I understand that the information may be released by forwarding a photocopy through the U.S. postal service or by confidential facsimile. Conversely, I authorize any of the above listed persons/facilities to release any medical information necessary for my child's (children's) medical treatment to the doctors of NOVA Pediatrics. Ltd.

*** Please note that under Virginia law, the person who brings the child in for services is responsible for the payment of the service (this takes priority over custody, child support, or property settlement agreements). ***

Print Name of Person Completing Form: _____

Signature of Person Completing this Form: _____ Date_____

NOVA PEDIATRICS AND YOUNG ADULT MEDICINE

FINANCIAL RESPONSIBILITY POLICY

REV 04/15/2016

1. NOVA Pediatrics, Ltd. follows both State and Federal guidelines in billing for services rendered to our patients. This requires us to obtain specific information for each individual patient in the family; including: Consent to Treat, Insurance Assignment Authorization, Medical Release Authorization, Individual Demographic, and Insurance Information. We understand that the collection of this information can seem overwhelming; however, it is necessary in order to provide you with more efficient service.
2. Please read carefully the information listed below. If you have any questions, our office staff will be happy to answer your questions. Questions can also be directed to our billing department at 703-451-8146.
3. The parent/guardian must provide accurate demographic and insurance information prior to patient treatment. Based on NOVA Pediatrics' contracts with various insurance companies, we must bill for our services within a timely manner (defined by the individual contracts). If it is found that the correct information was not provided by the parent for services rendered and we miss the timely filing time limit, the patient will be responsible for the entire amount owed for services rendered.
4. It is the parent/guardian's responsibility to know which benefits are covered or not covered by the insurance program in which they participate. Further, the parent/guardian is fully responsible for all fees that are denied as non-covered services, deductibles, coinsurance, and co-payments. The parent/guardian is also responsible for services not covered if NOVA Pediatrics has not been listed as the Primary Care Provider (PCP) with the insurance company and on the patient's insurance ID card. If the parent/guardian has questions concerning their coverage, they should contact their employer's human resource department, their insurance agent, or their insurance company directly.
5. Your insurance company may cover sick and well visits differently, and it is essential that you familiarize yourself with the details of your particular insurance coverage. While some insurance companies may pay for well visits 100% (where there is no cost to you), well and sick benefits may include a copay, co-insurance, and/or deductible as determined by your insurance company. If during a well visit your child is sick or has an issue that is not related to the normal growth and development of your child, and he/she needs treatment and/or medical attention for their concerns, your provider may bill the insurance company for both services (sick and well). **We will collect this copayment for a sick visit combined with a well visit at check out.** There are also times where the provider may decide to reschedule the well visit and focus on the issue that is causing the concern. In this case, you would pay your copayment for the sick visit at check out.
6. The parent or guardian that presents their child for medical services is the financially responsible party. Financial responsibility for services is not always based on the primary insurance subscriber. If there is a financial arrangement between individual parental parties concerning financial responsibility for medical care of their children, this arrangement is between the two parties and does not absolve the parent that brings the child for services from their financial obligation to our practice.
7. If your child is uninsured or covered by an insurance plan that does not have a provider agreement with NOVA Pediatrics, the parent / guardian is fully responsible for all fees at the time of service.
8. NOVA Pediatrics prefers that children not be seen unless they are accompanied by their parent, legal guardian, or authorized adult. However, we understand that teenagers may sometimes request services. If this happens the parent needs to let us know in advance that the child will be arriving by him/herself and authorize treatment. The parent authorizing treatment will be held financially responsible for services rendered in their absence. If you are reachable by phone, we can take your credit card information over the phone before the appointment and send the receipt home with your young adult or child's caregiver. For separated or divorced parents, financial responsibility still belongs to the parent bringing the child in for treatment. We will not bill another parent; it is your responsibility to bring what you will owe when you arrive.
9. If a minor child presents for services requesting privacy from their parent or legal guardian, this is their right based on Virginia Statute *54.1-2969*. The minor will be financially responsible for services rendered, under conditions which minors are considered adults for purpose of consent. However, if the minor patient chooses, he/she may then decide to give up privacy rights and have their parents' insurance billed for the services in question.
10. Payment of all outstanding balances and copayments is expected at the time of service or in accordance with the practice's agreement with your insurance company. We collect all copayments and past due balances during our check-in process. Non-urgent care may be denied to anyone having an unpaid or overdue balance. If your copay is due and is not paid at the time of service an additional $10.00 charge will be added to the patient's account by the end of the business day.
11. After an explanation of benefits from the insurance company is received, any balance that is determined to be patient responsibility is due within fifteen (15) days. Should timely payments not be made, the services of an attorney and/or a collection agency may be retained. Additional collection liabilities may be assessed to the account.
12. ***Any balances not paid within 15 calendar days of the statement date will accrue a Late Payment Charge of $10 per patient. The late fee will be charged every 30 days thereafter per patient account.*** To prevent late fees, please pay the full amount due upon receipt of your statement. All patient balances are due in full when billed. If you ever feel the amount does not reflect the amount you owe, please contact our billing department at **703.451.8146.** We will be happy to review the patient statement with you and answer any questions you may have. Payments can be made on our **website 24/7 at www.novapeds.com for your convenience (Click the link that says "Pay Your Bill".)**
13. Any outstanding balance is required to be paid **before** your next office visit. If the balance is not paid or reasonable payment arrangements are not made within 45 days, your account will be turned over to our collection agency. These accounts may be subject to a collection fee of **40%**, which will be added to the total balance due at the time of payment to clear your account. If you do not meet your financial obligation and refuse to pay the balance, we reserve the right to refuse care for and all subsequent visits resulting in a discharge from the practice.
14. If a check is returned for insufficient funds, a returned check fee of $50.00 will be assessed.
15. A valid government ID may be requested at the time of service from the person authorizing the health care services for the child designated below. Please note that if this right is being granted to a caregiver (i.e. nanny or grandparent) that is not the child's legal guardian, there must be written authorization. The written authorization must be for a specified time period, and can be revoked at any time in writing. Also, the legal guardian signing the authorization will be financially responsible for any services provided.
16. NOVA Pediatrics requires 24 hour notice if you need to cancel an appointment. If notice is not given or you do not show up to your appointment, you will incur a $50.00 charge on your account for the no show. It is also our policy to dismiss patients who do not show up for more than two (2) times for a scheduled appointment.
17. Our after-hours triage service provides emergency care whenever the offices are closed. There is a consultation fee of $25.00 per call.
18. There is a $10.00 prescription refill fee for all prescriptions not refilled at your scheduled appointment. There is also a $10.00 fee to call prescriptions into the pharmacy as a courtesy after your appointment.
19. I understand that there will be a charge for copies of my child's (children's) records as allowed by the Virginia state law. (See medical records policy).

SIGN ON BACK PAGE

20. NOVA Pediatrics will be happy to complete forms/letters for parents, educational facilities, camps, and sports programs. There is a **$10.00 charge per form/letter** that is requested to be filled out that must be paid before completion of the form or letter. Occasionally, there may be a form that requires extensive paperwork and will cost more than $10.00 but you will be informed of the price prior to it being filled out (Ex: Family Leave Act Forms). All forms require 72 hours for completion and must be picked up. For your convenience we will offer a rush form service. This will allow you to have your form completed within 24 hours. The cost of the **rush service is $20 per form** (This includes the $10 form fee and a $10 rush fee).

CONSENT TO TREAT AND MEDICAL RECORDS

Release of Medical Records, Immunization History, and Child Locator Information
I authorize NOVA Pediatrics to release and/or send medical information/records with regard to my child's health condition to other consultants and/or referring physicians, licensed healthcare facility, local or district health department, the department of health, and /or any education facility as appropriate. NOVA Pediatrics will share immunization and child locator information with other physicians, hospital, and health department for purposes of ensuring that he/she receives age appropriate immunizations. The information released may include but is not limited to: name of patient, date of birth, social security number, parents name(s), telephone number, address, and any other records of treatment, examination, and /or diagnosis. Furthermore, I understand that the information may be released by forwarding a photocopy through the U.S. postal service or by confidential facsimile. Conversely, I authorize any of the above listed persons/facilities to release any medical information necessary for my child's (children's) medical treatment to the doctors of NOVA Pediatrics. Ltd.

Copying of Medical records
NOVA Pediatrics follows the Virginia State law for copying medical records. All requests for medical records must be requested in writing and can be given in person or can be faxed or mailed to the office. There is a $0.50 per page and a $10.00 processing fee per child for the records that need to be mailed. Once the request is received, the office will contact you with the cost to copy the records. Once the payment is received, your child (children's) chart will be copied. NOVA Pediatrics has 15 days from the date of payment to provide the copies. There is no charge for a copy of the last physical and immunization record.

Insurance Assignment Authorization
I hereby authorize NOVA Pediatrics to apply for benefits on my behalf for covered services rendered to my child/dependent. I request payment from my insurance company(s) listed on my patient demographics form be made payable to NOVA Pediatrics. I am fully responsible for all fees that are denied as non-covered services, deductibles, coinsurance, and co-payments. I understand copayments are due at the time of service and a fee will be assessed if it is not paid.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any information concerning my child, to my child's insurance company in order to determine insurance benefits to which I may be entitled.

General Consent to Treat - Minor
I authorize the physicians, associates, assistants, and other designees of NOVA Pediatrics to evaluate and treat my child and to recommend medical care, diagnostic procedures and examination as necessary for health maintenance and diagnosis of medical conditions. I understand that NOVA Pediatrics will not perform invasive procedures on minors, unless the child is accompanied by a parent / legal guardian or an adult who has written permission from the child's parent or legal guardian to consent to medical treatment. Exceptions: 1) treatment in which the minor is considered an adult for consent purposes (see below) or 2) emergency services when a delay in treatment may adversely affect the minor's recovery. Invasive procedures may include administration of vaccines, allergy shots, and antibiotic injections.

Conditions under Which Minors are Considered Adults for Purpose of Consent
Virginia: I understand in Virginia, minors are considered adults for the purpose of consenting to: 1) treatment of venereal diseases, infectious or contagious diseases which require the physician to make a report to the Department of Health; 2) services related to birth control, pregnancy, or family planning (excluding sterilization); 3) outpatient treatment, care or rehabilitation for substance abuse; and 4) outpatient treatment, care or rehabilitation for mental illness or emotional disturbances.

Deemed Consent - Virginia
I understand that Virginia law (VA Code Ann. § *32.1-45.1)* provides that if my physician or any person employed by my physician is exposed to my child's body fluids in a way that might possibly transmit the human immunodeficiency virus (HIV) or Hepatitis B or C viruses, that I am deemed by law to have consented to allow testing for HIV and/or Hepatitis B or C infection. The results of this testing must be made available to the person who has been exposed to those body fluids.

If the person whose blood specimen is sought for testing refuses to provide such specimen, any person potentially exposed to the human immunodeficiency virus or hepatitis B or C viruses, or the employer of such person, may petition the general district court for an order requiring the person to provide a blood specimen or to submit to testing and to disclose the test results in accordance with the law.

General Consent to Treat (For patient 18 years or older and patients not requiring parental consent)
I authorize the physicians, nurse practitioners and other designees of NOVA Pediatrics, Ltd. to evaluate and treat me and recommend medical care, diagnostic procedures and examination as necessary for health maintenance and diagnosis of medical conditions.

I understand by signing I have read and agreed to the above paragraphs. I further realize I may revoke any authorization at any time in writing.

Patient Name (Please Print) _____ **Date of Birth** _____

Parent/Guardian Name (Please Print) _____

Signature of Parent/Guardian _____ **Date** _____

NOVA
PEDIATRICS, LTD.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI))

With my consent, Nova Pediatrics, Ltd. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Nova Pediatrics Notice of Privacy Practices for a more complete description of such used and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Nova Pediatrics reserves the rights to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Nova Pediatrics Privacy Officer, 6120 Brandon Avenue, Springfield, VA 22150.

With my consent, Nova Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent Nova Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Nova Pediatrics may e-mail to me appointment reminder cards and patient statements. I have the right to request Nova Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Nova Pediatric's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Nova Pediatrics may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian | Print Name of Patient or Legal Guardian

Patient's Name _____ Date _____

Patient's Name _____ Date _____

Patient's Name _____ Date _____

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

BIRTH HISTORY:

Hospital: _____ **Type of Delivery:** _____
Complications with Delivery: _____ **Birth Weight:** ___ (lbs) ___ (oz)
Term: ___ (wks) **Jaundice:** (yes/no) **Phototherapy:** (yes/no)

SOCIAL HISTORY: Please answer the following questions.

Who lives in the household? _____
_____

Are there any pets in the home? If yes, what kind?
_____

Are your child's parents married? If not, what is the custody arrangement? _____

Does anyone in the household smoke? _____
If yes, who and outside or inside? _____

Is your child in daycare? If so, what kind (in-home, group, babysitter, nanny)? _____

Are there any guns in the home? _____
If yes, are they locked and unloaded? _____

Languages spoken at home? _____
_____

Does your child visit the dentist every 6 months? _____

Lead risk: What year was your home/apartment built? _____

TB risk: Has your child traveled or lived outside the US for years? If so, what country/ies? _____
_____

CHRONIC MEDICATIONS: Please list the child's dose and frequency of chronic medications.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES: Please list any drug and/or food allergies, reaction if ingested, and date first noted.

_____
_____
_____

PAST MEDICAL HISTORY: Please indicate any chronic conditions or problems of the child.

_____
_____
_____

SURGERIES: Please list any past surgeries and dates.

_____
_____
_____

HOSPITALIZATIONS: Please list any past hospitalizations and dates.

_____
_____
_____

Completed by: _____ Date: _____

DEMOGRAPHICS: Completed by: _____ Date: _____

	Name and relationship to child Name	DOB	Occupation	Highest Education	Ethnicity
Mother					
Father					

Child 1	_____	**Child 3**	_____
Child 2	_____	**Child 4**	_____

FAMILY HISTORY: Please use the following legend to specify relatives with any of the following conditions:
Legend: M (Mom), D (Dad), S (Sister), B (Brother), GM (Grandmother), GF (Grandfather), A (Aunt), U (Uncle)

Medical Condition	Initial Date	Date	Date	Date	Date	Date	Date	Date
ADHD								
Anemia								
Autism								
Asthma								
Autoimmune Disease								
Birth Defect (type?)								
Bleeding Problems								
Cancer (type?)								
Depression								
Diabetes								
Eczema								
Endocrine Disease								
Food Allergy (which foods?)								
Genetic Disorder								
Heart Attack/Heart Disease								
Hearing Disorder								
High Cholesterol								
High Blood Pressure								
Immune Disorder								
Kidney Disease								
Learning Disability								
Liver Disease								
Mental Health Problems								
Neurologic Problems								
Seasonal Allergies								
Seizures								
Stroke								
Substance Abuse								
Thyroid Disorders								
Death before age 50								
Other								

Date: _____ **Provider:** _____

Reviewed and Discussed

NOVA PEDIATRICS, LTD.

HOW DID YOU HEAR ABOUT US?

NOVA Pediatrics would like to take this opportunity to thank the following person or persons for referring you to us.

Your Name: _____

Child's Name: _____

Date: _____

Name of OB/GYN:_____

___ Insurance Web Site / Book **Insurance Plan Name _____

___ Internet

___ Newspaper / Publications/Yellow Pages **Publication Name _____

___ Personal Reference:
- ___ Friend/Family
- ___ Another Patient

Name _____

Address _____

___ Referral from an Outside Physician:

Name / Specialty_____

___ Referral From a NOVA Pediatrics Physician:

Name _____

___ Referral from a NOVA Pediatrics Employee:

Name _____

___ Community Event: _____

___ Other: _____