Children's Orthopedic Center

Patient Information

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex of patient: M F (please circle one)

Address: _____
Street City State Zip

Home Phone: _____ Alternate Phone: _____

Primary Care Physician: _____ Phone: _____

BOTH PARENTS ARE RESPONSIBLE FOR PAYMENT. STATEMENTS WILL BE ADDRESSED TO THE PARENT WHO BRINGS THE CHILD FOR SERVICES.

FATHER	MOTHER
Name _____	Name _____
SS# _____	SS# _____
Marital Status _____	Marital Status _____
Address & Phone (if different than above)	Address & Phone (if different than above)
Street _____	Street _____
City, State, Zip_____	City, State, Zip _____
Phone _____	Phone _____
Employer _____	Employer _____
Work Phone _____	Work Phone _____

Insurance Information

1. **Primary Insurance Company**:_____
   Subscriber's Name: _____ Soc. Sec. # _____
   ID Number: _____ Group #: _____

2. **Secondary Insurance Company**:_____
   Subscriber's Name: _____ Soc. Sec.# _____
   ID Number: _____ Group#: _____

Children's Orthopedic Center

Susan E. Atkins, M. D.
1011 Hioaks Road, Suite D
Richmond, VA 23225
Phone: (804) 272-0726

Thank you for choosing Children's Orthopedic Center as your pediatric orthopedic provider. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment.

Assignment of Benefits: In consideration for the treatment that my child/I will receive, I irrevocably direct payment for such treatment to CHILDREN'S ORTHOPEDIC CENTER from my insurance company. I agree to be financially responsible for any unpaid balances and reasonable collection charges (including 33 1/3% of these charges, any attorney's fees for unpaid balances older than 90 days, and bounced check fees.) We are glad to work with you regarding reasonable payments on your account. In addition, we will attempt to help you find available funds for care when needed. We can also assist with applications for Shriners' Hospitals.

Preauthorization: Many insurance companies require pre-approval before they will cover the costs of surgery, treatment, and/or services rendered. Though we will try to obtain such approval prior to surgery, treatment, and/or services rendered, it is the patient/guardian's responsibility to ensure that any such insurance company requirements are met.

Medical Records Release: Further, I authorize CHILDREN'S ORTHOPEDIC CENTER to release information contained in the medical record as well as information relevant to diagnoses, care, and treatment including written, imaged, and electronic documentation, to any hospital, school official, medical professional, billing agency, or insurance company who requests such information whether in writing or as required or permitted by law or legal process.

****PLEASE INITIAL EACH BOX BELOW****

☐ I affirm that I am the legal guardian/parent, able to legally authorize care for this patient.

☐ I accept responsibility for payment of services/supplies not covered by insurance, and for the provision of accurate, updated insurance information.

☐ I acknowledge that I have received the **Notice of Privacy Practices** from Children's Orthopedic Center, required by the Virginia Department of Health. NOTE: Several copies of the Notice of Privacy Practices are available in the waiting room of Children's Orthopedic Center. Individual copies will be made available upon request.

Person Completing Form: _____ **Relationship:** _____
(please print) (to patient)

Patient's Signature: _____ **Date:** _____
(If patient is legally an adult)

Parent/Guardian Signature: _____ **Date:** _____
(If patient is a minor)