Insurance Assignment Authorization/Release Information

☐ *Non-applicable – No Insurance to submit.*

I hereby authorize Capital Area Pediatrics, Inc. (CAP) to apply for benefits on my behalf for covered services rendered to my child/dependent/myself. I request payment from my primary insurance _____ and my secondary insurance (if applicable) _____ to be made payable to Capital Area Pediatrics. I further authorize the release of any information concerning my child (Myself), to my insurance company to determine insurance benefits to which I may be entitled.

Further, I understand that the insurance companies listed above may have a contract with Capital Area Pediatrics, Inc., which designates Capital Area Pediatrics, Inc. as participating providers within their network. This relationship requires CAP to send information upon request to the insurance, for activates such as HEDIS, which is required by law for the insurance company to maintain their licensure in the State of Virginia. I hereby Authorize CAP to release this information.

I am fully responsible for all fees that are denied as non-covered services, deductible, and co-payments.

I certify that the information I have reported with regard to my insurance coverage is correct. This authorization must be updated annually and/ upon new coverage.

_____ Date: _____

Signature of Parent/Guardian/Adult Patient

General Consent to Treat

I authorize the physicians, associates, assistants, and other designees of Capital Area Pediatrics, Inc. to evaluate and treat my child (myself) and to recommend medical care, diagnostic procedures and examination as necessary for health maintenance and diagnosis of medical conditions.

I understand that Capital Area Pediatrics, Inc. 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, antibiotic injections, and suturing lacerations.

Conditions Under Which Minors are Considered Adults for Purpose of Consent

Virginia: I understand in Virginia, minors are considered adults for the purpose of consent 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 body 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.

I understand by signing I have read and agreed to general consent to treat statement above and have been informed of the Commonwealth of Virginia Statue.

_____ Date: _____

Signature of Parent/Guardian/Adult Patient