Capital Area Pediatrics

Insurance Assignment Authorization
I hereby authorize Capital Area Pediatrics, Inc. 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 the reverse side of this form be made payable to Capital Area Pediatrics, Inc. I am fully responsible for all fees that are denied as non-covered services, deductibles, and co-payments.

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.

I understand that Capital Area Pediatrics, Inc. will release and/or send medical information with regard to my child's health condition to other consultants and /or referring physicians as appropriate. Further, Capital Area Pediatrics, Inc. 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.

General Consent to Treat – Minor
I authorize the physicians, associates, assistants, and other designees of Capital Area Pediatrics, Inc. 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 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 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.

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 _____

Signature of Parent/Guardian _____ Date _____

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 Capital Area Pediatrics, Inc. to evaluate and treat me and recommend medical care, diagnostic procedures and examination as necessary for health maintenance and diagnosis of medical conditions.

Patient's Signature: _____ Date _____