# Burke Healthcare Solutions, LLC

8988 Fern Park Drive · Burke, VA 22015 · Phone 703978 -6061 · Fax 703-978-0291

## Patient Registration Form

**New Patient? Yes / No** **How were you referred? ______________________________**

| First Name | Last Name | Middle Initial | Date of Birth MM/DD/YYYY | Sex M / F |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| **Family race:** |
|---|
| **Language spoken at home:** |
| **Email (Only one for Patient Portal access):** |

### Mother/ Guardian

| Mother's full name | Social Security Number | Home phone |
|---|---|---|
| Home Address | Date of Birth | Cell phone number |
| City, State | Zip | Work Phone Number |
| Employer Name | Employer Address | |

### Father/ Guardian

| Father's full name | Social Security Number | Home phone |
|---|---|---|
| Home Address | Date of Birth | Cell phone number |
| City, State | Zip | Work Phone Number |
| Employer Name | Employer Address | |

**Insurance** (please provide insurance card and all information so we may file for benefits on your behalf)

| Name of Subscriber (Primary Insurance) | | Relationship (mother/father/ self) | |
|---|---|---|---|
| Primary Insurance Company | Phone Number of Insurance | Identification/ Subscriber # | Copay/ Deductible Amt ($) |
| Name of Subscriber (Secondary Insurance) | | Relationship (mother/father/ self) | |
| Secondary insurance Company | Phone Number of Insurance | Identification/ Subscriber # | Copay/ Deductible Amt ($) |

**Emergency Contact** (Friend or Relative) I acknowledge that protected health information may/ will be shared with this person.

| Name | Relationship to Patient (s) | Phone Number |
|---|---|---|

**Pharmacy** (We send prescriptions electronically)

| Pharmacy Name | Street/ City | Phone Number |
|---|---|---|

As part of the registration of my child for treatment with Burke Healthcare Solutions, I have reviewed and where necessary signed the following documents required for registration and treatment of my child. I agree to all the terms and conditions contained therein including: Office Policies, Consent to Share Medical information with Children IQ Network Providers, and Receipt of HIPAA Practices. I further understand that I am financially responsible for my family account.

______________________________ Signature of Responsible Party

______________________________ Print Name

______________________________ Date

# Burke Healthcare Solutions, LLC

8988 Fern Park Drive · Burke, VA 22015 · Phone 703978-6061 · Fax 703-978-0291

## Consent Form

Today's Date: ______________________

| Child's First Name | Child's Last Name | Date of Birth MM/DD/YYYY | Sex M/ F |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I, __________________________________________ (Parent/ Guardian), give permission for Burke Healthcare Solutions to treat the above child for medical care deemed necessary. Burke Healthcare Solutions has my permission to refer my child to a hospital or other physician for emergency services to provide appropriate care. I understand that confidential health information may be discussed with the authorized person (s) below during the patient's visit. If necessary, Burke Healthcare Solutions will convey any important information to me in a timely manner.

---

## Minor Consent

☐ My child is 16 years of age or older and is authorized to be treated for any necessary services at Burke Healthcare Solutions without an adult present.

## Immunizations

☐ Burke Healthcare Solutions has permission to administer any immunization/ vaccines as recommended by the AAP and CDC schedule without parent/ guardian present.

☐ Burke Healthcare Solutions DOES NOT have permission to administer any immunizations/ vaccines without a parent present.

---

### Authorization for Other Persons to Accompany Your Child

All persons accompanying your child to the office must be 18 years of age or older.
All persons must have a photo ID.

The following people are authorized to accompany my child to the office for medical services:

| Full Name | Relationship to Patient | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

By signing this form, I acknowledge that permission will continue until revoked in writing.

________________________________ ________________________________ ______________

Parent/ Guardian Signature Parent/ Guardian Name Date

# Burke Healthcare Solutions, LLC

8988 Fern Park Dr Burke VA 22015 Phone 703-978-6061 Fax 703-978-0291

## Office/Financial Policies

### Treatment Authorization

I authorize Burke Healthcare Solutions, LLC their Providers, and staff to provide and administer treatment within the field of medicine to myself/my child (ren). This includes access to my health information limited to the rights of HIPPA and to only be used within those means to treat my health care needs.

### Lifetime Authorization and Assignment of Insurance Benefits & Financial Responsibility

I authorize Burke Healthcare Solutions, LLC to apply for payment for services rendered to my family/my child(ren) on my behalf under any health insurance policies or programs that my family is enrolled in. I also assign and authorize payment of benefits from my insurance carrier directly to Burke Healthcare Solutions,LLC. This includes benefits payable under **TITLE XVII** of the Social Security Act or any other government entity. Furthermore, I authorize Burke Healthcare Solutions, LLC to contact my employer or health insurance company to ascertain existence of, coverage of information regarding health insurance. I also give my permission to Burke Healthcare Solutions, LLC to release any protected health information of my child(ren) or myself that is necessary for treatment, payment and healthcare operations. I understand that I will be financially responsible for the services rendered if Burke Healthcare Solutions, LLC does not participate with my insurance plan, or if my coverage becomes inactive at any time, and/or services are denied for payment. If my account is referred to a collection agency for non-payment @ @ I agree to the release of my information to a collection agency for the purpose of debt collection. I understand that if my account does not remain in good financial standing with the practice, I may be dismissed from the practice.

### Payment

Payment is due at the time of service. We accept cash, checks, and all major credit cards. Please be sure that the parent/guardian/adult accompanying your child(ren) is prepared to pay unless other arrangements have been made in advance.

### Referrals

I understand that if my insurance plan requires a pre authorization or referral for specialty visits/labs/procedures, that insurance requires authorization from Burke Healthcare Solutions,LLC prior to actually receiving those **NON-EMERGENCY** services and it is my responsibility to obtain the authorization or referral as necessary from Burke Healthcare Solutions, LLC or the insurance company as appropriate. I understand that if I fail to do so, the service may not be covered by my insurance company and I will be financially responsible. This denial is between the subscriber and the insurance plan and **I WILL NOT HOLD** Burke Solutions, LLC responsible.

### Teen Health/Scheduling appointments

I understand that according to Virginia law, a minor may be considered an adult and be able to consent for medical/health services related to **STD testing/treatment** or state of Virginia reportable communicable disease, contraception/family planning, mental health and substance abuse issue. Release of this information is dependent on the minor's agreement.

I understand that if I am more than 15 minutes late for my appointment, my appointment will be rescheduled.

### Prescription History

I authorize the release of my/my child(ren)'s prescription history.

### Testing

In the event of a needle stick or other potential hazardous exposure to body fluids involving our staff, I understand that my child will have blood drawn to test for communicable disease like HIV, Hepatitis B, Hepatitis C, etc. I authorize this testing and the results to be released to Burke Healthcare Solutions, LLC and the employee affected per **VIRGINIA LAW.**

### Administration Charges

I agree to pay the following charges and understand that are **NOT** billable to any insurance company at any time:

| | | | |
|---|---|---|---|
| **Missed Appointment/Cancel w/out 24-hour notice** | **$25** | **Record Release Fee Disk** | **$25 first 25 pages/$0.25 each add. page** |
| **Missed Consultation** | **$50** | **Medication Refill w/out office visit** | **$25** |
| **Returned Check Fee** | **$45** | **Form Fee/School/Sports** | **$25 each** |

### Signature

I agree to all terms above and fully accept all conditions. A copy of this signature may be used in place of the original for all insurance claims or for release of medical information.

____________________________ ________________________________________ ______________

**Signature of Responsible Party** **Name of Responsible Party** **Today's Date**

1) ____________________, 2) ____________________, 3) ____________________, 4) ____________________

**List All Patient(s) name(s) in Family (First Name, Last Name) – Use space below if additional members**

# Burke Healthcare Solutions, LLC

8988 Fern Park Drive · Burke, VA 22015 · Phone 703978-6061 · Fax 703-978-0291


## Well Visit/ Annual Physical Policy

The frequent and complex regulatory changes in the healthcare industry is a constant. Many times, the health insurance policy holder is the last to be communicated of these adjustments. Therefore, it is crucial to remain updated regarding your insurance plan benefits.

Burke Healthcare Solutions will bill your insurance carrier for your well visit (annual physical), however, should there be any pending balance, you are expected to pay the remainder. Any assessment, advice, and/ or treatment associated with a diagnosis addressed during the well visit (annual physical) is subject to co-pays/ deductibles, as defined in your insurance policy/ benefits.

Thank you for understanding,
Burke Healthcare Solutions, LCC.

I acknowledge and agree with the above,

_______________________________ _______________

Parent Signature Date