REGISTRATION

(PLEASE PRINT)

PRENATAL DIAGNOSIS CENTER

600 Peter Jefferson Pkwy., Suite 190
Charlottesville, VA 22911

Telephone: (434) 220-8620

Date__________ Home Phone (_____)__________ Cell (_____)__________

Patient__________ Last Name __________ First Name __________ Middle Initial

Responsible Party (if a minor)__________

Street Address__________ E-mail__________

City__________ State__________ Zip__________

Sex ☐ M ☐ F Age____ Birthdate________ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for____ years

Employer/School__________

Business/School Address__________

Occupation__________ Business/School Phone (_____)__________

Spouse (or responsible party) Name__________ Birthdate__________

Business Name and Address__________

Occupation__________ Business Phone (_____)__________

Who is responsible for this account?__________ Relationship to Patient__________

Social Security #__________ Spouse's Social Security #__________

Do you have Medical Insurance? ☐ No ☐ Yes ► If yes,

Name of Primary Insurer__________ Policyholder__________

Contract #__________ Group #__________ Subscriber #__________

Name of Secondary Insurer (if any)__________ Policyholder__________

Contract #__________ Group #__________ Subscriber #__________

☐ Medicare ☐ Medicaid Claim ID #__________

If Welfare, your number__________ County of__________

In case of emergency, who should be notified?__________ Phone__________

How did you learn of our practice?__________

AUTHORIZATIONS

Insurance Assignment and Release

I certify that I have insurance coverage with ____________________
Name of Insurance Company(ies)

and assign directly to Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to ____________________
Name of Doctor or Clinic
____________________ for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____________________ Signature of Beneficiary, Guardian or Personal Representative

__________ Date

____________________ Please print name of Beneficiary, Guardian or Personal Representative

__________ Relationship to Beneficiary

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DR. SIVA THIAGARAJAH, PRENATAL DIAGNOSIS CENTER, 600 PETER JEFFERSON PARKWAY, CHARLOTTESVILLE, VA 22911

PATIENT NAME:____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, the office of Dr. Siva Thiagarajah may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Siva Thiagarajah's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of Dr. Siva Thiagarajah reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Siva Thiagarajah's practice privacy officer at 1101 East Jefferson Street, Charlottesville, VA 22902

With my consent, the office of Dr. Siva Thiagarajah may call my home or other designated location and leave a message on voice mail or in person in reference to any itemts 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, the office of Dr. Siva Thiagarajah 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.

I have the right to request that the office of Dr. Siva Thiagarajah 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 signins this form, I am consenting to the office of Dr. Siva Thiagarajah'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 disclosures in reliance upon my prior consent. If I do not sign this consent, the office of Dr. Siva Thiagarajah may decline to provide treatment to me.

DEEMED CONSENT FOR DESIGNATED BLOOD BORNE PATHOGENS CONSENT TO MEDICAL CARE AND RELEASE OF INFORMATION

Virginia law requires health care workers to notify you that Hepatitis B and C or HIV (aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facitly.

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any health care worker associated with or working for the practice of Dr. Siva Thiagarajah is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Center for Disease Control, may transmit human immunodeficiency virus or Hepatitis B and C, the practice of Dr. Siva Thiagarajah will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for Hepatitis B and C for the safety of all concerned.

I voluntarily consent to medical care in the practice of Dr. Siva Thiagarajah which may include examinations, tests, photographs and treatments by doctors and the staff. No promises have been made to me as to the results of treatment or examination.

I certify that the information I have reported in regards to my insurance coverage is correct. I hereby authorize the release of pertinent information to my insurance company and any other doctors involved with my case. I authorize insurance benefits to be paid directly to this office, realizing that I am responsible to pay for any non-covered services. If my account becomes assigned to a collection agency, I agree to pay all costs of collections, including agency and attorney fees.

I have read, understand, and agree to all terms specified in the financial policy.

I acknowledge that I have received or been offered a copy of Dr. Thiagarajah's Notice of Privacy Practices.

Patient's relationship to signer:__Patient__Spouse__Parent__Other

Signed _______________________________ Date _______________

Signed _______________________________ Date _______________

Signed _______________________________ Date _______________

Signed _______________________________ Date _______________

OB/GYN Associates, 1101 East Jefferson Street, Charlottesville, VA 22902

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I AUTHORIZE TREATMENT AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT PROMPTLY UPON PRESENTMENT THEREOF. I ACKOWLEDGE THAT ALL PROCEEDS OF INSURANCE ARE ASSIGNED TO THIS OFFICE WHERE APPLICABLE AND THAT THIS OFFICE ASSUMES NO RESPONSIBILITY FOR THE COLLECTION OF ANY PROCEEDS OF INSURANCE.

IF MY ACCOUNT BECOMES ASSIGNED TO A COLLECTION AGENCY, I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING 25% AGENCY FEES, COURT COSTS AND ATTORNEY FEES.

SIGNED______________________________ **DATE**________________