CONDITIONS OF REGISTRATION

THE PRACTICE CONSENT FOR TREATMENT

Pediatric Associates of Alexandria, Inc. and/or its physicians, employees, agents or assignees will hereafter be referred to as "The Practice"

The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures and surgery as required by the physician rendering care for themselves and/or their child(ren). The procedures may include, but are not limited to, surgery, laboratory and x-ray procedures.

HIV/HEPATITIS B & C VIRUSES TESTING NOTIFICATION

In accordance with Virginia law, any patient to whose body fluids a healthcare worker has been exposed, will be deemed to have consented to HIV/HEPATITIS B & C TESTING. In all other cases, the patient shall have the right to informed consent or refusal for HIV/HEPATITIS B & C TESTING. We do not randomly test for HIV.

AUTHORIZATION & ASSIGMENT OF INSURANCE BENEFITS

I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION

I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Health Care Financing Administration, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs and to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons I agree to pay any applicable charges for having records copied. Please be aware that medical records can be obtained through the patient portal or Healow App FREE of charge.

REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care and diagnostic testing, to obtain such authorization from The Practice or insurance company prior to such non-emergency services being rendered. I further understand that I must notify The Practice prior to going, if possible, or within 48 hours, or in accordance with my insurance company's requirements, of any emergency room visit. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

COPY OF SIGNATURE

I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION

I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers. This certification will also apply to application for benefits under Title XVIII of the Social Security Act and/or any other governmental agency, if applicable. I also certify that I have read the forgoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

Information ***Insurance info and copy of insurance cards needed to file for benefits.***

I agree to terms & conditions of registration. I certify that the information I have reported is true and correct. As the Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on the Conditions of Registration Form. *****In cases of divorce or separation, unless otherwise specified in a court order, I understand that both parents will be permitted to schedule appointments, bring the child(dren) in for exams, and have full access to the child's medical records. If you have any concerns in this area, please contact the office supervisor for further questions.

PEDIATRIC ASSOCIATES OF ALEXANDRIA, INC.

Authorization for Treatment and/or Immunization of Minors

In absence of parents or guardians

Today's Date:_____

Patients' Names: Date of Birth

_____

_____

_____

I hereby authorize treatment of the above child(ren) and give permission for treatment during my child's preventive medical examination or sick examination. This form remains in full effect until rescinded in writting by parent/legal guardian.

The following person(s) listed below are authorized to bring my child(ren):

Name: Relationship:

_____

_____

* All persons selected to bring your child to our office must be 18 years of age or older and required to show a current photo ID.

☐ Pediatric Associates of Alexandria follows the recommended immunization schedule of the American Academy of Pediatrics. I give permission for the administration of the recommended vaccines.

☐ I hereby request no immunizations be given to my child at their examination.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Printed Name: _____

☐ My child is 16 years of age (or older) and has a current driver's license. I give Pediatric Associates of Alexandria authorization to treat my child for; preventive medical examination, vaccine administration, and/or sick visits.

If a provider needs to call me while my child is being seen you can contact me at:( )_____.

This form remains in full effect until rescinded in writting by parent/legal guardian.

[Type text]

Parent/Legal Guardian Signature: _____ _____

Parent/Legal Guardian Printed Name: _____ _____

Pediatric Associates of Alexandria

Inova Healthplex
6355 Walker Lane, Suite 401
Alexandria, VA 22310

Duke Street
2747 Duke Street
Alexandria, VA 22314

Potomac Yard Office
3600 S. Glebe Rd., Suite 150
Arlington, VA 22202

Billing Department

Email: Billing@pedsalex.com
FAX (571) 480-4751

CREDIT CARD CONSENT FORM

Dear Patients,

This letter is to inform you of our updated billing practice regarding receiving patient payments. We now use a Credit Card Merchant Service called Open Edge, which gives us the ability to swipe your credit card, debit card, or health saving account card to accept payment in the office and have the number securely stored on a remote server with Open Edge.

We want to assure you that our software has been thoroughly vetted according to the strict data retention rules required by the merchant processing system. The only information stored at our office in our secure, encrypted system, is the name on the card, the expiration date, and the last 4 digits of the card number.

We require your credit card information to be stored for future payment for some of the following reasons:

- **Your insurance company may not reimburse us for medical services or only make partial payment, because of the following:**
  - **Deductible has not been met for the current calendar year**
  - **Co-insurance may be applied to the charges**
  - **Service may be deemed as not a payable benefit for your plan.**
  - **Policy has terminated, or there is a gap in coverage.**
  - **Newborn has not been added to the policy and are not covered under parent's benefits.**
- **You may have a copayment for medical services.**
- **You wish to set up a payment plan for a large balance on account**.

AUTHORIZATION

By signing below, I authorize Pediatric Associates of Alexandria, Inc. to keep a credit card on file for future payments and to charge all balances accrued on the patients listed below with the information saved. **Please be advised your card will be charged the amount on your statement within 5-7 business days of statement date.** I am aware that if any of my personal information has changed, I am responsible to notify Pediatric Associates of Alexandria, Inc. of the change(s) to ensure they have the most current information to contact me or process payment accurately.

Credit card information:

Cardholder Name: _____

Credit Card Number: _____ Exp Date: _____ CVV: _____

Parent or Guardian Name (Print): _____

Parent or Guardian Signature: _____

☐ I have reviewed and understand Pediatric Associates of Alexandria, Inc Financial Policy and Notice of Privacy Act

Pediatric Associates of Alexandria Vaccine Policy
Revised January 1, 2026

Pediatric Associates of Alexandria (PAA) cares for thousands of children, with hundreds of families visiting our offices each day. Many of our patients are too young to receive certain vaccines and are therefore especially vulnerable to severe, potentially life-threatening infections. It is our responsibility to protect all of our patients, their families, and our community by maintaining a fully immunized patient population.

All PAA families **must** follow these guidelines, unless there is a documented medical contraindication:

1. Begin vaccines at the 2 month well check (before turning 3 months old)
2. Complete required childhood immunizations by 25 months of age (at the 2-year well check)
3. Complete all immunization boosters recommended after the fourth birthday before the start of kindergarten (usually by the 5-year well check and no later than 6 years of age)
4. Initiate required vaccines after the 11th birthday and complete within 12 months
5. Receive MenACWY (meningococcal meningitis) booster after the 16th birthday (no later than the start of 12th grade)
6. Children who are behind must begin catch-up vaccines within 30 days and complete all needed doses within 6 months.

PAA does not recommend an alternative vaccine schedule, but we are happy to work with you. Please note that following a different schedule may incur additional costs due to more frequent visits.

Families who do not comply with this policy will be discharged from Pediatric Associates of Alexandria.

Immunization status will be reviewed and discussed at office visits. This policy will be updated as new recommendations arise from the American Academy of Pediatrics, or Virginia Department of Health.

Required vaccines are those mandated by the State of Virginia for school entry include:

Diphtheria, Tetanus, & Pertussis (DTaP, DTP, or Tdap)

Meningococcal Conjugate (MenACWY)

Hepatitis B

Measles, Mumps, & Rubella (MMR)

Haemophilus Influenzae Type b (Hib)

Pneumococcal (PCV)

Rotavirus

Polio (IPV)

Varicella (Chickenpox)

Hepatitis A

For details, see the Virginia Department of Health:
https://www.vdh.virginia.gov/immunization/requirements/

A Commitment to Our Patients about Antibiotics

atients,

Antibiotics only fight infections caused by bacteria. Like all drugs, they can be harmful and should only be used when necessary. Taking antibiotics when you have a virus can do more harm than good: you will still feel sick and the antibiotic could give you a skin rash, diarrhea, a yeast infection, or worse.

Antibiotics also give bacteria a chance to become more resistant to them. This can make future infections harder to treat. It means that antibiotics might not work when you really do need them. Because of this, it is important that you only use an antibiotic when it is necessary to treat your illness.

How can you help? When you have a cough, sore throat, or other illness, tell your doctor you only want an antibiotic if it is really necessary. If you are not prescribed an antibiotic, ask what you can do to feel better and get relief from your symptoms.

Your health is important to us. As your healthcare providers, we promise to provide the best possible treatment for your condition. If an antibiotic is not needed, we will explain this to you and will offer a treatment plan that will help. We are ***dedicated*** *to prescribing antibiotics* ***only*** *when they are needed, and we will avoid giving you antibiotics when they might do more harm than good.*

If you have any questions, please feel free to ask us.

Sincerely,

GET SMART
Know When Antibiotics Work

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention