Smyrna Pediatrics

Chart #_____

*** **REFUSAL TO VACCINATE:** We are not accepting any families that do not vaccinate. Please return to the front desk to cancel this appointment.

Child's Name:_____ Gender: M / F Date of Birth _____

Parent's Contact

SS #:_____ Phone #'s: (H)_____ (W) _____(C)_____

Home Phone Work Phone Cell Phone

Address:_____ City:_____ State:_____ ZIP:_____

Patient Portal Access Email Address:_____ (This information is required for Patient Portal use.)

First Language: _____ Second Language: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Race: ☐ American Indian ☐ Asian ☐ Black ☐ Hawaiian, Native/Pacific Islander ☐ White

☐ Other Race: _____

Primary Insurance Information Please circle one for ***PRIMARY COVERAGE*** and allow us to make copies of all insurance information.

☐ Commercial/Employer Health Insurance: BCBS CIGNA AETNA UHC Other: _____

Insured's Name: _____ Employer: _____

Relationship

Insured's DOB: _____ SSN: _____ to Patient: _____

☐ Medicaid/Tenn Care: BlueCare TnCare Select AmeriGroup UHC Comm Plan

☐ Self-Pay (Payment is expected at the time services are rendered. WE DO NOT ACCEPT CHECKS! CASH OR CREDIT/DEBIT CARD ONLY!)

Secondary Insurance Information Please circle one for ***SECONDARY COVERAGE***

☐ Commercial/Employer Health Insurance: BCBS CIGNA AETNA UHC Other: _____

Insured's Name: _____ Employer: _____

Relationship

Insured's DOB: _____ SSN: _____ to Patient: _____

☐ Medicaid/Tenn Care: BlueCare TnCare Select AmeriGroup UHC Comm Plan

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Parent/Caregiver's Information

**Both biological parents have a right to information about a biological child unless it is legally documented otherwise. If this documentation exists, please allow us to make a copy for our records.)

Parent/Caregiver #1: _____ Relationship: _____ DOB: _____

Parent/Caregiver #2: _____ Relationship: _____ DOB: _____

Alternate Phone Number(s): _____

Emergency Contact In the event that we cannot reach you at the numbers above, list someone not living with you that we may contact?

Name: _____Relationship:_____Phone #: _____

This signature authorizes Smyrna Pediatrics, PLLC and any/all of its medical providers to treat your child and file appropriate insurance and/or Medicaid claims. It also requests payment of such claims to be made directly to Smyrna Pediatrics, PLLC and/or the provider of service. Should your account be referred to an outside collection agency, you will be responsible for a 30% collection fee.

X Authorized Signature:_____ Date: _____

Chart #_____

Smyrna Pediatrics

Contact Authorization and Social/Family History

CONTACT:

If at any time, I provide a wireless telephone number and/or my e-mail address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing, and payment for items and services, unless I notify the office/entity to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Parent/Caregiver Signature: _____ Date: _____

Please indicate the method in which you prefer to be contacted for the following information.

Please check only one per category. (The information indicated on this page should be listed on the first page of this packet.)

Medical issues, reminders, and general notices: ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Return phone calls: (Returning calls to you) ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Billing Statements – Statements will be mailed to the address we have on file. If you advise otherwise, please list where statements should be sent:

☐ Send statements to the patient address on file

☐ Send statements to: _____ Relationship _____

_____

SOCIAL:

**** The information on the following pages will provide beneficial social, personal and family history for the assessment and treatment of your child. It is recommended by the American Academy of Pediatrics. It will be reviewed by the provider with the parent/patient. Please be as complete and accurate as possible when filling in the information.*

Birthplace (Hospital and City) of patient: _____ State: _____

Parent/Caregiver's Occupation: Caregiver 1: _____ Caregiver 2: _____

Please list all persons living in the same home:

Name	Age	Relationship to patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list if the child's parents are: ☐ Married ☐ Not Married ☐ Separated ☐ Divorced

*Is violence a concern at home? ___ Yes ___ No *Are there guns in the home? ___ Yes ___ No

*Are there pets in the home? ___ Yes ___ No *Are there smokers in the home? ___ Yes ___ No

Family History: Please circle any family history and label who has/had the condition:

M=Mother **F**=Father **PGM**=Father's mother **PGF**=Father's father **MGM**=Mother's mother **MGF**=Mother's father

__ Alcohol Abuse _____ __ Thyroid disease _____ __ Skin disorders (eczema, psoriasis) _____

__ Drug Abuse _____ __ Bleeding problems _____ __ Cancer (what type) _____

__ Psychiatric disorders _____ __ Inherited/Genetic diseases _____ __ Heart Disease _____

__ High blood Pressure _____ __ Seizures _____ __ Stroke before age 50 _____

__ Asthma _____ __ Kidney Disease _____

Chart #_____

Smyrna Pediatrics

Pediatric Health History

Pediatric Health History:

Child's Previous Doctor: _____ Phone #:_____

Current Medications: _____

List any allergies or reactions to medicines or vaccinations: _____

Pregnancy & Birth Information:

This child is yours by: ☐ Birth ☐ Adoption ☐ Foster Parent ☐ Stepchild ☐ Legal Guardianship
(MUST provide LEGAL documentation)

Please indicate any medical problems during pregnancy: ☐ None

_____

Delivery by: ☐ Vaginal Birth ☐ Cesarean section, please explain why: _____

Birth Weight (if known): _____ Length: _____ APGAR score: 1 min_____ 5 min_____

Passed hearing test (if known)? ☐ Yes ☐ No

Received Hepatitis B Vaccination at birth (if known): ☐ Yes ☐ No

Please explain any medical problems during your baby's newborn hospital stay:

- ☐ None
- ☐ Prematurity; How early? _____
- ☐ Other Problems: _____

Past Medical History

Please describe any major medical problems and their approximate dates:

_____

_____

_____

Hospitalizations/Operations with approximate dates:

_____

_____

_____

Serious Injuries or accidents:

_____

_____

_____

Smyrna Pediatrics

Chart #_____

OTHER AUTHORIZATIONS, ACKNOWLEDGEMENTS, APPROVALS AND RESTRICTIONS

IMMUNIZATION RECORD SHARING

Our Electronic Medical Records (EMR) system can automatically share your child's immunizations with the State of Tennessee via TennIIS Exchange Database. TennIIS is an online database by which the State of Tennessee tracks your child's immunizations. This vaccine record will be available to any participating provider. It will also help to keep your child's vaccine record currently updated.

☐ **I DO NOT** WANT MY CHILDS IMMUNIZATIONS SHARED ON THIS DATABASE. Please initial X _____

☐ **I CONSENT** to having immunization information released to the State Registry. Please initial X _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I have reviewed the **Notice of Privacy Practices** of Smyrna Pediatrics, PLLC, detailing how my (child's) information may be used and disclosed as permitted under federal and state law. I understand the content of the Notice and I request specific restriction(s) concerning the use of my (child's) personal medical information. ***PLEASE LIST ANY SPECIFIC RESTRICTIONS ON THIS PATIENT'S PROTECTED HEALTH INFORMATION ON THE LINES BELOW.***

☐ **I DO NOT** require a copy of Privacy Practices at this time. Please initial X _____

☐ **I WOULD LIKE** to have a copy of the Notice of Privacy Practices for this office. Please initial X _____

RESTRICTIONS:

Please list any ***RESTRICTIONS*** of information about this child. This may include other people/family members that should not be given information about the patient:

_____

_____

_____

APPROVALS:

Please list any other people and/or family members that are authorized to seek medical attention, pick up prescriptions, or receive information for your child at Smyrna Pediatrics:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

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Information Regarding Insurance and Billing

1. It is the ultimate responsibility of the subscriber to understand his/her insurance benefits. If you are not sure if a service or treatment is covered, you should contact your insurance carrier. We do not provide *exhaustive* information about co-payment, co-insurance or deductibles. If our electronic verification of benefits indicates a co-payment, that amount will be requested at the time of the patient's visit. If there is any additional balance due, you will receive a bill from the Company.
2. Your co-payment is due (according to your insurance benefits) at each visit while you are in the office. We accept cash, Visa, Mastercard, American Express.
3. Delinquent accounts may be placed with an outside collection agency or put through a small claims court. If your unpaid balance is remanded to an external collection agency, a 30% collection cost will be added to your balance due. If it becomes necessary to proceed to legal action, all legal fees will also be added to the total balance due.
4. We are a participating provider for many health insurance plans. This means we will file a claim for services we provide to you/your child(ren). You will be responsible for non-covered charges as indicated by your insurance carrier/plan. THIS IS INCLUDING charges denied due to lack of information that has been requested from the subscriber, such as coordination of benefits (COB or other insurance) information.
5. If we are NOT PARTICIPATING PROVIDERS for your insurance plan, payment will be expected when services are rendered. You will be given an estimate of charges when we learn that the visit will be SELF-PAY and PAYMENT IN FULL will be expected when services are rendered. We will give you an itemized statement (upon request) so that you may file your insurance carrier directly for reimbursement.
6. All insured patients must present their insurance ID card(s) at the time of check-in. If you do not have your insurance ID cards or provide other means (SS#) for us to verify coverage, you will be asked to pay for your visit at the SELF-PAY rates.
7. If ALL active insurance policies are not presented at the time services are provided; rendering us unable to bill a subsequent insurance, you may become liable for the outstanding balance.
8. Some lab specimens (blood, urine, other cultures) are sent to an outside facility for testing. Additional lab charges will be incurred for this testing.
9. The fees we charge for office visits, surgery, pathology/labs, and related services are set by Medicare and are closely followed by the insurance companies. We do not randomly choose a fee and must operate our busines within the confines of this structured fee Schedule.
10. Any questions regarding your account should be addressed to the appropriate office personnel or Office Manager. The doctor(s) are not intimately involved in these administrative matters.

By signing (or e-signing) below, I certify that I have read the above information and any questions concerning these policies have been addressed. My signature also certifies my understanding and agreement with the above policies. I understand that I am responsible for all charges "not covered" by my insurance policy. A photocopy of this document is valid as the original. You may receive a copy of this document upon request.

X Parent/Caregiver Signature: _____ Date: _____

Chart #_____

Smyrna Pediatrics

AUTHORIZATION TO RELEASE PHI/ MEDICAL RECORDS TO:

SMYRNA PEDIATRICS, PLLC
739 President's Place, Suite 110
Smyrna TN 37167
Phone: (615) 625-7780
Fax: (615) 625-7781

Patient Name: _____ Date of Birth: _____

I hereby authorize any physician, person, or entity who has attended and examined my child to release for purpose of treatment ***his/her entire medical records*** (pursuant to states and federal law) without limitation.

Smyrna Pediatrics is requesting records from:

Facility and/or Medical Providers Name: _____

Fax Number: _____ Phone Number: _____

I understand that information in my health record may include information relating to sexually transmitted diseases. Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable disease, behavioral health care and treatment related to drug or alcohol use; my signature authorizes the release of such information.

This authorization expires in 90 days from the date specified, unless I revoke this authorization earlier. I understand that I may revoke this authorization at any time, except to the extent that actions based on this authorizations has already been taken. Our Notice of Privacy Practices explains the process of revocation, which includes a request in writing.

I understand that I may refuse to sign this authorization and my refusal will affect my ability to obtain treatment, payment of claims, and/or eligibility for benefits.

I understand that if any of the information to be release relates to the treatment of alcohol or drug abuse, there are special requirements for my consent to release as found in Federal Confidentiality Rules (42 CFR Part 2) which prohibits the further release of that information without my consent, as referenced to the Federal Regulations or otherwise permitted by law.

I understand that the provider releasing the PHI/ medical records to Smyrna Pediatrics, PLLC cannot control how the recipient uses or shares the information, and the laws protecting its confidentiality at releasing provider may or may not protect this information once it has been disclosed to the recipient.

Print Name of Parent/Guardian:_____ Date:_____

X Signature is required for release: _____

This patient's record is released for the sole purpose revealed above. Any futher release of information, review, dissemination, distribution or copying of this information is strictly prohibited. If you received this message in error, please notify us immediately by phone at (615) 625-7780.

Smyrna Pediatrics

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Please note a few of our Office Policies regarding the most discussed topics in the practice:

(The office manager may make exceptions on a case-by-case basis.)

Refusal to Vaccinate:

Initials: _____

As of January 1, 2018, we are no longer accepting new families that choose not to vaccinate their child(ren). At any point after establishing care with any provider at Smyrna Pediatrics, if you choose not to vaccinate your child(ren), termination of the family/physician relationship will occur.

Financial Responsibilities:

Initials: _____

Once you have been made aware of a balance owed on your child's/family's account, and it remains UNPAID, we reserve the right to postpone well-child visits until the balance is either:

1) Paid in full
2) Payment arrangements are agreed upon in writing AND consistent payments are being made.
3) In the event that a balance remains unpaid for more than 4 months without consistent payments being made – the entire account may be referred to an outside collection company and a 30% fee will be added to the balance. This also results in termination of patient/physician relationship.
3) In the event that a **NON-CUSTODIAL PARENT** has financial responsiblity for medical care:
   - Co-Pays are still due at the time of service. Please be prepared to fulfill this responsibility.
   - Any outstanding balances will follow the same rules as listed above.
   - We will not bill the non-custodial parent for any amount without their written consent.

Late Arrival:

Initials: _____

If you are more than 15 minutes late for your scheduled appointment, you may be asked to reschedule. If this happens, you will be given the next available appointment time which may not be until the next business day. If you see that you are going to be late, please call ahead to see if a reschedule is necessary.

No-Shows:

Initials: _____

We understand that sometimes circumstances arise that are beyond your control and you may fail to keep a scheduled appointment. When this happens, PLEASE CALL the office to reschedule AS SOON AS POSSIBLE. When you do not call to cancel/reschedule and thus 'no-show' your appointment, that time is wasted and could have been utilized by another patient.

*****After three (3) no-show appointments, you may be dismissed from the practice.**

Office Hours:

Initials: _____

* We close for lunch daily between 12:00pm and 1:00pm. Phones are not answered during this time.
* In the event of inclement weather, we may be forced to close the office without notice. You will be notified by phone at the number we have on file. Please update your information as it changes.

**These policies may be updated without notice. Changes to this document will be made as soon as possible.