IM & P | Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Pediatric Welcome Form

Patient Name: _____ _____ _____ _____
First Middle Last AKA

Gender: M F DOB: _____ S.S. # _____ Marital Status: _____

Race: _____ Ethnicity: _____ Language: _____

Primary Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: _____ _____ _____ _____
Home Cell Work Other

Email: _____ Preferred Contact Method: _____

Name and Phone Number of Preferred Pharmacy: _____

Parent's Contact Info: Mother's Full Name: _____ DOB: _____

Father's Full Name: _____ DOB: _____

Insurance Information

Primary Insurance: _____ Member ID: _____
Group ID: _____

Secondary Insurance: _____ Member ID: _____
Group ID: _____

If insurance is through someone other than yourself, please provide the following information:
Name: _____ DOB: _____ S.S. # _____

- I authorize release of any Information that I have provided or related to my treatment or the treatment of my child, for the purpose of evaluating and administering claims for insurance benefits.
- I also assign any payment of insurance benefits to be paid to the treating physician and understand that any costs incurred on my behalf or on my child's behalf that are not paid by insurance are my responsibility.
- I acknowledge that the HIPAA policies of CSIMP have been made available to me.
- I have been given the opportunity to ask questions concerning these policies and been offered a personal copy.

_____ _____
Signature Date

IM P

Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Pediatric New Patient Questionnaire

Guardian Name(s): _____

Relationship to Patient: _____

Parental Marital Status: _____

Who was your child's last Pediatrician? _____

Date of last physical: _____

Please list any specialists your child sees regularly: _____

_____

Does your child have any drug allergies? If so please list the medication and the reaction that occurred:

_____

_____

Illnesses or Medical Problems Past & Present (Ex: ADD, congenital defects, allergies)	**Date of Onset**
Operations or Injuries	

Current Medications (include over the counters, supplements, herbals, etc)	**Dosage**

Was the patient adopted? _____

Please check each box that applies for family history

	Mother	Father	Grandparent	Sibling
Heart Attack				
Stroke				
High Cholesterol				
High Blood Pressure				
Diabetes				
Asthma or Breathing Problems				
Seizures or Epilepsy				
Mental Illness (Depression, Anxiety, ADHD)				
Birth Defects				
Alcoholism				
Bleeding or Clotting Problems				
Cancer				

Other (Please list condition and family member affected):_____
_____
_____

Does the child attend daycare? _____
Are there any smokers in the household? _____
Are there any guns in the household? _____
Do you have a pool, spa or, pond on your property? _____
Are there any pets in the house? _____
Do you regularly use a car seat, booster, and/or seatbelt for your child? _____
Do you have any safety concerns? _____
Has there been any history of abuse or neglect? _____

IMP Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Consent to Treat Minor

Any patient under 18 years of age must be accompanied by a parent or legal guardian unless consent is given. Please complete the following information ONLY if you want to allow your minor child to be seen without a parent or legal guardian present.

I, _____, (Parent/Legal Guardian) give North Franklin Internal Medicine & Pediatrics permission to treat (including any and all services) the minor child named above in my absence.

_____ _____

Signature of Parent/Legal Guardian Date Signed

Consent for Minor Accompaniment

If there are other adult(s) over the age 18 that may accompany your minor child to any physician visit, please complete the information below.

I, _____, (Parent/Legal Guardian) give the following adult(s) permission to accompany the minor child named above to North Franklin Internal Medicine & Pediatrics in my absence. These individuals may give consent for treatment, including any and all services, in my absence.

_____ _____

Name of Adult Relationship

_____ _____

Name of Adult Relationship

_____ _____

Name of Adult Relationship

_____ _____

Name of Adult Relationship

_____ _____

Signature of Parent/Guardian Date Signed

Reviewed and updated 06/22/2020

IMP | Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

North Franklin Internal Medicine & Pediatrics
HIPAA Compliance Form

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA), in order for your physician or the staff of **North Franklin Internal Medicine & Pediatrics (NFIMP)** to give copies of and/or discuss your condition, exams, procedures, or x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. We must also obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

☐ I authorize NFIMP to communicate with me by any means I provide. I also authorize NFIMP to share my information with the following individuals:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

☐ I authorize NFIMP to communicate with only me by any means I provide.

☐ I DO NOT authorize NFIMP to communicate with me by any means other than in person, by phone, or via the portal. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

Medication Access Authorization

☐ I authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts.

☐ I DO NOT authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

Immunization Access Authorization

☐ I authorize NFIMP to download or update my immunization information to the Tennessee Department of Health Immunization Registry.

☐ I DO NOT authorize NFIMP to download or update my immunization information to the Tennessee Department of Health Immunization Registry.

I acknowledge receipt of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act about how NFIMP may use and disclose my protected health information. I understand that NFIMP reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____
Signature of Patient/Guardian Date Signed

Reviewed and updated 06/22/2020

IM P | Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

North Franklin Internal Medicine & Pediatrics, PLLC
Patient Down Payment Policy

Based on the insurance information you provide Cool Springs Internal Medicine & Pediatrics/North Franklin Internal Medicine & Pediatrics (CSIMP/NFIMP), either a down payment or a co-payment may apply for your visit. Below are details regarding these payment types:

- **Down Payment** -Where a deductible remains, CSIMP/NFIMP collects a $50 down payment per visit towards what will eventually be due once your insurance receives and processes our claims. You will be billed the difference between what you have already paid and what your insurance applies to your responsibility. Down payments are not payments in full for services rendered. **Example**: Mr. Smith has $1500 remaining on his deductible. He paid a $50 down payment for his visit. The claim for the visit is processed and his insurance assigns $150 to the patient's (Mr. Smith) responsibility. CSIMP/NFIMP will bill Mr. Smith for the remaining $100.
- **Self-Pay** – Patients who do not have insurance will be required to make a down payment of $100 per visit towards what will be eventually due once charges have processed through our billing department. New patients who are self-pay will be required to pay $140 at their first visit. Self-Pay down payments are not payments in full for services rendered. **Example**: Mrs. Johnson does not have insurance. She paid a $100 down payment for her self-pay visit. After the provider has completed the visit note and submitted charges, the total charge for the visit is $200. CSIMP/NFIMP will bill Mrs. Johnson for the remaining $100.
- **Co-Payment** – Where a co-pay applies, CSIMP/NFIMP collects a fixed amount per visit. This amount is not always shown on insurance cards and it is the patient's responsibility to let CSIMP/NFIMP know if they have a co-payment. The patient is required by their insurance to pay this fixed amount at each visit. Patients who refuse to pay their co-payment amount will not be seen.
- **None** – Based on verification made, CSIMP/NFIMP will not be collecting on a per visit basis. Patient will not be required to make payment before visit if the patient has met their out of pocket maximum. This can also be the case if the patient has a primary & secondary insurance where no deducible needs to be met. A balance still may be due and will be billed to the patient once the claim has been processed.
- **Wellness Visits** – Most health plans will pay for one wellness or preventative exam per year. Your insurance provider may consider this to be once per calendar year or one year and one day since the date of your last wellness exam. Patients will not be required to pay down payments for wellness visits.
- **CSIMP/NFIMP unable to guarantee benefits details** – Insurance does not mandate that healthcare providers verify and communicate benefits to patients. CSIMP/NFIMP does this as a courtesy. CSIMP/NFIMP is unable to obtain guarantees regarding benefits we verify and therefore cannot pass any guarantees along to our patients. Benefits differ from insurance plan to insurance plan.
- **Independent verification** – We ask that patients contact their insurance company and obtain benefits for services independent of CSIMP/NFIMP.

_____ _____

Signature of Patient or Legal Guardian | Date Signed

Reviewed and updated 06/22/2020

IMP Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

Patient Name: _____

Date of Birth: _____

Today's Date: _____

North Franklin Internal Medicine & Pediatrics, PLLC
Telemedicine Patient Consent Form

1. The purpose of this form is to obtain your consent to participate in a telemedicine or electronic consult.
2. During the telemedicine consultation:
    a. Details of your medical history, examination, imaging, and test results will be used.
    b. You will be speaking with a licensed provider through the use of patient portal, telecommunication, and or interactive video.
3. Medical information and records: All existing laws regarding access to your medical information and copies of your medical records apply to this telemedicine consultation. Please note, telecommunications are not recorded or stored.
4. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protection under federal and Tennessee state law apply to information disclosed during the telemedicine consultation.
5. Rights: You may withhold or withdraw consent to the telemedicine consultation at any time.
6. No Shows: A "missed" telemedicine appointment is considered the same as a missed in office visit. We respectfully request our patients cancel or reschedule their appointment a minimum of 24 hours in advance of the appointment time. If a 24-hour notice is not reasonable for the circumstances, any notice prior to the appointment will be accepted.

By signing below, I acknowledge I have been advised of all the potential risks, consequences, and benefits of telemedicine. I had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All questions have been answered and I understand the written information provided above.

_____ _____

Signature of Patient or Guardian Date Signed

Reviewed and updated 06/22/2020

IM P Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

The undersigned authorizes:

Cool Springs Internal Medicine & Pediatrics
1607 Westgate Circle, Suite 200
Brentwood, TN 37027
Phone: (615) 376-8195 FAX: (615) 376-2601

North Franklin Internal Medicine & Pediatrics
109 Del Rio Pike
Franklin, TN 37064
Phone: (615) 435-3854 FAX: (615) 376-2601

To release my health information as noted below:

Patient Information

Patient Full Name: _____ Other Names?_____

Patient Address:_____ Date of Birth:_____

City:_____ State:_____ Zip:_____ Phone #:_____

Facility Information

⚠ Please specify: [__]*Release Information to:* **OR** [__]*Request Information from:*

Name/Facility:_____ Attention:_____

Address:_____ Phone #:_____

City:_____ State:_____ Zip:_____ Fax #:_____

Purpose of Request: (check one) ___Personal ___Treatment ___Legal ___Insurance ___Transfer ___Other:

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on BACTES Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Bac tes.com containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.

Email: (optional) _____

Information To be Released:

If you fail to specify, a 1 year abstract will be provided

___**Please release/request a 1 year abstract of my records**
(includes most recent notes, labs, procedures & testing)
___**Please release/request a 2 year abstract of my records**
(office notes, labs, procedures & testing, up to 2 years)
___**Date Range:**_____
□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other:_____

(Please pick ONE delivery option)

[ ] Send by Email	[ ] Records on CD
[ ] Fax to Doctor	[ ] Records on Paper

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Tennessee State law: Statute 63-2-102. Records being sent to another healthcare provider will be sent at no cost.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____(Please Initial)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**_____ *If I do not specify expiration this authorization will expire in 1 year.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety – if form is incomplete, or if protected information is not released, we may be unable to fulfill this request

Signature*: _____ Date:_____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

IM P | Internal Medicine & Pediatrics Clinic, PLLC
COOL SPRINGS • NORTH FRANKLIN

North Franklin Internal Medicine and Pediatrics Patient Portal Document

The North Franklin Patient Portal is a password-protected and secure section of our site that is designed with your privacy in mind. The patient portal supports your ability to request an appointment, review statements, update demographics, and securely communicate questions to our front desk staff, billing department, and physicians.

We will be posting lab results on the patient portal. We will not be calling patients with lab results as that information can be found on the portal.

If you are having a medical emergency please call 911. DO NOT USE the Patient Portal for medical emergencies. The portal should never be used for time-sensitive issues. Messages will generally be checked daily, but there may be delays if the physician is out of the office for any reason. If you need an immediate response it is always best to call 615-435-3854.

Patient Login: https://gateway.aprima.com/portal/home/10644

Your Login ID is the email address that we have on file for you. Please see your temporary password below:

Logging into the Aprima Patient Portal:

Logging into the North Franklin Patient Portal requires you to enter a unique Username and Password. Your login credentials guarantee that your communications with our staff will be secure and confidential.

- Click the North Franklin Patient Portal link from our website at: www.coolspringsinternalmedicine.com.
- Then follow the directions. The patient portal login page will display in a new browser window.
- Next, do one of the following:
- If you already have an account, enter your case sensitive username and password and click the "Login" button.
- If you have forgotten your username and password, please contact the office at **(615) 435-3854** and our staff will reset your password and provide you with your username information.
- If you DO NOT have an account, please contact the office at **(615) 435-3854** and our staff will issue you a username and temporary password. Upon login for the first time you will be prompted to change your password.

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W. Daniel Edmondson, M.D. | Kavita Karlekar, M.D.
Peter J. Swarr, M.D. | Dorsey R. Thorley, M.D. | Samuel Bastian, M.D.

North Franklin Internal Medicine & Pediatrics, PLLC
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health is important to us.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/2018) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed above.

Uses and Disclosures of Health Information

Treatment: We may use or disclose your health information to a physician or other healthcare facility, providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give your insurance company information about your visit so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Business Associates: There are some services provided to our patients by third party agencies who are under contract with our organization, known as business associates. When these services are contracted, we may disclose your health information with our business associates to the extent necessary for them to complete the job they have been asked to do. They may also bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Reviewed and updated 09/15/2020.

Your Authorization: In addition to our use of your health information, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Research: The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy.

Future Communications: We may communicate with you by any means provided to us regarding treatment options, health related information, chronic care management programs, wellness programs or other initiatives or activities our facility may be participating in.

Required by Law: We may use or disclose your health information when we are required to do so by law. We may also use or disclose health information when permitted by the law to entities such as the FDA or public health/disease control facilities.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may also disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. Health information may also be disclosed to correctional institutions or law enforcement officials in the event of incarceration.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders in the form of voicemail messages, emails, or texts.

Reviewed and updated 09/15/2020.

Our Office Policies

Communications Regarding My Accounts: Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as: 1. Any cell phone, landline, or text number that I provide; 2. Any email address I provide; 3. Auto dialer systems; 4. Voicemail messages and other forms of communications.

Co-pay, Unmet Deductible, Unpaid Balances: Please note that it is our office policy to collect all copay amounts, unmet deductibles, and unpaid balances prior to you being seen by our providers. I also understand I am fully responsible for any additional fees related to the collection of my account(s).

Appointment Policy: Should you need to cancel or reschedule an appointment we ask that you advise us a minimum of 24 hours in advance of your scheduled appointment. Failure to notify the office will result in a $35 charge to your account on the second no show and every additional one after.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a reasonable cost-based fee for expenses such as copies, staff time, postage, etc. If you request an alternative format, we will charge a reasonable cost-based fee for providing your health information in that format. We will also prepare a summary or an explanation of your health information in lieu of providing medical records, if requested. You must make a request in writing to obtain access to your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. The request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request we amend your health information. The request must be in writing and explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our web site or by e-mail, you are entitled to receive this in it's written form.

Questions or Complaints

If you want more information about our privacy practices or are concerned that we may have violated your privacy rights in any way, you may contact us using the information at the beginning of this notice. You may also submit complaints to the U.S. Department of Health and Human Services. *You will not be penalized for filing a complaint.*

Reviewed and updated 09/15/2020.