TENNESSEE PEDIATRICS

Patient Information

Please complete all information in each section in order to ensure accurate medical records for your child.

Patient Name _____ Sex: F M

Patient Date of Birth _____ Patient SSN _ _ _ - _ _ - _ _ _ _

Primary Phone # _____ Secondary Phone # _____

Address _____ City _____

State _____ Zip Code _____

Parent/Guardian Email Address _____

Parent/Guardian Information

Mothers Name _____ Fathers Name _____

Mothers SSN _____ Fathers SSN _____

Mothers Date of Birth _____ Fathers Date of Birth _____

Mothers Phone Number _____ Fathers Phone Number _____

Insurance Information

Primary Insurance Company _____

ID/Policy # _____ Group # _____

Policy Holders Name _____Policy Holder Date of Birth _____

Relationship to Patient _____

Secondary Insurance Company_____

ID/Policy # _____ Group # _____

Policy Holders Name _____Policy Holder Date of Birth _____

Relationship to Patient _____

Pharmacy

Pharmacy Name _____

Pharmacy Address _____

TENNESSEE PEDIATRICS

HIPAA RELEASE OF MEDICAL INFORMATION

Please list all persons that may have access to your child's medical information.

Example: appointments, prescription pick up, general medical information, lab results or medical emergencies.

If their name and phone number is not on the list, they will not be allowed to have any information on the patient. Please make sure to update any changes at each appointment.

CHILD'S NAME: _____

DATE OF BIRTH: _____

GUARDIAN SIGNATURE: _____

DATE: _____

Name	Phone Number	Relationship
1.		
2.		
3.		
4.		
5.		
6.		

TENNESSEE PEDIATRICS

Financial Policy Sheet

We are happy that you have chosen our practice to provide for your child's health care needs. We are committed to providing the best medical care and customer service available. As part of this commitment, it is important that you have a clear understanding of our financial policies. Our staff will be happy to answer any questions you may have.

Our physicians participate with most major insurance plans. Due to constant coverage changes, we cannot guarantee that your insurance company will cover the service we provide. We will file your charges as a courtesy. Should the services not be covered, you will be responsible for the bill. It is your responsibility to pay your copay at the time of each visit. We cannot bill you for your co-pay. It is also your responsibility to make certain that the physician that your child is scheduled to see is on your insurance plan.

Unless arrangements have been made in advance either by you, or by having insurance coverage, payment for all services is due at the time of service. For your convenience we accept all major credit cards, cash and check.

I have read, understand and agree to abide by the financial policy of the practice. I hereby authorize the release of information necessary to process insurance and also authorize my insurance company to pay directly to the physician any benefits due for services rendered.

Patient Name _____

Date of Birth _____

Parent/Guardian Name (print) _____

Parent/Guardian Name (signature) _____

Date _____

5505 Edmondson Pk, Ste 104
Nashville, TN 37211
Ph (615) 331-5898
Fx (615) 331-5705

100 Springhouse Ct., Ste 100
Hendersonville, TN 37075
Ph (615) 826-2080
Fx (615) 822-3213

4720 Traders Way, Ste 600
Thompsons Station, TN 37179
Ph (615) 302-1279
Fx (615) 302-5279

1370 Gateway Blvd., Ste 110
Murfreesboro, TN 37129
Ph (615) 890-9008
Fx (615) 890-0193

TENNESSEE PEDIATRICS

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

I hereby authorize the use or disclosure of my health information as described below. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

_____ _____

Patient Name **Date of Birth**

Practice / Physician providing the information:

_____
_____
_____
_____

Practice / Physician receiving the information:

_____
_____
_____
_____

☐ All Medical Records at this Facility

☐ Other (Please Specify):_____

_____

Purpose of the use or disclosure: ☐ At the request of the individual ☐ Changing Physician

☐ Moving ☐ Physician/Staff Request ☐ Other _____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with the following exceptions:

1. The provision of research related treatment for which protected health information is created, my refusal may result in the physician declining to provide the research related treatment.
2. The provision of healthcare that is solely for the purpose of creating protected health information for disclosure to a third party, my refusal may result in the physician declining to provide the service to create said protected health information.

This authorization will expire on _____ ***(Expiration Date or Defined Event*).**

I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be submitted to the designated Privacy Officer.

Signed by:

_____ _____

Signature of Patient or Legal Guardian **Relationship to Patient**

_____ _____

Print Name of Patient or Legal Guardian **Date**