



# 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**