Christian Family Medicine & Pediatrics

PEDIATRIC PATIENT REGISTRATION FORM

<u>*Please Print Clearly*</u>

Patient Information

Legal Name____ Mother's Maiden Name_____________________

Gender: M F *(Circle One)* SSN__________________ Date of Birth________________

Race: African American Asian Caucasian Other *(Circle One)* Ethnicity: Hispanic Not Hispanic Preferred Language___________

Primary Provider__________________ Religion ______________ Dominant Side: Right Left Ambidextrous *(Circle One)*

Address____ City / State / Zip ___________________________

Home Phone____________________ Cell Phone_________________________ Work Phone______________ Ext _____

Email address:_________________________________

Preferred Contact Method: Phone Text Mail Email *(Circle One)* Preferred Reminder Method: Cell Home Office Mail Email

Consent: Immunization Sharing Yes No *(Circle One)* Health Information Exchange Yes No *(Circle One)*

Emergency Contact: ____________________Contact #________________Relationship:______________

Local Pharmacy of Choice________________________ City_______________ Phone:______________

Parent/Guardian Information* (Person who is legally responsible for above patient)

Guardian Relationship: *(Circle One)* Self Spouse Mother Father Grandmother Grandfather Aunt Uncle Other

Guardian Name_______________________________ Date of Birth_____________ Gender: M F *(Circle One)*

SSN ________________________ Marital Status_____________ Phone___________

Address____ City/State/Zip____________________________

*Christian Family Medicine & Pediatrics MUST obtain a copy of any legal documents related to child custody.

Insurance Information

Primary Insurance

Ins. Co_________________________________ Effective Date _____________ Copay Amount $_________

Policy # ____________________________________ Group/ Plan # ______________

Policy Holder's Name______________________________ Date of Birth _________ SSN_________________

Address____ City / State / Zip ___________________________

Phone # ___________________________________ Relationship to Patient _________________

Secondary Insurance

Ins. Co_________________________________ Effective Date _____________ Copay Amount $_________

Policy # ____________________________________ Group/ Plan # ______________

Policy Holder's Name________________________________ Date of Birth _________ SSN_________________

Address____ City / State / Zip ___________________________

Phone # ___________________________________ Relationship to Patient _________________

Please list all household members that may be attached to this guarantor's account with Christian Family Medicine:

____

Patient Financial Responsibilities Notification

Insurance Claim Filing
We will submit all charges to all insurance (primary, secondary, etc.) as a courtesy to you. However, we do require payment at the time of service for all co-payments, deductibles, and co-insurance. We cannot bill your insurance unless you bring all current insurance information with you. It is your responsibility to provide us with complete and accurate information at EACH office visit. Failure to do so will result in the patient incurring complete and total financial responsibility for all charges. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services provided may be "non-covered" under the terms of your contract and, therefore, not paid by insurance. You are responsible for the payment of your deductible and co-pay if there is no secondary insurance. Copies of your information will be made for our files.

It is the patient's responsibility to inform us of any special requirements or specific facilities associated with your benefit plan. If we inadvertently order services, such as lab work, diagnostic tests, etc. that are not covered or ordered at an out of network facility, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

All patients are expected to provide their insurance card at the time of check in at each visit. All patients are responsible for making sure they know what benefits are included under their insurance plan and ensure they are following all regulations/ rules defined in their plan.

Self Pay with No Insurance
A deposit will be required for all patients that do not have insurance coverage prior to seeing the provider. Payment in full is expected at the time of service unless billing arrangements have been made by our billing staff PRIOR to the visit.

Adult Patients: Adult patients are responsible for full payment of their accounts.

Minor Patients: Patients under the age of 18 years will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment. The adult, parent or guardian accompanying a minor will be responsible for full payment of the account.

There is a $50.00 form fee for any forms presented to the office for completion not presented during a regular visit. Including but not limited to: FMLA, Disability, Adoption forms

Payment in full or payment arrangements can be made on any outstanding balance. No payment activity within 120 days from the date of service will result in the account being turned over to an outside collection agency. The patient will be responsible for all collection fees, cost, interest, and/or attorney fees and will be applied to the outstanding balance.

Any account that has been turned over to a collection agency **MUST** be paid fully before any treatment is rendered. Failure to meet your financial responsibilities may result in discharge from the practice.

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the primary care provider. I understand if there are any changes in my insurance coverage, I will notify my primary care provider immediately. I hereby give consent for treatment of myself to the primary care provider at Christian Family Medicine.

__ I understand that Christian Family Medicine, Inc. is a PCMH facility and I have been given information to explain the program.

__ I understand that I have been made aware of CFM&P Notice of Privacy Practices.

I request payment of authorized Insurance/Medicare benefits be paid to Christian Family Medicine, Inc. on my behalf. I authorize any holder of medical information about me to release to the Healthcare Financing Administration, any information needed to determine these benefits. I understand my signature authorizes the physician to furnish information to insurance carrier concerning my illness necessary to pay my medical claims and I hereby irrevocably assign payments to Christian Family Medicine, Inc. I understand I am financially responsible for all charges, whether or not covered by insurance. I also understand my medical records may not be released if I am not financially in good standing with Christian Family Medicine, Inc. A copy of this authorization shall be considered as valid as the original.

____
Signature of Patient or Responsible Party (state relationship)

____
Date

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Patient Disclosure Authorization Form

Christian Family Medicine Inc. has provided me notification of their Privacy Practice for protected health information. I authorize Christian Family Medicine, Inc. the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

□ ______________________________ □ ______________________________

□ ______________________________ □ ______________________________

□ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Delegation of Authority

In addition to disclosure of protected health information, the following person(s) have permission to obtain medical care for my child in my absence. I understand that I am responsible for all expenses incurred for my child's treatment. Christian Family Medicine & Pediatrics may discuss my child's medical status with the designated person(s).
I understand that a parent or legal guardian MUST be present for a wellness exam.

Designated Person(s):	Relationship to Child:	Phone Number:
1.____________________	____________________	____________________
2.____________________	____________________	____________________
3.____________________	____________________	____________________
4.____________________	____________________	____________________

You may release information to the following:
- □ primary home
- □ primary work
- □ primary cell number: ________________

If unable to reach me:
- □ you may leave a detailed message
- □ please leave a message asking to return your call
- □ do not leave a message

______________________________ ________________

Signature of patient or guardian *Date*

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Authorization for Release of Medical Records

Date: ___________________

Previous Doctor: ____

____

Phone: ______________________ Fax: _________________________________

Hospital of Birth: ____

I hereby authorize the release of medical and immunization records for:

Patient Name: ____

Date of Birth: ____

Home Address: ____

____

Purpose of Disclosure: _____ Changing Provider _____ Moving _____ Other: __________________

In compliance with HIPAA Privacy Policies and Procedures, I am advised that this release may include information regarding communicable diseases, psychiatry, drug, and/or alcohol abuse, unless specifically requested to omit. The requested medical records will be released in their entirety unless otherwise noted.

I am requesting these records be released to:

Christian Family Medicine & Pediatrics
79 Hwy 51 South
Ripley, TN 38063

I have the authority to request this information by virtue of being the patient's parent/legal guardian and have signed the release form below.

____ ____

Parent/ Legal Guardian Date

Note: This consent is valid for 90 days from the date of signature. It may be revoked by the signer at any time.
This release is not valid retroactively.

Christian Family Medicine & Pediatrics

Policy on Access to & Release of a Minor's Medical Record

Background: Capacity and Age.

- In Tennessee, as in other states, a patient must give consent for treatment (usually consent is inferred by voluntarily presenting for treatment). Without consent, the treatment can be charged as a battery by the physician.
- In order to give valid consent, the person must have the capacity to consent. Capacity may be described as the ability of an average person to understand and weigh the risks and benefits of undertaking the treatment.
- **<u>The law presumes capacity exists for any person age 18 or older</u>** - if an adult lacks the capacity to consent, the law provides various means whereby another person may give consent for treatment (durable power of attorney, conservatorship, etc.). In Tennessee, a "minor" is a person under the age of 18.
- The capacity to give consent includes the ability to deny consent outright or to withdraw consent after it has first been given.

Background: Treatment of Minors and Protections in the law.

- The general rule in Tennessee is that a minor child (under age 18) obtains treatment when consent is given by the child's parent, or a guardian or other person acting in place of a parent. If a parent accompanies a minor child and seeks medical care for the child, consent is presumed by conduct.
- Tennessee, like many other states, recognizes certain "rights" of minors to seek and obtain treatment without knowledge or consent of a parent. Those exceptions are listed below. In all other situations, if an unaccompanied minor child presents requesting treatment, and none of the exceptions apply, the provider should make reasonable attempts to contact the parent (or guardian) to obtain consent to treat the child. Absent consent, the provider should refuse to treat the child (unless an exception applies).
- Tennessee law provides the following exceptions:
  1. Furnishing of **contraceptive supplies** and information to any minor "who requests and is in need of birth control procedures, supplies or information." T.C.A. § 68-34-107.1
  2. **Prenatal care** (including pregnancy testing). T.C.A. § 63-6-223.
  3. **Sexually transmitted disease**. T.C.A. § 68-10-104(c). The law provides that any physician "may examine, diagnose and treat minors infected with sexually transmitted diseases without the knowledge or consent of the parents of the minors, and shall incur no civil or civil or criminal liability in connection therewith..."
  4. **Juvenile drug abuse**. T.C.A. § 63-6-220. This is the only provision that includes the following language: "A physician may use his own discretion in determining whether to notify the juvenile's parents of such treatment."
  5. **Emergency medical or surgical treatment**. T.C.A. § 63-61222. This law requires that the physician make "a reasonable effort to notify the parents if known or readily ascertainable," and has a requirement that the physician have a "good faith belief' that rendering emergency care is necessary to protect the health of the child.
  6. **The "Mature Minor" exception**. Tennessee recognizes the right of mature minors to control their own medical decisions. Cardwell v. Bechtol, 724 S.W.2d 739 (Tenn. 1987). Although rarely applied, **this is a case-by-case situation that will come into play with minors who are 17, 16 and perhaps 15** (the decision is not strictly age-dependent, but the closer to 18 the more likely the doctrine is to apply), **and who evidence the capacity to consent by ability, experience, education, training, degree of maturity and demonstrated judgment, and the adolescent's general conduct and demeanor**. Given all these factors and circumstances, the call that has to be made is whether the child, although a minor, is able to appreciate the risks and consequences of the medical treatment decision to be made ... and that call must be made by the treating physician.
- <u>A child seeking treatment independent of a parent (including for any of the exceptions listed above) should be advised that the medical service is not free</u>; that it will be billed to applicable health insurance; and that because health insurance is obtained through a parent, the household will likely receive information from the insurance company through the mail about the medical treatment. The child also should be provided with a copy of Christian Family Medicine & Pediatrics' ***Notice of Health Information Privacy Practices***.

General Privacy Principles Concerning a Minor's Health Information.

- Generally, the medical record and health information of a minor child should be protected and kept confidential in the same manner as the record of an adult patient
- A person with capacity to consent to medical treatment also has the capacity to exercise limited control over the use and disclosure of the individual's health record/information. Therefore, a parent will usually exercise these rights with respect to the records of a minor child under the age of 18.
- The federal HIPAA Privacy Regulation requires that a minor be treated the same as an adult with respect to any situation when, under state law, the minor is able to consent to treatment without need of parental consent. 45 CFR § l62.502(g)(3). Therefore, if one of the exceptions listed above applies, a minor can, acting on his or her own behalf, exercise whatever rights of control may exist for the patient over health information in the Clinic's medical record.
- Federal law provides that a patient may request to restrict a Clinic from disclosing particular health information to a health insurance company or health plan. However, the same federal law also provides that the Clinic must agree to such a request ONLY if the service to which the information pertains is aid in full "out-of-pocket" by the individual patient or patient's representative. 45 CFR l64.522 (a)(1)(vi). The Clinic requires such payment-in-full on the date of service. Without payment in full at the time of service, a request to restrict the use or disclosure of the health information in the medical record will be denied.
- For any other situation, a request to restrict disclosure of an individual patient's health information requires a written request and approval by Christian Family Medicine & Pediatrics' Privacy Coordinator. Only the Privacy Coordinator (or other authorized designee of the organization) may agree to a request to restrict how protected health information is used, and the Privacy Coordinator is not required to agree to a restriction request. No physician or other employee of Christian Family Medicine & Pediatrics may bind The Clinic to a request to restrict disclosure of health information. Generally, disclosure restrictions that may deprive another treating provider of important health information are disfavored as unfair to both the other treating provider and the patient's overall health. Similarly, restricting disclosures to health insurance companies or health plans when needed to obtain payment for services also are disfavored and not ordinarily approved. These general rules and policies apply to the medical records of a minor patient as well as an adult patient.

Parent's Right to Receive a Copy of the Health Record of a Minor Child

- A parent exercises "patient control" over the medical record of the parent's minor child (under the age of 18).
- A parent is entitled under both federal and state law to access the medical record of his/her child. If the parent of a minor child (under age of 18) submits a request in writing for a copy of the child's medical record, a copy will be provided unless The Clinic has received a court order to the contrary.
- The parent's entitlement under the law is to the entire medical record, unless some portions have been restricted from disclosure because of the federally-mandated right cited above, or because The Clinic has agreed to a request to restrict disclosure of certain health information (a very rare occurrence).
- There are many families with divorced parents. Even a non-custodial parent has a statutory right in the state of Tennessee to receive a copy of the minor child's medical record upon written request. T.C.A. § 36-6-103. If a non-custodial parent requests a copy of his/her child's medical record, the copy will be provided unless The Clinic has been presented with a court order that restricts such disclosure of the medical record to the non-custodial parent.

Christian Family Medicine & Pediatrics

Pediatric Patient Health History

Child's Legal Name:____ Date of Birth: ___________________

Your Name: ____ Relationship to Child: ____________

MEDICATIONS: Please list (or show us a printed record) of ALL prescriptions and non-prescription medications. This includes vitamins, supplements, birth control, and over the counter pain medications (Advil, Aleve, Tylenol, etc).

□ Check box if your child does not take any prescription or over the counter medications.
□ Check box if you brought a printed record of your child's medications (please give it to the nurse).

Medication	Dose (e.g. mg/pill)	How often?

ALLERGIES or intolerance to medications? □ None (If yes, to what & what reaction?) ____________________________________

____

Child's Past Medical History

Where was your child born? ____________________ Gestational Age at Birth: ______ Birth Weight: _____ Length: _____

Is the child yours by: *(Circle One)* Birth Adoption Step Child Other: _____________

Pregnancy Complications: _______________________ Delivery by: *(Circle One)* Vaginal C-section Reason for C-section: _________________

Any problems/ abnormal screening in the Newborn period: ____

If your child has had immunizations please list ALL facilities your child may have received immunizations.

____

Does patient have now, or has patient ever had, any of the following conditions? (please circle all that apply)

ADHD/ADD	Bruise Easily	Excessive Bleeding	High/Low Blood Pressure	Mitral Valve Prolapsed	Stomach/ Intestinal Disease
Anaphylaxis	Cancer	Fainting/Dizziness	Hypoglycemia	Mumps- Age __	
Anemia	Chicken Pox – Age _	Hay Fever	Jaundice	Psychiatric Care	Thyroid Disease
Artificial Heart Valve	Cold Sores/ Blisters	Hearing Problems	Joint Disorders	Rheumatic Fever	*Please list any other Conditions below:*
Asthma	Cortisone Medication	Heart Murmur	Kidney/ Bladder Disease	Sickle Cell Disease/ Trait	
Blood Disease	Diabetes	Heart Trouble/Disease	Liver Disease	Sinus Trouble	
Blood Transfusion	Epilepsy or Seizures	Hepatitis A, B, C	Lung Disease	Skin Problems/ Eczema	

Social History

Who lives in the household with the child? *(Circle all that apply)*

Mom Dad Stepmom Stepdad Siblings (#) _____ Grandparent(s) Other: ___________

Child's parents are: *(Circle One)* Married Unmarried Divorced Other: ________________

Childcare: *(Circle One)* Parent(s) Daycare Relative(s) Babysitter/Nanny Days per week: _____

Do any household members smoke? *(Circle One)* Yes No

How many hours per day does your child: Watch TV _____ Play Video Games _____ On the Computer _____

Name of Child's School: _____________________________ Current Grade Level: _________

Any Concerns Regarding Child's Performance at School: No Yes: ___________________________________

Sports/Exercise: Type: ____________________ How often? _____________________________

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

FAMILY HEALTH HISTORY: Please indicate which relative has had the following diseases. Write in the number of siblings in the appropriate boxes. If some siblings are alive and some are deceased use the space to the right to explain further.
Adopted? □ No □ Yes If adopted and you do NOT know your family history skip the Family History Section and continue to Health Issues.

	Mother	Father	* Sister(s)	*Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	List age(s) at diagnosis if known and mark if this disease/ condition was the cause of death.
Alive									
Deceased									
Age currently or at death									
Diseases & Conditions									
No significant history known									
Hypertension – high blood pressure									
Hyperlipidemia – high cholesterol									
Heart Attack, Angina									
Diabetes Type II (adult onset)									
Diabetes Type I (childhood onset)									
Cancer, (please specify type)									
Osteoporosis									
Depression									
Alcoholism/ Drug Abuse									
Alzheimer's									
ADD/ ADHD									
Anemia									
Asthma									
Autoimmune disease									
Bleeding/ Clotting Disorder									
Colon Polyp									
Emphysema (COPD)									
Genetic Disorder (Please Explain)									
Glaucoma									
Heart Disease (CHF)									
Hepatitis									
Hip Fracture									
Hypothyroidism/ Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Stroke									
Sudden Cardiac Death									
Other:									
Other:									

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform Christian Family Medicine, Inc. of any changes in my child's medical status. I also authorize the health care staff to perform the necessary services my child may need.

____

Signature of patient/parent/guardian Date