pediatric associates
OF FRANKLIN

Date: _____ _____ _____ _____ _____ _____ _____
Annual Verification/Date/initials

Best Contact Number to Reach You: _____**Chart #** _____

Patient Information: **Please List All Children in the Family**

	Last	First	Middle	Birthdate	Gender	Race	Nickname
1.							
2.							
3.							
4.							
5.							
6.							

Guarantor (Parent Responsible for Payment) **Other Parent**

Full Legal Name _____ _____
Male or Female (circle one) Male or Female (circle one)
Birthdate _____ _____

Address _____ _____

City, State, Zip _____ _____

Home Phone ( ) _____ **( )** _____

Work Phone ( ) _____ **( )** _____

Cell Phone ( ) _____ **( )** _____

E-mail _____ _____

Employer _____ _____

Occupation _____ _____

Person Child Lives with _____

Emergency Contact _____ **Relationship**_____

Emergency Contact Phone ( ) _____ **Cell ( )** _____

Whom may we thank for referring you to our office? _____

Please list any person other than parents who are allowed to bring your child to the physician visit and whom you give permission to speak to the physician regarding your child's health.

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Guarantor/Patient Confidential Communication Preference (Example: Automated Appointment Reminders or Payment Reminder)

Circle one/or all **Text** **Email** **Telephone Call**

List the number and/or email _____

Authorization for Payment and Financial Responsibility (Please read and sign):

I agree to provide my insurance card at each visit and pay my co-pay/deductible. Co-payments, co-insurance, deductibles, and previous balances are due at the time of service by the parent who accompanies the child. I understand that fees for services rendered are my financial responsibility. I understand that unpaid claims that are not paid by my insurance company within 30 days from the date of service will be transferred to patient responsibility and will be due upon receipt of the statement. I also understand that balances for items that my insurance company deems as "non-covered services" or "not medically necessary" are also my financial responsibility. I understand that if my account is transferred to an outside collection agency I will be dismissed from the practice until the balance is paid in full. Furthermore, I understand that I will be responsible for all fees charged by the agency, including applicable attorney fees and court costs. Pediatric Associates of Franklin charges **$35.00** for a returned check. **We require a 24 hour cancellation notice to avoid any charges**. **A $30 missed appointment fee may be charged for appointments that are missed or not cancelled more than 24 hours before the scheduled appointment time.**

Authorization to Release Medical Information and Consent to Treatment:

I authorize the release of any medical records in accordance with HIPAA guidelines, via the fax, e-mail, and/or the United Postal Service including the diagnosis, treatment or examination rendered to my child during the period of treatment for the processing of insurance claims, or to satisfy requirements of managed care organizations of which I am a member. I assign to the physician or physician's group all payments for the medical services rendered to my child. I authorize Pediatric Associates of Franklin to leave or send appointment reminder messages on voicemail, text or email. I also authorize Pediatric Associates of Franklin to utilize any e-mail address that I provide to them as a form of communication. I understand that if I request any change in this information that I am responsible for notifying this office in writing of such request**. I consent to treatment of my child by the physicians of Pediatric Associates of Franklin. These policies supersede and replace any prior verbal or written published policies.**

Acknowledgement of Receipt of the Notice of Privacy Practice:

I acknowledge that I have been offered/received the Notice of Privacy Practices from Pediatric Associates of Franklin. This notice describes how this office may use and disclose my protected health information. I understand that I can obtain additional copies on the website at www.pediatricsoffranklin.com at any time or request that a copy be provided to me at any visit.

Normal Lab & Test Results Authorization:

I authorize for Pediatric Associates of Franklin to leave a message on my voice mail/answering machine that my child's test results are normal. I understand that the actual test results will not be left on the message just that they are normal. If you elect not to authorize this then please notify the Nurse so it can be noted on your child's chart.

I understand that by signing below, I, as the parent/guardian authorize and agree to the terms indicated above.

_____ _____
Signature of parent/guardian **Date**

_____
Signature of PAF Witness