pediatric associates
OF FRANKLIN

Initials: _____

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/Female/decline to answer (circle one) Male/Female/decline to answer (circle one)
Birthdate _____ _____

Address _____ _____

City, State, Zip _____ _____

Home Phone ( ) _____ ( ) _____

Work Phone ( ) _____ ( ) _____

Cell Phone ( ) _____ ( ) _____

E-mail _____ _____

Employer _____ _____

Occupation _____ _____

Person Child Lives with _____

Emergency Contact _____ **Relationship** _____
(Other than a Parent)
Emergency Contact Phone ( ) _____ **Cell** ( ) _____

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

Please Complete Back Side and Sign ***Over***

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

Cell Phone Number for Texting: _____
E-mail Address: _____

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 accompanying the child. I understand that fees for services rendered are my financial responsibility. I understand that unpaid claims not paid by my insurance company within 30 days of service will be transferred to the patient's 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. Considering services rendered, I agree to pay all charges incurred for my account as the patient and/or responsible party. If I default in the obligation of payment to my provider, I understand that my account(s) can be placed with a collection agency or attorney for collection. I further agree to pay reasonable attorney fees, collection, and court costs if my account(s) is placed for legal or third-party collection action. ***A 30% fee will be added to all accounts placed with a collection agency.*** 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. Pediatric Associates of Franklin charges **$35.00** for a returned check. **We require a 24-hour cancellation notice to avoid any charges**. **A $75 missed appointment fee may be charged for missed appointments or not canceled 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 by HIPAA guidelines via fax, e-mail, and/or the United Postal Service. Including the diagnosis, treatment, or examination rendered to my child during the treatment period to process insurance claims or to satisfy the requirements of managed care organizations that I am a member. I assign all payments for the medical services rendered to my child to the physician or physician's group. 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 I provide them as a form of communication. I understand that if I request any change in this information, I am responsible for notifying this office in writing of such a request. **I consent to my child's treatment by the Pediatric Associates of Franklin physicians. These policies supersede and replace any prior verbal or written published policies.**

Acknowledgment of Receipt of the Notice of Privacy Practices:

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 Pediatric Associates of Franklin to leave a message on my voicemail/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, please notify the Nurse to note it on your child's chart.

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

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

_____

Signature of PAF Witness

Lk/2023