Smyrna Pediatrics

Chart #_____

Patient Update Form

*** **REFUSAL TO VACCINATE:** We are not accepting any families that do not vaccinate.
Please return to the front desk to cancel this appointment

Patient Information

Child's Name : _____ DOB: _____ SSN : _____ M or F

Parent's Contact Phone #'s: _____
Home Phone Work Phone Cell Phone

Address:_____ City:_____ State:_____ ZIP:_____

Patient Portal Access Email Address:_____ (This information is **required** for Patient Portal use.)

Primary Insurance Information

- ☐ Commercial/Employer Health Insurance: BCBS CIGNA AETNA UHC Other: _____
- ☐ Medicaid/Tenn Care: BlueCare TnCare Select AmeriGroup UHC Comm Plan
- ☐ Insured's Name: _____ Employer: _____
  Insured's DOB: _____ SSN: _____ Relationship to Patient: _____

- ○ Self-Pay (Payment is expected at the time services are rendered. CASH OR CREDIT/DEBIT CARD ONLY!)

Secondary Insurance Information

- ☐ Commercial/Employer Health Insurance: BCBS CIGNA AETNA UHC Other: _____
- ☐ Medicaid/Tenn Care: BlueCare TnCare Select AmeriGroup UHC Comm Plan

Parent/Caregiver's Information

Parent/Caregiver #1: _____ Relationship: _____
DOB: _____ SSN : _____
Parent/Caregiver #2: _____ Relationship: _____
DOB: _____ SSN : _____
Alternate Phone Number(s): _____

Emergency Contact In the event that we cannot reach you at the numbers above, list someone not living with you that we may contact?
Name: _____ Relationship:_____ Phone #: _____

This signature authorizes Smyrna Pediatrics, PLLC and any/all of its medical providers to treat your child and file appropriate insurance and/or Medicaid claims. It also requests payment of such claims to be made directly to Smyrna Pediatrics, PLLC and/or the provider of service. Should your account be referred to an outside collection agency, you will be responsible for a 30% collection fee.

If at any time, I provide a wireless telephone number and/or my e-mail address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing, and payment for items and services, unless I notify the office/entity to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

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Parent/Caregiver Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I have reviewed the **Notice of Privacy Practices** of SmyrnaPediatrics, PLLC, detailing how my (child's) information may be used and disclosed as permitted under federal and state law. I understand the content of the Notice and I request specific restriction(s) concerning the use of my (child's) personal medical information. ***PLEASE LIST ANY SPECIFIC RESTRICTIONS ON THIS PATIENT'S PROTECTED HEALTH INFORMATION ON THE LINES BELOW.***

I DO NOT require a copy of Privacy Practices at this time. Please initial X _____

I WOULD LIKE to have a copy of the Notice of Privacy Practices for this office. Please initial X _____

IMMUNIZATION RECORD SHARING

Our Electronic Medical Records (EMR) system can automatically share your child's immunizations with the State of Tennessee via TennIIS Exchange Database. TennIIS is an online database by which the State of Tennessee tracks your child's immunizations. This vaccine record will be available to any participating provider. **It will also help to keep your child's vaccine record currently updated**.

I **DO NOT** WANT MY CHILDS IMMUNIZATIONS SHARED ON THIS DATABASE. Please initial X _____

I **CONSENT** to having immunization information released to the State Registry. Please initial X _____

RESTRICTIONS: Please list any RESTRICTIONS of information about this child. This may include other people/family members that should not be given information about the patient: _____

_____

APPROVALS: Please list any other people and/or family members that are authorized to seek medical attention, pick up prescriptions, or receive info for your child at Smyrna Pediatrics:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient:_____

Information Regarding Insurance and Billing

1. It is the ultimate responsibility of the subscriber to understand his/her insurance benefits. If you are not sure if a service or treatment is covered, you should contact your insurance carrier. We do not provide *exhaustive* information about co-payment, co-insurance or deductibles. If our electronic verification of benefits indicates a co-payment, that amount will be requested at the time of the patient's visit. If there is any additional balance due, you will receive a bill from the Company.
2. Your co-payment is due (according to your insurance benefits) at each visit while you are in the office. We accept cash, Visa, Mastercard, American Express.
3. Delinquent accounts may be placed with an outside collection agency or put through a small claims court. If your unpaid balance is remanded to an external collection agency, 30% collection costs will be added to your balance due. If it becomes necessary to proceed to legal action, all legal costs will also be added to the total balance due.
4. We are a participating provider for many health insurance plans. This means we will file a claim for services we provide to you/your child(ren). You will be responsible for non-covered charges as indicated by your insurance carrier/plan. THIS IS INCLUDING charges denied due to lack of information that has been requested from the subscriber, such as coordination of benefits (COB or other insurance) information.
5. If we are NOT PARTICIPATING PROVIDERS for your insurance plan, payment will be expected when services are rendered. You will be given an estimate of charges when we learn that the visit will be SELF-PAY and PAYMENT IN FULL will be expected when services are rendered. We will give you an itemized statement (upon request) so that you may file your insurance carrier directly for reimbursement.
6. All insured patients must present their insurance ID card(s) at the time of check-in. If you do not have your insurance ID cards or provide other means (SS#) for us to verify coverage, you will be asked to pay for your visit at the SELF-PAY rates.
7. If ALL active insurance policies are not presented at the time services are provided; rendering us unable to bill a subsequent insurance, you may become liable for the outstanding balance.
8. Some lab specimens (blood, urine, other cultures) are sent to an outside facility for testing. Additional lab charges will be incurred for this testing.

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9. The fees we charge for office visits, surgery, pathology/labs, and related services are set by Medicare and are closely followed by the insurance companies. We do not randomly choose a fee and must operate our business within the confines of this structured fee Schedule.
10. Any questions regarding your account should be addressed to the appropriate office personnel or Office Manager. The doctor(s) are not intimately involved in these administrative matters.

By signing (or e-signing) below, I certify that I have read the above information and any questions concerning these policies have been addressed. My signature also certifies my understanding and agreement with the above policies. I understand that I am responsible for all charges "not covered" by my insurance policy. A photocopy of this document is valid as the original. You may receive a copy of this document upon request.

Parent/Caregiver Signature:_____ Date: _____

Please note a few of our Office Policies regarding the most discussed topics in the practice:

Refusal to Vaccinate:

Initials: _____

As of January 1, 2018, we are no longer accepting new families that choose not to vaccinate their child(ren). At any point after establishing care with any provider at Smyrna Pediatrics, if you choose not to vaccinate your child(ren), termination of the family/physician relationship will occur.

Financial Responsibilities:

Initials: _____

Once you have been made aware of a balance owed on your child's/family's account, and it **remains UNPAID**, we reserve the right to **postpone well-child visits until the balance is either**:

1) Paid in full
2) Payment arrangements are agreed upon in writing **AND** consistent payments are being made.
3) In the event that a balance remains unpaid for **more than 4 months** without consistent payments being made – the entire account may be referred to an outside collection company and a 30% fee will be added to the balance. This also results in termination of patient/physician relationship.
4) In the event that a **NON-CUSTODIAL PARENT** has financial responsibility for medical care:

- Co-Pays are still **due at the time of service**. Please be prepared to fulfill this responsibility.
- Any outstanding balances will follow the same rules as listed above.
- We will not bill the non-custodial parent for any amount without their written consent.

Late Arrival:

Initials: _____

As of April 1st, 2020 we will not allow patients to be late for their scheduled appointment, you may be asked to reschedule. If this happens, you will be given the next available appointment time which may not be until the next business day. If you see that you are going to be late, please call ahead to see if a reschedule is necessary.

No-Shows:

Initials: _____

We understand that sometimes circumstances arise that are beyond your control and you may fail to keep a scheduled appointment. When this happens, PLEASE CALL the office to reschedule AS SOON AS POSSIBLE. When you do not call to cancel/reschedule and thus 'no-show' your appointment, that time is wasted and could have been utilized by another patient.

*****After three (3) no-show appointments, you may be dismissed from the practice or a $25 no-show fee for each missed appointment after the third missed appointment.**

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Office Hours:

Initials: _____

* We close for lunch daily between 12:00pm and 1:00pm. Phones are not answered during this time.
* In the event of inclement weather, we may be forced to close the office without notice. You will be notified by phone at the number we have on file. Please update your information as it changes.

**These policies may be updated without notice. Changes to this document will be made as soon as possible.