SODDY DAISY FAMILY CARE

9089 DAYTON PIKE
SODDY DAISY, TN 37379
PHONE: 423-452-0623 FAX: 423-452-0624

PATIENT INFORMATION:

LAST NAME: ______________ FIRST NAME: ______________ MI: __________

NICK NAME: ______________ DATE OF BIRTH: ______________

STREET ADDRESS: ______________________________

CITY: ______________ STATE: ______________ ZIP: __________

HOME: (____) ______________ CELL: (____) ______________

Email Address: ______________________________

SS#: ______-______-______ GENDER: MALE ______ FEMALE ______

PRIMARY INSURANCE:

COMPANY: ______________________________

ID#: ______________________ GROUP#: ______________

INSURED NAME: ______________ RELATIONSHIP: ______________

INSURED MAILING ADDRESS: ______________________

CITY: ______________ STATE: ______________ ZIP: __________

INSURED SS#: ______________ DATE OF BIRTH: ______________

SECONDARY INSURANCE:

COMPANY: ______________________________

ID#: ______________________ GROUP#: ______________

INSURED NAME: ______________ RELATIONSHIP: ______________

INSURED MAILING ADDRESS: ______________________

CITY: ______________ STATE: ______________ ZIP: __________

INSURED SS#: ______________ DATE OF BIRTH: ______________

PHARMACY NAME: ______________________

PHONE#: (____) ______________

ADDRESS: ______________________ CITY: ______________ ZIP: __________

NAME OF SCHOOL OR DAYCARE*: ______________________

*(if child in school)

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PATIENT NAME: ______________________________

LEGAL GUARDIAN(S) INFO (WHO HAS LEGAL CUSTODY OF CHILD)

LAST NAME: ____________________ FIRST NAME ______________ MI: ______

SS#: ______-__________-__________ DATE OF BIRTH: ________________

HOME PHONE: (____) ______________ CELL PHONE: (____) ______________

ADDRESS (IF DIFFERENT THAN PATIENT) ______________________________

CITY: ____________________ STATE: ______________ ZIP: __________

LAST NAME: ____________________ FIRST NAME: ________________

SS#: ______-__________-__________ DATE OF BIRTH: ________________

HOME PHONE: (____) ______________ leave message: ___ yes ___ no

CELL PHONE: (____) ______________ leave message: ___ yes ___ no

PRIMARY EMAIL ADDRESS: ______________________________

ADDRESS (IF DIFFERENT THAN PARENTS) ______________________________

CITY: ____________________ STATE: ______________ ZIP: __________

Consent to Treat

The undersigned hereby consents to basic medical treatment which may include strep, flu, RSV, routine blood work, hem occults, eye staining, and urine by Soddy Daisy Family Care. By signing this form, I give Soddy Daisy Family Care permission to access my pharmacy record. This consent is continuing in nature and does not need to be signed with each treatment. This may be revoked at any time by providing written notice to Soddy Daisy Family Care. I have received a copy of the privacy and office policy. I have read and agree with the privacy and office policy. I acknowledge that no guarantees have been made as to the effect of such treatment.

Assignment of Benefits

I hereby authorize Soddy Daisy Family Care to bill and receive direct payment of medical benefits for services rendered. I understand that the payment of changes incurred in this office is due at the time of service. I understand that I am financially responsible for any balance not covered by my insurance. It is my responsibility to check my account for balances left to me by my insurance. If this account is turned over to a collection agency I agree to be responsible for all cost of collection including late fee, attorney's fee, cost of collection fees and all court costs if any.

Authorization to Release of Medical Information

I hereby authorize Soddy Daisy Family Care release any medical information that may be necessary for medical care or to process insurance claims.

Photo Identification

I agree to have my/my child's photo and a copy of my photo I'D taken. I understand that this will be put into my/my child's chart for identification purposes only. I understand that my/my child's photo will not be shared with anyone outside of this office. I know that anytime I can request that the photo be removed by providing a written notice to Soddy Daisy Family Care.

This authorization shall be in force and effect until the patient transfers out of our practice, at which time this authorization to use and disclose this PHI information expires.

______________________________ ______________________

Signature of Patient/ Responsible Person **Date**

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H.I.P.A.A.

CONSENT TO TREATMENT OF PATIENT OR A MINOR WHEN PARENT/GUARDIAN ARE NOT AVAILABLE

The undersigned parent or legal guardian of ________________DOB:________________
(patient/child's name) (patient/child's birth date)
Authorizes the person(s) listed below to consent to treatment of the patient/child,including, but not limited to, emergency, x-rays,anesthetic,surgical services,medical or billing information,pick up prescriptions) when I am not immediately available in person,or by a telephone call.

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the patient/child even when the parent or guardian is not present.

1.Person(s) who may bring the patient/child to the office to be seen or to discuss any medical information including appointments (please print):
The doctor will not discuss any other health conditions with this person

Name of Person	Phone Number	Relationship

2. Person(s)who may have complete access to patient/child's health information(please print):
The doctor will discuss all/any health problems with this person including all test results

Name of Person	Phone Number	Relationship

We ask that if you have any changes in this request,that you please inform the receptionist.
I understand that Soddy Daisy Family Care will ask for identification of the person picking up patient information, prescription or products on behalf of the patient/child.

May we leave appointment information on:

Home:_________Yes_________No

Work:_________ Yes_________No

Other:_________Yes_________No

Name of Patient or Legal Guardian:___________________

Relationship to Patient/Child:______________________

Address:_________________City:________________State:_______________________

Signature:___________________Date:________________

FERPA/HIPPA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS AND SCHOOL

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal Laws (including HIPPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: ____ ____/____/____

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers): SODDY DAISY FAMILY CARE to provide health information from the above-named child's medical record to and from:

________________________________ ________________________________

Name of School Address/ City and State/ Zip Code

________________________________ ________________________________

Contact Person at School Area Code and Telephone Number

The Disclosure of health information is required for the following purpose:

____

Requested information shall be limited to the following:

- ☐ All minimum necessary health information; or
- ☐ Disease-specific information as described:

____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _______ (enter date) or for One year from the date of signature, if no date entered.

RESTRICTIONS

Law prohibits the Requestor from making further disclosure of mu health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOU'RE RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and deliver3ed to the school district/ health care agencies/persons listed above. My revocation will be effective upon receipt, but will be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District of the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

________________________ ________________________ ________________

Printed Name Signature Date

________________________________ ________________________________

Relationship to Patient/Student Area Code and Telephone Number

SODDY DAISY FAMILY CARE
9089 DAYTON PIKE
SODDY DAISY, TN 37379
PHONE: 423-451-0623 FAX: 423-451-0264

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of privacy Practices from time to time and that I may contract this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: ______________________________

Signature: ____

Date: ______________________

PRACTICE USE ONLY

I attempted to obtain the [patient's signature in acknowledge of the Notice of Practice Practices Acknowledgement but was unable to do so as documented below:

Date: _________ Initial's: _____________ Reason: ____________________________

Soddy Daisy Family Care

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Please update the following information. Updated information is needed in order to confirm appointments, reschedule appointments, and contact you regarding the patient. No spam is ever sent through email. The following information will be used for office purposes only.

Patient's Name: ______________________________

Date of Birth: ______________________________

Parent/Guardian's Home Number: ______________________________

Parent/Guardian's Work Number: ______________________________

Parent/Guardian's Cell Phone Number: ______________________________

Parent/Guardian's Email Address: ______________________________

May we leave appointment information on:

Home: ____ Yes ____ No

Work: ____ Yes ____ No

Cell: ____ Yes ____ No

Name of parent or legal guardian: ______________________________

Relationship to child: ______________________________

Signature: ______________________ Date: ______________________

Family History		Soddy Dasiy Family Care								
		9089 Dayton Pike								
		Soddy Daisy Tn 37379								
Name: ____________________				DOB: __________						
		MOM	DAD	Brother	Sister	Gfather	Gmother	Aunt	Uncle	Cousin
Name of Person										
Alive or Deceased										
DOB:										
Allergy										
Asthma										
Eczema										
Psoriasis										
Cystic Fibrosis										
Stomach Probles										
Acid Reflux										
Ulcerative Colitis										
Diabetes										
Anemia										
Heart Disease										
Hig Blood Pressure										
Cholesterol										
Sudden Death										
Epilepsy/Seizure										
Migraines										
Brain Aneurysm										
Mental Retardation										
Aids/HIV										
Stroke										
Muscle Dystrophy										
Arthritis										
Tuberculosis										
Early Deafness										
Vision Problems										
Behavioral Problems										
Alcoholism										
Drug Problems										
If yes to the following, Please specify what type:										
Thyroid Problems										
Blood Disorder										
Cancer										
Birth Defect										
Any Syndromes										
Other										

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you to our general Patient Consent Form. On occasion, the patient and the practice may want to use PHI for reasons other than treatment, payment, health care operations. This form summaries the anticipated use of information about you for which this authorization is required. The practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Please release medical records on the patient listed below:

To: Soddy Daisy Family Care 9089 Dayton Pike Soddy Daisy, TN 37379

From: ________________________________

Address: ______________________________

Phone: ____________________ Fax: ___________________

Patient Name: ______________________ DOB: ______________

What is to be released? ___ all medical records ___ Specific Date(s) _______
The Medical Record Information will be used and/or disclosed for the following purposes:
X Change of Primary Physician

Expiration date of this authorization: ___________________

The above mentioned protected health information may be subject to disclosure by the party receiving the information and may no longer be protected by the privacy rules.
By signing this form, you authorize the Practice to use and disclosure protected health information about you for the reasons mentioned above. You have right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of Soddy Daisy Family Care.

This Authorization was signed by: ________________________________
Print Name-Parent, Guardian or Patient

Relationship to Patient (if other than patient): _______________________

Signature: ________________________ Date: ____________________

I understand that by forwarding my records to another primary care physician, this will end my relationship with Soddy Daisy Family Care as a patient and that I may not be allowed to return to this practice.