Soddy Daisy Family Care
9089 Dayton Pike
Soddy Daisy, TN 37379
Phone:423-451-0622 Fax: 423-451-0624

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security: _____

Address: _____

Apt_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Leave message: Yes / No

Email: _____Mother's Maiden Name: _____

Sex: ◯ Female ◯ Male

Race: ◯ American Indian/Alaska Native ◯ Asian ◯ Native Hawaiian/Pacific Islander ◯ Black/African American

◯ White ◯ Hispanic ◯ Other _____

Language: ◯ English ◯ Spanish ◯ Indian: Hindi, etc. ◯ Chinese ◯ Korean ◯ Other_____

Ethnicity: ◯ Hispanic or Latino ◯ Non-Hispanic or Latino

PRIMARY INSURANCE:

Company: _____

ID#: _____Group#: _____

Insured Name: _____Relationship: _____

Insured DOB: _____Insured SS#: _____

Insured Mailing Address (If different from patient)_____

City, State and Zip:_____

SECONDARY INSURANCE:

Company: _____

ID#: _____Group#:_____

Insured Name:_____Relationship:_____

Insured DOB:_____ Insured SS#: _____

PHARMACY NAME:_____

Phone:_____ Address:_____

City:_____ Zip:_____

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Patient Name(s):_____

PARENT(S) OR LEGAL GUADIAN(S) INFORMATION (WHO HAS LEGAL CUSTODY OF PATIENT)

Last Name:_____ First Name:_____ MI:_____

SS#_____ Date of Birth: _____

Relationship to Patient: _____ Court Paper Involved ◯ Yes ◯ No

Home Phone: _____May we leave a message ◯ Yes ◯ No

Cell Phone: _____May we leave a message ◯ Yes ◯ No

If different for patient Address: _____

City, State and Zip: _____

Other Parent or Gaudian Information

Last Name:_____ First Name:_____ MI:_____

SS#_____ Date of Birth: _____

Relationship to Patient: _____ Court Paper Involved ◯ Yes ◯ No

Home Phone: _____May we leave a message ◯ Yes ◯ No

Cell Phone: _____May we leave a message ◯ Yes ◯ No

If different for patient Address: _____

City, State and Zip: _____

Consent to Treat

The undersigned hereby consents to basic medical treatment which may include strep, flu, RSV, ear cleaning, tymp, routine bloodwork, hemoccult, eye staining, urine, ECG, Spirometry test by Soddy Daisy Family Care. By signing this form, I also give Soddy Daisy Family Care permission to access my pharmacy records. 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 fees, attorney's fee, cost of collection fees and all court costs if any.

Photo Identification

I agree to have my/my child's photo and a copy of my photo ID 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 the 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 or Responsible Party Date

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H.I.P.A.A FORM

CONTSENT 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 birthdate)

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.

Person(s) who may bring the patient/child to the office to be seen (please print): Check one below

Name of Person	**Relationship**	**Phone Number**
_____	_____	_____

Per visit- Dr. not discuss any other health condition out of the visit they are here for. ◯ Only Per visit access
Whole Chart- Dr. will be allow to discuss any or all health conditions with this person. ◯ Access to whole chart

Name of Person	**Relationship**	**Phone Number**
_____	_____	_____

◯ Only Per visit access ◯ Access to whole chart

Name of Person	**Relationship**	**Phone Number**
_____	_____	_____

◯ Only Per visit access ◯ Access to whole chart

Name of Person	**Relationship**	**Phone Number**
_____	_____	_____

◯ Only Per visit access ◯ Access to whole chart

We ask that 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.

Name of Patient or Legal Guardian: _____ Relationship to Patient:_____

Signature: _____ Date:_____

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We are pleased that you have chosen Soddy Daisy Family Care as your healthcare provider. We have a code of medical practice that staff members follow. We recognize equal value of each individual we serve and we promise you will receive respectful and compassionate care.

Patient Rights

You, the patient have the right to:

- Competent, safe, respectful and dignified care
- Be informed of your condition
- Be involved in care planning and treatment
- Consent to all treatment
- Refuse treatment and drugs
- Get a second opinion
- Privacy in treatment and personal care
- Confidentiality including your records
- Review your records and have them explained to you by your physician
- Receive care in a safe setting
- Have your guardian exercise your rights when you are unable to do so or if you are a minor
- Access your health information

To help us keep our promises to you and to help with your care please:

- Cooperate to the best of your ability with your plan of care
- Provide honest and complete information about your health
- Keep you scheduled appointments
- Know that financial information may be required

The patient bill of rights is emphasized because we are dedicated to giving our patents the best care possible while protecting their dignity. If you feel that your or your child are not being treated fairly or properly you have the right to discuss this with the Doctor.

_____ _____

Signature of Patient or Responsible Party Date