"Where good health is home"

www.frontporchpediatrics.com

# Front Porch Pediatrics

Patient Information Form

**Patient Information:**

Child's Last Name: ______________________ First Name ____________________ Middle Name ________________

Date of Birth: _____/_____/________ Age ________ Male Female (circle one) SS# ______________________

Address: ____________________________________________________________________________
(Street) (City) (State) (Zip)

Phone (Include area code) Home: (_______) ___________________ Cell: (________) ______________________

Name of School ____________________________________________ Languages(s) ______________________

**Mother's Information:**

Name: __________________________________________ Social Security # ______________________

Address: ________________________________________ Date of Birth: _______/________/___________

City/State/Zip: ____________________________________ Home Phone: (_______) _________________

Employer: _______________________________________ Cell Phone: (_______) _________________

Work Phone: (_______) _____________________ Ext _________ E-Mail: ______________________________

**Father's Information:**

Name: __________________________________________ Social Security # ______________________

Address: ________________________________________ Date of Birth: _______/________/___________

City/State/Zip: ____________________________________ Home Phone: (_______) _________________

Employer: _______________________________________ Cell Phone: (_______) _________________

Work Phone: (_______) _____________________ Ext _________ E-Mail ______________________________

**Guardian's Information** (if different from Mother's or Father's Information)

Name: __________________________________________ Social Security # ______________________

Address: ________________________________________ Date of Birth: _______/________/___________

City/State/Zip: ____________________________________ Home Phone: (_______) _________________

Employer: _______________________________________ Cell Phone: (_______) _________________

Work Phone: (_______) _____________________ Ext _________ E-Mail ______________________________

**Emergency Contact** (other than parent or guardian)

Name: ______________________________________________

DOB: ______/______/______ Relationship to Patient ______________________

Phone: Home (_____) ______________________ Cell (_____) ______________________

Employer: ______________________ Work Phone (_____) ______________________

**Primary Insurance**

Carrier: ______________________________________________

Group # ______________________ Insurance ID #: ______________________

Name of Person Insured ______________________ Relation to Patient: ______________________

Insured Date of Birth: _____/_____/_____ Insured Social Security # ______________________

Insured Employer: ______________________________________________

**Secondary Insurance**

Carrier: ______________________________________________

Group # ______________________ Insurance ID #: ______________________

Name of Person Insured ______________________ Relation to Patient: ______________________

Insured Date of Birth: _____/_____/_____ Insured Social Security # ______________________

Insured Employer: ______________________________________________

Does your child participate in the "Reduced Lunch Program" at school? (circle one) Yes No

It is the policy of this office to keep all medical records confidential. There may be occasions when you need this information released to another office/person. Please answer the following questions and authorize us to give your confidential information in these situations:

1. May we leave your medication information, including lab tests, on an answering machine or give it to another person, such as a spouse, adult or caregiver? (circle one) Yes No
   a. Preferred way of contact: ______ phone ______e-mail
   b. Please list person(s) to whom we may give medical information: ______________________

   ______________________________________________

I, the undersigned, give my authorization to treat and assign directly to Front Porch Pediatrics, all medical benefits, if any otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges other or not paid for by insurance. I hereby authorize the physician to release all information necessary to secure payment of benefits and authorize the use of the signature on all insurance submissions. I authorize release of medical information for treatment.

I attest the above information is correct and complete to the best of my knowledge

SIGNATURE: ______________________________________________ DATE: _____/_____/_____

# Front Porch Pediatrics

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

**Purpose:** Front Porch Pediatrics follows the privacy practices described in this Notice. Front Porch Pediatrics maintains your health information in records that are kept in a confidential manner, as required by law. Front Porch Pediatrics must use and disclose or share your health information as necessary for treatment, payment, and health care operations to provide you with quality health care.

**What Are Treatment, Payment, and Health Care Operations?** Treatment includes sharing information among health care providers involved in your care. For example, your health care provider may share information about your condition with the pharmacist to discuss medications, or with radiologists or other consultants to make a diagnosis. Front Porch Pediatrics may use your health information as required by your insurer or HMO to obtain payment for your treatment. Front Porch Pediatrics may use and disclose your health information to improve the quality of care and for education and training purposes of faculty.

**How Will Front Porch Pediatrics Use and Disclose My Health Information?**
Your health information may be used for the following purposes unless you ask for restrictions on a specific use or disclosure:
*Note:* You will have the opportunity to refuse some of these communications about your health information indicated by (*).

Front Porch Pediatrics directories, which may include your name and general condition
Family members or close friends involved in your care or payment of treatment.*
Disaster relief agency if you are involved in a disaster relief effort.*
To inform you of treatment alternatives or benefits or services related to your health.*

- Appointment reminders.
- Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence.
- Health oversight activities, such as audits, inspections, investigations, and licensure.
- Law enforcement.
- Coroners, medical examiners, and funeral directors.
- Organ and tissue donation.
- Certain research projects.
- To prevent a serious threat to health or safety.
- To military command authorities if you are a member of the armed forces or a member of a foreign military authority.
- National security and intelligence activities to authorized persons to conduct special investigations.
- Workers' Compensation. Your medical information regarding benefits for work-related injuries and illnesses may be released as appropriate.

- Alcohol and drug abuse information has special privacy protections. Front Porch Pediatrics will not disclose information identifying an individual as a being a patient or provide any health information relating to the patient's substance abuse treatment unless the patient consents in writing; to carry out treatment, payment, and operations; or requires by law.
- To carry out health care treatment, payment, and operations functions through business associates, such as to install a new computer system.

**Your Authorization is Required for Other Disclosures.** Except as described above, we will not use or disclose your medical information, unless you allow Front Porch Pediatrics in writing to do so. For example, we will not use your photographs for presentations outside Front Porch Pediatrics without your written permission. You may withdraw or revoke your permission, which will be effective only after the date of your written withdrawal.

**You Have Rights Regarding Your Health Information.** You have the following rights regarding your medical information, if requested on the form(s) provided by Front Porch Pediatrics:

- Right to request restriction. You may request limitations on your health information that we use or disclose for health care treatment, payment, or operations, although we are not required to comply with your request. For example, you may ask us not to disclose that you have had a particular procedure. We will release the information if necessary for emergency treatment.
- Right to confidential communications. You may request communications of your health information in a certain way or at a certain location, but you must tell us how or where you wish to be contacted.
- Right to inspect and copy. You have the right to review and obtain a copy of your medical record. We may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed health care professional chosen by Front Porch Pediatrics. Front Porch Pediatrics will comply with the outcome of the review.
- Right to request amendment. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment on the form provided by Front Porch Pediatrics. Front Porch Pediatrics is not required to accept the amendment.

**Requirements regarding This Notice.** Front Porch Pediatrics is required by law to provide you with this Notice. We will comply with this Notice for as long as it is in effect. Front Porch Pediatrics may change this Notice, and these changes will be effective for health information we have about you, as well as any information we receive in the future.

**Complaints.** If you believe your privacy rights have been violated, you may file a complaint with Front Porch Pediatrics or with the Secretary of the United States Department of Health and Human Services. We will not penalize or retaliate against you in any way for making a complaint to the Department of Health and Human Services.

Front Porch Pediatrics, PLLC
6847 Mountain View Road
Ooltewah, TN 37363

## Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

The undersigned parent or legal guardian of ____________________ (Child's Name) authorizes the person(s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to ____________________ (Phone Number).

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 child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: ______________________ Relationship to Child: ____________ Phone: ______________

   Name: ______________________ Relationship to Child: ____________ Phone: ______________

   Name: ______________________ Relationship to Child: ____________ Phone: ______________

2. Medical concerns: ________________________________

3. Known allergies: ______________

Name of Parent or Legal Guardian: __________________________ (Print Name) Relationship to Child: ________________

Contact Number(s): ________________________________________________

Address: ____________________________________ City, State, Zip: ____________________________

Signature: ______________________________ Date: ______________

This Consent is effective until withdrawn in writing by the child's parent or guardian.

# Front Porch Pediatrics

## Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Front Porch Pediatrics maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and procedural information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Practices* for review that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information:

☐ I have read, have no additional restrictions, and I would like to be provided with a hard copy of the Notice of Privacy Practices.

☐ I have read, the notice of Privacy Practices, have no additional restrictions, and I do NOT require a printed hard copy

Date Notice Effective Date or Version ______________________________

_____Accepted _______ Denied

______________________________ ______________________________
Signature of Patient/Legal Representative Witness

____________________
Date

# Front Porch Pediatrics

General Consent For Treatment

The undersigned patient and/or responsible relative or person hereby consent to and authorize **Front Porch Pediatrics** physicians and medical personnel to administer and perform any and all medical examinations, treatments, designated procedures, vaccinations and immunizations against diseases which may be now or during the course of the patient's care as an outpatient be deemed advisable or necessary.

The undersigned also consents to the release of medical information to other institutions accepting the patient for medical care relative to continuity of care.

| ______________________ | ______________________ | __________ |
|---|---|---|
| Signature of Patient | Witness | Date |
| | | |
| Signature of Responsible Relation or Person | Witness | Date |

The undersigned consents to **Front Porch Pediatrics** contacting him/her if needed regarding appointments and follow-up needs, and understands that communications may not be 100% confidential or secure, intentionally or accidentally. I understand and consent to communications.

______________________ ______________________

Signature Witness

______________________

Phone Number

______________________

Date

# Front Porch Pediatrics

6847 Mountain View Road, Ooltewah TN 37363
PHONE: 423-910-1289

## POLICIES AND PROCEDURES

OFFICE HOURS: Monday-Friday 9am-5pm, CLOSED FOR LUNCH: 12:00-1:00pm
CLOSED: Saturday and Sunday

**Welcome to our practice and thank you** for choosing us as your child's healthcare provider. A goal of Front Porch Pediatrics is to provide high quality medical care to our patients. Policies and Procedures are provided to keep you better informed.

Please provide us with any previous medical records to ensure complete medical care

- At your initial visit and annually you will be asked to complete a patient information form. This form is to be updated when any changes occur to your insurance or your personal information.
- You will be asked to present your insurance card at each visit. If you do not have all the necessary information with you, you will be billed directly until you are able to provide all the required information.
- You need to supply your insurance carrier with any information they request. Claims are held from processing while your insurance carrier waits to hear from you.
- Please be aware that not all services are a covered benefit in all insurance contracts. You are responsible for knowing what services are covered under your insurance plan.
- If your plan requires a PCP to be listed, make sure you choose a physician. If one of the physicians of Front Porch Pediatrics is not chosen as your PCP, your insurance may deny your claim making you financially responsible.
- If we do not participate with your insurance carrier, payment in full is expected at the time of your visit.
- Failure to report any changes in your information may result in nonpayment from your insurance & you will be responsible for all bills.
- Co-payments are due at the time of services rendered. If you are unable to make your co-payment at this time, please reschedule your appointment for another time. **Please note:** if you are being seen for a well-child exam or annual physical and an acute problem is found and addressed during this visit, you may be charged a co-payment for the treatment of your acute problem by your insurance.
- As a courtesy to you, we will file your insurance claim for services rendered. If for any reason the claim remains unpaid after 6 months after the date of service you will be billed for the balance. It is your responsibility to collect any money that is owed to you from your insurance carrier.
- You must add your newborn to your insurance policy within the 30-day period required by most insurance carriers. If the child is not added within that time frame, you may have to wait for open enrollment, thereby leaving your child uninsured until that time.
- The person listed on your account is responsible for payment at the time of service. The parent or guardian will be billed for the services rendered.
- Our fee for returned checks is $25.00, if two returned checks are received within any period of time, we request that all future payments be paid with cash or credit cards.
- Our appointment times for physicals are limited, therefore we have an established fee for missed physical (well child) appointments. Our charge is $20 per child per missed appointment if the appointment is not cancelled within 24 hours. This fee cannot be billed to the insurance. Please call at least 24 hours prior to the scheduled appointment time to cancel. If we have closed for the day please leave a message. If you miss three appointments within a twelve-month period we reserve the right to dismiss the patient from our practice.
- We will complete one form (Head Start, sports physical, or school form, etc.) free of charge at the time of your visit. For any additional forms there will be a $5 fee. Please inform the nurse at the beginning of the visit that you need this done. Please get school or work excuses before leaving.
- There will be times when you have an appointment for a well child checkup and your child is sick. Your child will be seen for the sick visit and the well child checkup may be rescheduled. This is in accordance with federal insurance guidelines.
- After hours phone calls are handled by an answering service that will take urgent messages and will notify the physician on call. All non-urgent questions, please call during normal business hours. If it is a life-threatening emergency, please call 911.
- No prescriptions will be called in after hours or on weekends and no antibiotics or controlled medications will be called in without seeing the doctor. All refills must be requested at least 24 hours in advance (no exceptions)
- Copies of medical records will be available within 10 days of written request for a $20.00 copy fee.
- We firmly believe immunizations are one of the most important way parents can protect their children against serious infectious diseases. We strongly recommend following the guidelines of the American Academy of Pediatrics and the Center for Disease Control. In support of this belief, we have come to a decision that parents who disagree with these guidelines need to find care elsewhere.
- We reserve the right to change or amend these policies at any time without notice.

Please visit our website at www.frontporchpediatrics.com or ask the staff for a complete version of our office policies.

We look forward to being the medical home for your child. Thank you,

*The staff at Front Porch Pediatrics*

| ______________________________ | ______________________________ | ______________ |
|---|---|---|
| I HAVE READ AND UNDERSTAND THE POLICY ABOVE | FOR PATIENT (Please Print Patient Name) | DATE |

# Front Porch Pediatrics

Release of Information Request Form

Release To: Front Porch Pediatrics

Obtain from: ________________________________________

Address: ________________________________________

Re: Patient: ________________________________________

D.O.B: ______________ Last 4 digits of SS#: ____________

Stated purpose or need for release:

________________________________________________________

________________________________________________________

____________________________________________

Specific medical information to be released:

| | | |
|---|---|---|
| □Results of psychological testing | □Prognosis | □Diagnosis |
| □Disciplinary compliance | □Medication (s) | □Discharge summary |
| □Recommendations for treatment | □Physical status | □Legal information |
| □Results of medical testing/exam | □Laboratory reports | □Treatment plan |
| □Academic accommodations | □X-rays reports | □Immunizations |
| □Other: | | □ALL MEDICAL RECORDS |

I hereby authorize Front Porch Pediatrics to □ obtain/ □ release the above information regarding myself or my dependent, above named.

It is further understood that this release is subject to revocation at any time in writing, and unless otherwise specified hereinafter, automatically expires in 360 days from the signature date.

________________________ ________________________

Relationship to Patient Patient or Legal Guardian

________________________ ________________________

Date Witness

Please send correspondence to:
Front Porch Pediatrics
6847Mountain View Road
Ooltewah, TN 37363
Phone: 423-910-1289 Fax: 423-910-1260

# Front Porch Pediatrics

The undersigned patient and/or responsible guardian hereby consent to and authorize **Front Porch Pediatrics** to send SMS text or voice messaging regarding appointments.

Patient Name (Please print):

Signature of Patient (if 18 or older):

Date:

Signature of Guardian (if patient under 18):

Date: