KIDS KARE
PEDIATRICS

758 South Willow Avenue • Cookeville, TN 38501
Phone (931) 526-6173 • Fax (931) 526-5084
Email: kidskare@kidskare.biz
Website: www.tnkidskare.net

PREFERRED PROVIDER: ____________________

PATIENT'S NAME ______________________________ GENDER: MALE ☐ FEMALE ☐

ADDRESS ______________________________
STREET CITY STATE ZIP

SS# ____/____/____ DATE OF BIRTH ____/____/____ PHONE#:( ) ____________

ETHNICITY: ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Decline to answer Primary Language: ____________

RACE: ☐ Am. Indian/Alaska Native ☐ Asian ☐ African American/Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Decline to answer

MOTHER'S NAME/GUARDIAN ____________________ DATE OF BIRTH ____ / ____ / ____

ADDRESS(if different than child's) ______________________________

CELL PHONE (____) ____________ *(may receive text messages)* HOME/WORK PHONE (____) ____________

EMAIL ______________________________ SS# ____________
**** VERY IMPORTANT - Required to access patient portal!***

FATHER'S NAME/GUARDIAN ____________________ DATE OF BIRTH ____ / ____ / ____

ADDRESS(if different than child's) ______________________________

CELL PHONE (____) ____________ *(may receive text messages)* HOME/WORK PHONE (____) ____________

EMAIL ______________________________ SS# ____________
**** VERY IMPORTANT - Required to access patient portal!***

PREFERRED CONTACT METHOD FOR RECALLS? ☐ TEXT TO CELL ☐ EMAIL ☐ PHONE CALL ☐ MAIL
PREFERRED CONTACT METHOD FOR GENERAL ISSUES? ☐ TEXT TO CELL ☐ EMAIL ☐ PHONE CALL ☐ MAIL
PREFERRED CONTACT METHOD FOR REMINDERS? ☐ TEXT TO CELL ☐ EMAIL ☐ PHONE CALL ☐ MAIL

PERSON RESPONSIBLE FOR ACCOUNT ______________________________

WHO REFERRED YOU TO OUR OFFICE? ______________________________

PRIMARY INSURANCE ____________________ SECONDARY INSURANCE ____________________

ALL PATIENTS CHECKING IN FOR APPOINTMENTS WILL BE REQUIRED TO SHOW THEIR VALID HEALTH INSURANCE CARD TO OUR FRONT DESK STAFF BEFORE BEING SEEN BY OUR NURSES OR PROVIDERS.
IF YOU DO NOT HAVE ANY INSURANCE, YOU WILL BE RESPONSIBLE FOR PAYING AT THE TIME OF SERVICE.

ASSIGNMENT AND RELEASE

I, the guardian or parent, agree that the above information is true to the best of my knowledge. I authorize the physicians of Kids Kare Pediatrics to provide myself or my child with reasonable and proper care according to today's standards. I authorize the release of any medical information necessary to process an insurance claim. I also authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I understand they have the right to refuse or accept assignment of such benefits. If these benefits are not assigned to this office, I agree to forward the clinic all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt. I understand that I am financially responsible for all charges even though insurance may be pending on all or a portion of the charges. I authorize the use of this signature on all insurance submissions.

____________________ ____________________ ____________
RESPONSIBLE PARTY'S SIGNATURE RELATIONSHIP TO PATIENT DATE

EMERGENCY CONTACT PERSON (not parents of patient): ______________________________

PHONE:(______) ____________ RELATIONSHIP TO PATIENT ____________

Kids Kare Pediatrics

Cookeville, TN 38501, Tel. no. (931) 526-6173

BIRTH & FAMILY MEDICAL HISTORY

Child's Name ________________________ **DOB:** ____________ **Sex:** ______

Pregnancy and Birth of Patient: (pls. encircle one)

Were there any illnesses or complications during pregnancy with this child?	Yes	No	Don't know
Was the baby born premature? ____________________	Yes	No	Don't know
Were there any problems during labor and delivery? ____________	Yes	No	Don't know
Were there any problems with the baby at birth? ____________	Yes	No	Don't know
Were there any problems during the first week of life? ____________	Yes	No	Don't know

Family Medical History: (pls. encircle one)

Are the parents related other than by marriage? ____________	Yes	No	Don't know
Have any of this child's brothers or sisters died? ____________	Yes	No	Don't know
Have any of this child's brothers and sisters had serious health problems? __	Yes	No	Don't know

List Diseases That Run in the Family:

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

5. ____________________ 6. ____________________

Child's History:

Illnesses: ____

Hospitalizations: ____

Surgeries: ____

Is he/she presently taking any medications or drugs? Yes No (pls. encircle one)

Are you aware of any ALLERGIES? Yes No

Has he/she ever had a convulsion? Yes No

Are there any vaccines or shots that still haven't been given? Yes No

If there are any "YES" answers to any of the questions above, please provide a brief explanation here:

____

____

____

Thank you.

Kids Kare Pediatrics

Practice Policies

Financial Responsibility

Please read the following very carefully, then sign and date below:

- I understand that co-pays and balances or deductibles are due at the time-of-service **Failure to settle them will result in rescheduling my appointment or refusal by practice to see the patient.**
- I understand that, as a courtesy, Kids Kare will attempt to verify my insurance coverage based on information that I provide.
- I understand that it is my responsibility to confirm which treatments or procedures are covered and/or paid by my insurance including but not limited to, any applicable exclusions, deductibles, and annual to lifetime maximums.
- I understand that although I pay my estimated patient responsibility on the date of service, the estimated balance due to Kids Kare may differ from what my insurance carrier ultimately pays them. I will therefore be responsible for any amounts not paid by my insurance for any reason, and that I may receive a bill/statement for a balance due which will immediately be payable upon receipt.
- I understand that unless patient records are sent directly to another provide, the charge for copies of medical records is $20.00 for the first 5 pages and 50 cents per page thereafter or $20.00 for a USB drive.

No Show Policy

Not showing up for appointments limit our ability to provide quality and timely service to your child(ren) and also limits other patients from access to medical care. Scheduled appointments that are cancelled within two (2) hours of appointment time or arriving more than 15 minutes late will also be considered No-shows.

The 15 minute late policy does not apply to the last appointment before lunch, or the last appointment before the end of the day. THOSE APPOINTMENTS MUST BE ON TIME.

Patients who fail or no-show two (2) or more appointments with our office, or no-show referrals placed by our office will be notified and will be placed on probation.

After three (3) or more no-shows or failed referral appointments, patient will be terminated from our office.

We request that you call us as early as possible when you know you cannot make it your appointment. And please keep our front office updated with your most current contact information to avoid missing out on future appointment reminders.

____

Patient Name (please print) Patient's date of birth

____

Signature of Parent or authorized guardian **TODAY'S DATE**

Kids Kare Pediatrics

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I HEREBY GIVE MY CONSENT FOR KIDS KARE PEDIATRICS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME OR MY CHILD TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO). PLEASE REFER TO KIDS KARE'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURE.

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. KIDS KARE RESERVES THE RIGHT TO REVISE ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. A REVISED NOTICE OF PRIVACY PRACTICES MAY BE OBTAINED BY FORWARDING A WRITTEN REQUEST TO KIDS KARE PRIVACY OFFICER AT 758 SOUTH WILLOW AVENUE, COOKEVILLE TN 38501.

WITH MY CONSENT, KIDS KARE MAY CALL MY HOME OR OTHER DESIGNATED LOCATION AND LEAVE A MESSAGE ON VOICEMAIL OR IN PERSON IN REFERENCE TO ANY ITEMS THAT ASSIST THE PRACTICE IN CARRYING OUR TPO, SUCH AS APPOINTMENT REMINDERS, INSURANCE ITEMS AND ANY CALL PERTAINING TO MY OR MY CHILD'S CLINICAL CARE, INCLUDING LABORATORY TEST RESULTS, AMONG OTHERS.

WITH MY CONSENT, KIDS KARE MAY MAIL OR EMAIL TO MY HOME OR OTHER DESIGNATED LOCATIONS ANY ITEM THAT ASSISTS THE PRACTICE IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDER CARDS AND PATIENT STATEMENTS. I HAVE THE RIGHT TO REQUEST THAT KIDS KARE RESTRICT HOW IT USES OR DISCLOSES MY PHI TO CARRY OUT TPO.

BY SIGNING THIS FORM, I AM CONSENTING TO KIDS KARE'S USE AND DISCLOSURE OF MY PHI TO CARRY OUT TPO.

I MAY REVOKE MY CONSENT IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ALREADY MADE DISCLOSURES IN RELIANCE UPON MY PRIOR CONSENT. IF I DO NOT SIGN THIS DOCUMENT, KIDS KARE MAY DECLINE TO PROVIDE TREATMENT TO ME OR MY CHILD.

______________________________	______________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN	TODAY'S DATE
______________________________	______________
PRINT PATIENT'S NAME	DATE OF BIRTH
______________________________	______________
PRINTED NAME OF LEGAL GUARDIAN	RELATIONSHIP TO PATIENT

PATIENT/GUARDIAN MUST BE PROVIDED WITH A SIGNED COPY OF THIS AUTHORIZATION FORM.

758 South Willow Avenue, Cookeville, TN 38501, Phone No. (931)526-6173

AUTHORIZATION BY PARENT OR LEGAL GUARDIAN TO BRING CHILD TO HEALTHCARE PROVIDER

I/We authorize the following person/s to bring my child/children to the doctor's office for medical treatment.

PERSON'S NAME	RELATIONSHIP TO CHILD
____________________	____________________
____________________	____________________
____________________	____________________

Listed are the names of my children

NAME OF CHILD/CHILDREN:	DATE OF BIRTH:
____________________	____________________
____________________	____________________
____________________	____________________

INFORMED CONSENT FOR TELEMEDICINE/TELEHEALTH

Patient understands and consents:

1. **My child's healthcare provider will be providing telemedicine/telehealth visits to my child/children.**
2. **All releases, assignments, history, privacy, and other forms that I have previously signed for Kids Kare Pediatrics applies to this visit by telemedicine technology.**
3. **That all medical conditions are not appropriate for telehealth visits. My provider may withdraw from providing services if a determination is made in the provider's best medical judgment that treatment can no longer be safe, private or effective through telemedicine. In that event, the provider can instruct me to seek in-person care from this or another provider and I agree to follow such recommendation, especially if I require emergency care.**
4. **That this telemedicine visit will be filed to my insurance plan. However, in the event that the insurance denies the claim, or there is patient responsibility such as deductible, co-pay or coinsurance, I will be held financially responsible for all services rendered to me by my provider.**

____________________	____________________
Signature parent or legal guardian	**Relationship to child/children**

____

Today's Date

KIDS KARE
PEDIATRICS

Authorization to Release Medical Records / Information

Patient's Name: ______________________________ **DOB:** ____________________

Release Records to/ from: ____

____

PLEASE MAIL, FAX OR EMAIL MEDICAL RECORDS TO:

Kids Kare Pediatrics
758 South Willow Ave.
Cookeville, TN 38501
Phone: (931) 526-6173 Fax: (931) 526-5084
Email: kidskare@kidskare.biz

Please release the selected records:

1. Records generated by this facility ONLY (excluding records from other sources) ☐
2. ONLY Portions of Records maintained at this facility (specify dates or illnesses below) ☐
   ____
3. All medical records at this facility ☐

Please provide reason for authorization: ______________________________

If this authorization is for the purpose of transferring the care of your child(ren) and medical records to another Primary Care provider, please understand that there will be a moratorium of 3 years if you decide to return to our practice in the near future, unless it is for the following reasons: 1) Moving to another state 2) Moving to another location more than 1 hour away 3) To see a specialist 4) to submit records to the school or health Dept. 5) All other reasons other than transfer of care.

PLEASE SIGN AND DATE TO INDICATE YOU UNDERSTAND ABOVE CONDITIONS:

____________________	____________________	____________
Parent's or Guardian's name	Parent's or Guardian's signature	Date:

If there are certain portions of your medical records you do not want to release, please read this section carefully and check the box(es) next to the records **you do not want released.** They will be excluded from the selected records above.

☐ Substance abuse, if any

☐ Psychological conditions, if any

☐ AIDS / HIV, if any

☐ Others (please specify) ______________________________

Expiration of authorization: ____________________

Revocation of authorization: I understand that I may revoke this authorization at any time before the transfer. is completed.

______________________________	____________________
Parent's or Guardian's name	Today's date
______________________________	____________________
Parent's or Guardian's signature	Relationship to patient

Advance Vaccine Consent

In accordance with Tennessee Code Annotated 63-1, my signature below indicates that I consent for Kids Kare Pediatrics and its staff to provide vaccination(s) for my child/children.

I attest that I am the parent or legal guardian of the following child/children:

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

I consent for (please check one)

- ☐ All vaccines recommended for my child by the AAP (American Academy of Pediatrics)
- ☐ All vaccines recommended by the AAP, **EXCEPT** for

  ____

- ☐ **ONLY** the following vaccine(s):

  ____

I understand that I can review the vaccine information sheets (VIS) for these vaccines by using this QR code

Or by going to https://www.immunize.org/vis/

I understand that having my signature on file with Kids Kare Pediatrics means that non-parent, non-legal guardian caregivers that bring my child to vaccination appointments, do not need to provide formal consent for vaccines. My written consent as a parent/guardian is adequate for vaccination.

This consent automatically expires one year from the date of my signature.

____

Printed Name of Parent or Legal Guardian

____ __________________

Signature of Parent or Legal Guardian Date

Kids Kare Pediatrics witness: ____