KIDS CHOICE PEDIATRICS
UPDATED PATIENT INFORMATION

PLEASE FILL OUT ONE FORM PER CHILD.
ALL INFORMATION MUST BE COMPLETE AND ACCURATE.

PATIENT INFORMATION:

Name:_____ Preferred Name:_____
Last First MI

_____
Street City County State Zip

Date of Birth:_____ Sex: M F SSN:_____

Patient Reside with: ○Both Parents ○ Father ○Mother Other (specify):_____

Optional: Primary Language:_____ Race:_____ Hispanic/Latino? Y N

PARENT/LEGAL GUARDIAN INFORMATION:

MOTHER's Name:_____ DOB:_____ SSN:_____

Address:_____
Street City County State Zip

Home Phone #:_____ Cell #:_____ Work #:_____ Email:_____

Employer Name:_____ Occupation:_____

FATHER's Name:_____ DOB:_____ SSN:_____

Address:_____
Street City County State Zip

Home Phone #:_____ Cell #:_____ Work #:_____ Email:_____

Employer Name:_____ Occupation:_____

Parents' Marital Status: ○Married ○Divorced ○Separated ○Widowed ○Single

INSURANCE INFORMATION: ***Please present Insurance ID card(s) to Receptionist.***

Primary Insurance Carrier:_____ Subscriber ID:_____

Group #:_____ Group Name:_____

Guarantor Name:_____ Sex: M F

DOB:_____ Relationship to Patient:_____

Secondary Insurance Carrier:_____ Subscriber ID:_____

Group #:_____ Group Name:_____

Guarantor Name:_____ Sex: M F

DOB:_____ Relationship to Patient:_____

-- OVER --

EMERGENCY CONTACT **(someone outside of the household):** I hereby authorize Kids Choice Pediatrics to contact the individual listed below in the event of an emergency occurring to my child and/or myself during an on-site medical visit or in the event that I am unable to be reached at the phone number(s) listed above. I understand that, with regards to the emergency situation, this individual may receive test results and/or additional information pertinent to the care and treatment of my child and/or myself.

Name:	**Phone Number:**	**Relationship to Patient:**

☐ **Check here if you would like the Emergency Contact also included on the CONSENT below.**

CONSENT: I hereby authorize the following individual(s) to bring my child to Kids Choice Pediatrics for medical treatment in my absence. Additionally, the individual(s) listed below may receive test results and additional information pertinent to the care and treatment of my child. This list replaces any previous authorization and will remain in effect until revoked by me in writing.

Name:	**Phone Number:**	**Relationship to Patient**

FINANCIAL POLICY: All co-pays, co-insurance and deductibles are due at the time of service. *****The parent/guardian seeking medical treatment for the child is responsible for any bill incurred, regardless of any divorce decree or court order stating otherwise.***** We gladly accept cash, personal checks or credit card payments from Visa, MasterCard, and Discover. No bills larger than $50 are accepted for co-pays. We must charge a fee, which is posted in our reception area, for any returned checks. In order to file your insurance for you, we need to have a current copy of your insurance card on file. It is your responsibility to inform us of any changes in your insurance. ***We recommend that you verify whether your insurance covers well child visits and immunizations.*** Even though insurance may be filed, all bills are payable upon receipt and the patient/guarantor, not the insurance company, is responsible for the payment of all services. If the balance on your account exceeds 30 days past due, a $15 Late Fee will be assessed to the balance owed. In the event that a past due balance is turned over to our collection agency, the patient/guarantor will be responsible for all fees incurred, including but not limited to, court costs and legal fees. In addition, the patient/family will be discharged from the practice.

TENNCARE POLICY: Our doctors are providers with BLUECARE ONLY. We are NOT providers with *United HealthCare Community Plan* or *AMERIGROUP*. If your child has obtained TennCare coverage through United HealthCare Community Plan or AMERIGROUP, you must notify us immediately and either have the coverage changed to BlueCare or locate another physician who will accept your plan.

NO-SHOW POLICY: We understand that situations arise in which you must cancel your child's appointment. If you must cancel an appointment, a minimum of 24-hours notice is required. This will enable another patient in need of medical care to be scheduled in that timeslot. Patients who do not show up for their appointment without a call to cancel will be considered a NO-SHOW. Additionally, if you are more than 10 minutes late for a scheduled appointment, you will be asked to re-schedule and this will also be considered a NO-SHOW. Should you incur three (3) NO-SHOWS in a 12 month period, your family will be discharged from the practice.

My signature indicates that, to the best of my knowledge, the information provided is complete and correct and that I have read and understand the FINANCIAL and TENNCARE policies.

Signature of Person Completing this Form (must be a Parent or Legal Guardian) **Date**

Name (Printed)

Relationship to Patient: ◯ Mother ◯ Father ◯ Legal Guardian