State of Franklin
HEALTHCARE ASSOCIATES™

Your Health, Our Focus

Riverside Pediatrics New Patient Policy

Thank you for choosing Riverside Pediatrics as your child's pediatrician. The first step to becoming a patient with us is to complete a new patient packet. All forms included in the packet will need to be completed in full and given to the receptionist. At this time we will request a copy of the legal guardian's driver's license and a copy of your insurance card. Once we process your new patient paperwork you will receive a letter by mail stating the date and time of your first appointment. You will also receive a text message reminder 2 days prior to your appointment. Please reply to this text message to confirm your appointment. If you do not confirm the appointment by text we will try to reach you by phone. If you need to cancel your new patient appointment you will need to do so no less than 48 hours in advance.

If you fail to keep your new patient appointment you will NOT be rescheduled.

Regretfully we are not in network with TNCARE SELECT or COVERKIDS.

Sincerely,

Riverside Pediatrics

423-547-9400

Riverside Pediatrics Family History Sheet

PATIENT'S NAME________________________ DATE OF BIRTH ________________

PLEASE LIST THE NAMES & DATE OF BIRTH FOR ALL SIBLINGS CURRENTLY SEEN IN OUR OFFICE:

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE. THIS WILL AID US IN PROVIDING CARE FOR YOUR CHILD.

DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF:

	NO	YES	RELATIONSHIP *TO CHILD*	MOTHER / FATHER'S SIDE
ASTHMA				
BIRTH DEFECTS				
BLEEDING DISORDER				
CANCER (PLEASE SPECIFY TYPE)				
DIABETES				
HEART ATTACK BEFORE AGE 55				
HEART DISEASE				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
KIDNEY DISEASE				
MENTAL ILLNESS				
DEVELOPMENTAL DELAY				
SEIZURES				
SIDS				
STROKES				

Does anyone in the home use tobacco, including smokeless and e cigarettes? ________

OTHER HEALTH PROBLEMS WE SHOULD BE AWARE OF:

(Turn Over Page)

MEDICATIONS

List current medicines your child is taking including the dosage and how often it is taken (include nonprescription drugs).

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

ALLERGIES

List any allergies your child may have (medications, foods, plants, insects)

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

HOSPITALIZATIONS/SURGERY

List illnesses requiring hospitalization, all medical procedures and operations. Give approximate date if possible.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

SERIOUS INJURIES/ILLNESSES

List any serious injuries or illnesses your child has had.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

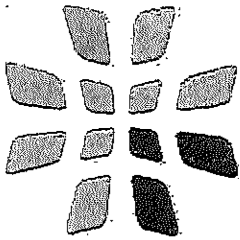
SPECIALISTS SEEN

List any specialists that your child is currently seeing or has seen in the past.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________



State of Franklin HEALTHCARE ASSOCIATES™

Riverside Pediatrics

Patient's Legal First Name ______ M.I. ______ Patient's Legal Last Name ______

Patient's Birthdate ______ Patient's Social Security Number ______ Patient's Email Address ______ M/F

Patient's Address ______ City ______ State ______ Zip ______

Home Telephone Number ______ Patient's Cell Phone Number ______ Patient's Place of Employment (if applicable) ______

Mother's Full Name ______ Mother's Address (if different from patient) ______ Mother's Cell Phone ______

Mother's SS# ______ Mother's DOB ______ Mother's Place of Employment ______ Mother's Email Address ______

Father's Full Name ______ Father's Address (if different from patient) ______ Father's Cell Phone ______

Father's SS# ______ Father's DOB ______ Father's Place of Employment ______ Father's Email Address ______

Are there any Custody, Guardianship, Adoption, or any other legal documents related to this patient that Riverside Pediatrics would need to have on file? YES / NO:__ If YES please present documents at first appointment.

Please list anyone else living in the home and their relation to the patient.

______

______

Date ______ Signature of Patient's Legal Guardian ______

State of Franklin OB / GYN Specialists
Johnson City Internal Medicine Associates
Johnson City Pediatrics
FirstChoice Family Practice
FirstChoice Internal Medicine
FirstChoice Pediatrics
Family Physicians of Johnson City
Blue Ridge Family Medicine

Pinnacle Family Medicine
First Medical OB / GYN
Riverside Pediatrics
SoFHA Central Laboratory
SoFHA Physical Therapy
SoFHA Sleep Center
SoFHA Walk-In Clinic
SoFHA Clinical Research

Acknowledgement of Notice of Privacy Practices

I have been given the opportunity to review the Notice of Privacy Practices and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to take a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected medical information, i.e. lab results or billing issues, you can either leave or discuss the information with the following individual(s):

	Name	**Relationship**
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________
4.	______________________	______________________
5.	______________________	______________________

Emergency Contact Number other than YOUR home phone number:

Name: ______________________ Phone Number: ______________

By signing below, I agree to the fore mentioned statements.

____
Patient or Guardian

____
Date

____
Practice Representative

____
Date

Patient Name: ______________________ Account Number: ______________

State of Franklin Healthcare Associates, PLLC
Registration, Billing and Collection

Payment Policy

We are participating with Medicare, Tennessee Medicaid, and most Managed Care plans in the area. We will file these claims for you. Patients are expected to pay any deductibles, coinsurance or copay amounts owed at the time of service.

If you are a Medicare patient and do not have a supplemental plan or a Medicare Advantage plan, you are responsible for payment of the annual deductible, co-insurance and non-covered services at the time of service.

Patients with a third party coverage with whom we do not contract are responsible for payment in full at the time of service. As a courtesy, we will file your charges with this third party payer upon receipt of payment in full. Otherwise, we will provide you with a completed third party payer claim form to use in filing your insurance.

Patients with a High Deductible Health Plan that have not met their annual deductible amount on the date of service will be asked to pay SoFHA's estimate of the allowed charges at the time of service. You will be billed for any additional deductible amounts after the insurance processes the claim.

Patients without verifiable insurance will be responsible for payment of all services rendered at the time of service. We accept cash, check, Visa, MasterCard, Discover and American Express.

Please realize, however, that:

1. Your insurance is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance benefits and the portion you will be liable for.

2. Depending on the specifics of the agreement we have with your insurance company, any portion of our fees not covered may be the responsibility of the patient.

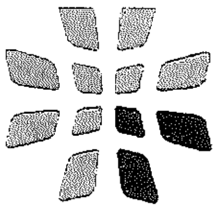
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Any service not covered is the responsibility of the patient.

Regardless of insurance payment, the patient and/or guardian remains responsible for all financial obligations incurred at the time of service. We realize that some balances may not be able to be paid in full at time of service and we will be happy to assist you in making satisfactory payment arrangements.

By signing this financial policy acknowledgement of the financial responsibility is accepted. This will remain in effect until revoked in writing.

______________________________ ____________________
Patient Name Patient Date of Birth

______________________________ ____________________
Patient or Guardian Signature Date



Authorization for Disclosure of Health Information

1. I, hereby authorize ______________________________ (clinic name and phone #) to disclose the following information from the health records of:

Patient Name: ____________________ Date of Birth: ____________________

Address: ____________________ Telephone: ____________________

____________________ Social Security: ____________________

Covering the period(s) of health care:

From (date): ____________________ to (date) ____________________

From (date): ____________________ to (date) ____________________

2. Information to be disclosed:

___ Complete health record(s)
___ History & physical examination
___ Consultation reports
___ X-ray reports
___ Other (please specify)
____

___ discharge summary
___ progress notes
___ laboratory tests
___ photographs, videotapes, digital or other images

3. This information will be disclosed to: **State of Franklin Healthcare Associates**
Riverside Pediatrics
1503 West Elk Avenue Suite 12
Elizabethton TN 37643 P:423-547-9400 Fax:423-547-9401

For the purpose of ______________________________

4. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. To revoke the Authorization, I understand I must contact the following in writing: State of Franklin Healthcare Associates, attn: Privacy Officer, 2528 Wesley St., Suite 2, Johnson City, TN 37601. Unless otherwise revoked, this authorization will expire on the following date, event condition or within one year from the time I signed this form:

5. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please be aware that information will be released to a non-custodial parent unless we have a court order stating otherwise.

Signed: ______________________________ (Patient) Date: ____________
______________________________ or (legal rep.)
______________________________ (relationship to patient)

Signature of Witness: ______________________________ Date: ____________

Consent to Treatment of a Child by Authorized Persons

The undersigned parent or legal guardian of ____________ ________ authorizes the person(s) listed below to
(Child's Name) (DOB)
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: _________________________ Relationship to Child: _______________
(Print Name)

Contact Number(s): ____

Address: ______________________________________ City, State, Zip: _____________________________

Signature: ____________________________ Date: ______________

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

Rev 3/15

State *of* Franklin
HEALTHCARE ASSOCIATES™

Your Health, Our Focus

State of Franklin Healthcare strives to provide excellent, quality care to each and every patient in a timely manner. In an effort to provide care when you need it, we have updated our policies on missed or canceled appointments and patient discharges.

We try to be good stewards of your time and ours. So, when at all possible, **please notify us as soon as possible and at least 24 hours in advance when you are unable to keep your appointment**. We will assist you in selecting another time better for you and will still be able to allow someone else to be seen.

In addition, we need time to greet you and complete registration for your appointment. Therefore, we ask that you **always arrive at least 15 minutes prior to your appointment**. Should you be running later than 15 minutes past your appointment time, we may consider this a "no show" but will make an effort to see you.

We realize things happen and you may miss an appointment. We do track missed appointments and will notify you if this happens. Your provider determines how often you need to be seen; so, to receive proper care, you need to keep or reschedule appointments within the time frame discussed at your visit.

We never want to say goodbye to a patient but sometimes circumstances cause us to determine our relationship isn't working the way it should. If you miss or "no show" an appointment three times, you are not receiving the frequency of care you need nor are we able to use that time for another patient in need. At that point, you may be asked to establish with another provider for your care.

We feel a good relationship consists of mutual respect. However, sometimes challenges arise that may cause us to discontinue the relationship. In addition to a trend of missed appointments, other issues that qualify for dismissal include failure to comply with a prescribed treatment plan, inappropriate/ abusive behavior to providers, staff or other patients or failure to pay outstanding balances.

Please let us know if you have any questions related to our policies. We are always available to answer your questions and thank you for the privilege to participate in your care.

State of Franklin
HEALTHCARE ASSOCIATES
Your Health, Our Focus

Notice of Nondiscrimination

State of Franklin Healthcare Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. State of Franklin Healthcare Associates does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

State of Franklin Healthcare Associates:

- Provides free aids and services to patients with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact the Office Manager.

If you believe that State of Franklin Healthcare Associates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Vicki Moody
2528 Wesley Street, Suite 2
Johnson City, TN 37601
P: 423.794.2440
F: 423-283.9730
vickimoody@sofha.net

or

Sandra Westelaken
2528 Wesley Street, Suite 1
Johnson City, TN 37601
P: 423.794.2435
F: 423.794.1842
sandrawestelaken@sofha.net

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Vicki Moody or Sandra Westelaken are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201
1-800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

STATE OF FRANKLIN HEALTHCARE ASSOCIATES
Johnson City, TN 37604

Account #: ____________________
DOB: ________________________

GO GREEN
with electronic billing

Every month, thousands of trees are used to make millions of paper billing statements for healthcare services. Now you can more easily manage your healthcare payments while helping the planet at the same time with online billing through Patient Notebook. It's as secure and easy as online banking.

Greener is easier.

- Enjoy the convenience of paperless bills and online payments
- Streamline tax season with a system that stores your records indefinitely so it's easier to itemize your medical expenses
- Save trees, time and postage

It's simple to switch.

1. Fill out the form below and return it to our office.
2. Instead of a paper statement, you will receive an email alert that contains instructions and a link to a secure website.
3. View your statement and pay your bill online with a credit card or bank account. (If you do not view your statement, you will receive electronic and paper reminders.)

PatientNotebook

The greenest, quickest and easiest way to manage healthcare statements paperlessly.

☐ Yes, I would like to enjoy the benefits of electronic billing through Patient Notebook.

Patient Name: ____

Your name (if different): ______________________________________

Email address: ____

Security Question: **THE TOWN WHERE YOU LIVE?**

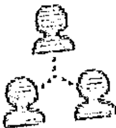
Security Answer: ____

Account # ____________

Access Your Medical Information Online!

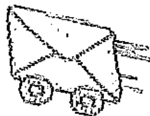
24/7 anywhere, anytime access

View test and lab results



Set up proxy accounts for children and dependent adults

Schedule appointments



Send and receive secure online messages

Receive email care reminders

Request Rx refills

After signing up below, expect to receive additional information on how to register via email.

☐ Yes, I would like to enjoy the benefits of accessing my personal health information through Follow my Health.

Patient's Name (please print): ____________________

Patient's DOB: ____________

Guarantor's Name: ____________________

E-mail Address: ____________________