ALLIED PEDIATRICS

5564 Little Debbie Pkwy Ste 114, Ooltewah, TN 37363-4356
email | info@MyAlliedPediatrics.com **web** | www.MyAlliedPediatrics.com **tel** | 423-602-9545 **fax** | 423-602-9546

Welcome to Allied Pediatrics,

We are happy that you have chosen our office for your child's care – thank you for trusting us! To help make your first visit as smooth and enjoyable as possible, we have prepared this packet of information.

Please take a few moments to complete the enclosed forms and return them. **We will not be able to schedule your first appointment until these forms have been returned**. You can bring them in person, fax them, email, or mail them to our office. All of our contact details can be found on the letterhead above.

❑ **Completed New Patient Packet**
❑ **Release of Records:** Please complete a separate release form for each doctor your child has seen. We must receive your child's medical records before the first visit. Without them, we cannot refill medications, give vaccines, or provide a school vaccine certificate at that appointment.
❑ **Custody Documentation:** If you have a FOSTER CHILD or legal CUSTODY of a child, you must provide the appropriate legal documentation before your first appointment. Without this paperwork on file, we will not be able to see the child.
❑ **Vaccine Record**

When you come for your appointment, please bring the following and **arrive 15 minutes early:**

❑ **Medical Insurance Card:** If no card is submitted at the time of your appointment, you will be asked to pay cash or reschedule your appointment.
❑ **Method of payment:** we accept cash, checks, VISA or Master Card
❑ **Credit Card:** Office policy requires a credit card on file.
❑ A complete list of all medications, vitamins, minerals, supplements, and herbs including the strengths and dosages.

Payment information for your visit: Please be prepared to pay for the following at the time of your appointment:

- **Co-payment**: We accept cash, checks, VISA or Master Card
- **No insurance**: If your child is uninsured, please call our billing office in advance for a cost estimate. Full payment is expected at the time of service.
- **No proof of insurance**: Patients without proof of insurance are expected to pay for services on the date of service. If for some reason you are not able to pay for your visit, it is your responsibility to contact our office in advance to arrange a payment plan. Accounts that remain unpaid may be referred to a collection agency, and the patient may be dismissed the practice.
- **Additional charges (if applicable)**:
  - Additional well check: If your child has already had an age-specific well check billed to insurance, and you request another well visit not covered by insurance, a **$75 fee** will apply.
  - School/Sport's Physicals: These are typically not covered by insurance if performed outside of a scheduled well visit. A **$75 charge** will be due at the time of service

For TN Medicaid Patients
If your child is covered by TN Medicaid, please contact your insurance provider before the appointment to update or confirm your child's primary care provider (PCP).

Office hours
Monday through Friday 8:00AM-5:00PM.

We look forward to meeting you and your family soon!

Sincerely,

Allied Pediatrics

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Patient Demographic Form

How did you hear about Allied Pediatrics (choose one)?

❑ Community event	❑ Friend	❑ School advertising
❑ Employer health fair	❑ Hospital	❑ School event
❑ Facebook ad	❑ Insurance company	❑ Search engine (e.g. Google, Bing)
❑ Facebook event	❑ Lactation specialist	❑ Street sign
❑ Facebook friend	❑ Midwife or doula	❑ Urgent care
❑ Family	❑ OB	

Patient Information

Last Name _____ First Name _____ MI ___

Nickname _____ Gender ❑ Male ❑ Female

Date of Birth _____ Social Security Number _____

Home Address _____ Apt# _____

City _____ State _____ Zip Code_____

Home Phone _____

Responsible Party (Guarantor) Information

Relationship to Patient ❑ Self (*if self, skip to Next of Kin*) ❑ Spouse ❑ Parent ❑ Other

Last Name _____ First Name _____ Middle ___

Date of Birth _____ Social Security Number _____

Home Address_____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Other Phone _____ Email _____

Employer _____ Employment Status _____

Emergency/Next of Kin Contact Information

Last Name _____ First Name _____

Relationship to Patient _____

Home Address_____ Apt# __

City _____ State _____ Zip Code _____

Home phone _____ Work phone _____

Primary Insurance Information

Policy Holder Name _____ DOB _____

Insurance Company Name _____

Member/subscriber ID# _____ Group # _____

Secondary Insurance Information

Policy Holder Name (if different from patient) _____

Insurance Company Name _____

Member/subscriber ID # _____ Group # _____

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Immunizations

At Allied Pediatrics, we strongly support the importance of immunizing children according to the American Academy of Pediatrics (AAP) standard immunization schedule. Vaccination is a critical component of preventive pediatric care and helps protect both individual patients and the broader community.

We understand that families may have different perspectives or medical considerations. Please indicate one of the following immunization choices by initialing next to your selected option:

_____**Religious Exemption**: I am a member of the Christian Science or Scientology religion. I would like to request religious exemption from vaccinations and will provide a letter from our head pastor on church letterhead.

_____ **Medical Exemption**: I am requesting a medical exemption for one or more vaccinations. I will provide documentation from a medical professional for the reason(s) for exemption.

_____ **Delayed Immunization Schedule**: I choose to follow one of Allied Pediatrics' approved delayed vaccine schedules.

_____ **Standard Immunization Schedule**: I choose to follow the Allied Pediatrics and AAP-recommended standard vaccination schedule.

_____ _____

Signature of Patient or Guardian Date

Allied Pediatrics

Recommended Vaccine Schedule

Providers at Allied Pediatrics strongly believe that vaccines save lives and are proponents of preventative medicine

Patient Name: _____ **DOB:** _____

Parent Signature: _____ **Date Signed:** _____

2 month well check*	Hib, Pediarix (dtap, hep B, polio), Prevnar, Rotarix (oral)
4 month*	Hib, Pediarix (dtap, hep B, polio), Prevnar, Rotarix (oral)
6 month*	Hib, Pediarix (dtap, hep B, polio), Prevnar
9 month*	No vaccines
12 month*	Hep A, MMR, Prevnar, Varivax
15 month*	Dtap, Hib
18 month*	Hep A
4 year well check*	Kinrix (Dtap, polio), MMR, Varivax

The * denotes regular well-checks. The visits in between are for vaccinations only and will require a scheduled appointment with a co-pay.

Allied Pediatrics recognizes that some parents have concerns about the recommended vaccine schedule, even though we fully support the recommended CDC/AAP schedule - this is how we can support you.

Once this schedule is agreed on and signed by the parent/guardian, it will be a permanent part of the patient's chart and no deviations will be allowed.

Patients who do not receive vaccinations according to the recommended schedule can contract the illnesses that vaccinations prevent and can transmit the illnesses to others who may be too young to vaccinate or who may have immune problems.

If your child is not fully vaccinated against a particular disease and there is an outbreak of that illness, your child may be required to stay home from school or daycare until the outbreak is over.

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Patient Authorization to Release Medical Records

Patient Information

Name of Patient:_____ Date of Birth: _____
I request that my provider share my protected health information (PHI) as directed below.

Doctor/Facility to **PROVIDE** records:

Name of Doctor/Facility:_____

Phone # :_____ Fax # : _____

Doctor/Facility to **RECEIVE** Records

Name of Doctor/Facility _AlliedPediatrics_____

Phone # _423-602-9545_____ Fax # _423-602-9546_____

Records TO BE Released

For the purpose of _____ continuity of care or _____ personal use, initial one box indicating which records you would like sent

[ ] All Medical Records (complete copy including test results, labs, X-rays, photos, reports, dictations and all records from other physicians)
[ ] Medical Records for specific date(s) of service: _____ to _____

Expiration or Revocation of Authorization
I understand that I may revoke this authorization at any time and that, unless an earlier date is specified, it will automatically expire 12 months after the date below.

_____ _____
Signature of patient or guardian Date

_____ _____
Name of patient or guardian Authorization is to expire on:

_____
Relationship if guardian

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If with Power of Attorney please attach supporting documentation.

I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. If I do not specify a format below, I understand that my PHI will be mailed to the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format:

- ___ via secure electronic delivery; or
- ___ other (please specify) _____

- If I have requested records be sent unencrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
- If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will then no longer be protected by federal privacy regulations.
- I understand I may revoke this authorization by notifying my provider in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.

NOTE: FEES FOR COPIES: when a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED; INCOMPLETE FORMS WILL NOT BE PROCESSED.

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Information for New Patients

***Please initial these policies indicating that you have read, understand and *agree* to comply with each**

_____ **After Hours -** Office hours are 8:00 AM to 5:00 PM Monday through Friday. For emergencies, call 911 or go to your nearest Emergency Department. For non-emergent illness after hours, please visit your nearest Urgent Care. Prescription refills are not considered emergencies and will be handled during regular office hours. If you need to speak to a provider outside of normal business hours, please call 423-602-9545 and leave a message. Your call will be returned within 1 hour.

_____ **Coming Late -** If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule. If you contact the office with a valid reason for being late, the provider will determine, based on the day's schedule, whether you can still be seen.

_____ **Insurance Verification -** Patients must provide an active insurance card at each visit. Without it, patients may be rescheduled or registered as self-pay.

_____ **Insurance Benefits -** It is the patient's responsibility to know his/her insurance benefits including wellness benefits prior to time of service.

_____ **Insurance Co-Pay -** Due at the time of service. When a patient is diagnosed with a problem during a well check and it is addressed, a co-pay may be required, depending on how insurance processes the claim.

_____ **Insurance Deductibles and Co-insurance -** Due upon receiving the mailed statement. Patients will be asked to settle any outstanding amounts before their next appointment.

_____ **Patient Balances –** Unpaid balances not resolved promptly will be automatically sent to our collection agency through our electronic system, and additional fees may apply.

_____ **Personal Bio –** Inform the office every time you change your address, phone number, name or insurance information.

_____ **Patient Self-Pay -** We recognize that not every patient has insurance. We strive to work with patients to manage their healthcare expenses. Payment plans can be set up by calling during office hours.

_____ **Billing Claims to Insurance –** As a courtesy, we submit insurance claims on behalf of our patients. After your insurance processes the claim, any remaining balance will be billed to you. If payment is denied due to missing information from the patent, the full amount will be your responsibility until the required information is submitted to your insurance and our office is notified.

_____ **Payments –** Payments can be made at or mailed to:
Allied Pediatrics
5564 Little Debbie Pkwy Ste 114
Ooltewah, TN 37363-4356

_____ **Newborns –** Newborns are covered under their mother's medical insurance for the first 30 days provided that the insurance company was informed of the child's birth. After 30 days the child will be seen as a self-pay patient until they have their own insurance and the information has been provided to Allied Pediatrics.

_____ **Co-Payment Information –** During a well check, a co-pay is typically not required. However, if a new or existing medical issue is addressed during the visit, it will be documented and billed to your insurance. This may result in a co-pay, depending on how your insurance processes the claim.

_____ **Sick Visits –** For same-day sick visits, the best time to call is between 8AM – 10AM. Appointments are limited and scheduled on a first-call, first-served basis. Once booked, we expect you to keep the appointment.

_____ **ER Follow up** – If your child was seen in the ER and was discharged after midnight, we will not be able to schedule a follow-up visit for the same day.

_____ **Legal Custody –** Paperwork indicating who is the legal custodian of the patient has to be on file at the office.

_____ _____
Signature of Patient or Guardian Date

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No Show/ Missed Appointment Policy

We understand that schedules can change and that you may occasionally need to reschedule an appointment. If that happens, we kindly ask that you call our office as soon as possible, preferably at least **24 hours in advance**. This allows us to schedule other patients who may be waiting for an appointment.

- If you are more than 10 minutes late, it counts as a missed appointment and you may be asked to reschedule.
- If you are a new patient and miss your first appointment without calling at least 24 hours ahead, you may not be able to make another appointment.
- If you are already a patient and your family misses or cancels an appointment without 24-hour notice **three times**, you will be dismissed from the practice.
- If you miss an appointment or cancel too late, you may be charged a fee:
  - $50.00 for regular visits
  - $100 for well checks or physicals
  - $200 for procedures
- The fee will be charged to the patient, not the insurance company, and is due prior to the time of the patient's next scheduled visit.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office. If there is no answer, leaving a message is acceptable.

I have read and understand the No Show/Missed Appointment policy and agree to its terms.

_____ _____

Signature of Patient or Guardian Date

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Financial Policy

Insurance Verification:
At each visit, the patient must provide an active insurance card with current, correct information. Without proof of insurance, the patient may be re-scheduled. Allied Pediatrics makes it a priority to verify proof of a patient's insurance; however, it is the patient's responsibility to know his/her benefits **including wellness benefits** prior to time of service.

Patient Cost Co-Pays & Co-Insurance:
Insurance companies require Allied Pediatrics to collect co-pays, deductibles or co-insurance amounts at the time of service. A deposit equal to 1/3 of costly procedures or visits is required in advance for services not covered by the patient's insurance.

Outstanding Balances:
Patients will be asked to settle any outstanding balances with Allied Pediatrics before their appointment. As a patient, you may pay any outstanding balances at our office or you may go to our website at www.myalliedpediatrics.com.
Patients with outstanding balances may be declined treatment or triaged for non-emergency care until the balance is resolved.
Patient balance which are not resolved in a timely manner will be sent to an outside collection agency. If the patient's balance is transferred to an outside agency, the patient will be responsible for paying any additional collection fees associated with the collection of the patient balance.

Self-Pay:
Allied Pediatrics recognizes that not everyone has insurance coverage. It is difficult to accurately predict what services a patient may ultimately need, but Allied Pediatrics will try to work with the patients to help them anticipate charges and manage their healthcare expenses. Patients without insurance who pay in full at the time of service may be eligible for a discount.

No-Show and Late Cancellation Fee:
Patients who cancel appointments with less than 24 hours notice or do not come to scheduled appointments may be subject to a $50.00 fee, not for any service, but for the lost opportunity to see another patient. This fee may be higher for missed well checks or procedures other than routine office visits.

Billing Insurance:
Allied Pediatrics contracts with most insurance companies for patient services. The patient remains financially responsible for all his/her care, but the remaining balance for services rendered to the patient will not be billed to the patient until payment is received from the insurance company(s), the insurance company denies the claim, or the insurance company unreasonably fails to pay in a timely manner. A statement will be sent to the patient or responsible party. The billed amount on the statement is due when the first statement is received.

Payments:
Allied Pediatrics accepts cash, check, Visa, Mastercard or Discover. There is a $30.00 fee for all returned checks. Payments can be made at or mailed to:

Allied Pediatrics
5564 Little Debbie Pkwy Ste 114
Ooltewah, TN 37363

If you have any questions regarding our financial policies, please contact our office at (423)602-9545.

Note:
Patient Accounts with outstanding balances and no payment activity will be forwarded to a collection agency at the patient's expense. In addition to any outstanding balances, the Patient or the Patient's representative who signs below agrees to pay all costs associated with such collection activity, including reasonable collection agency fees, attorney fees and court costs.

_____ _____
Patient Signature or Responsible Party Date

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Notice of Personal Health Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

We reserve the right to revise or amend our Notice of privacy practice without additional Notice to you. Any revision or amendment to this Notice will be effective for all of your records our practice has created or maintained in the past, and for any of your records we may create or maintain in the future. Allied Pediatrics, PLLC will post a copy of this notice as amended in a prominent place in our office and on our website.

This notice becomes effective July1, 2011 and amends our previous form of Notice. No amendment relates to any substantive right of an Allied Pediatric patient or any duty of Allied Pediatrics. If you have any questions about the Notice of Personal Health Information Practices, please contact our Privacy Officer at 423-602-9545.

Treatment - Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing a medical condition, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment - Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations - Your health information may be used as necessary to support the day-to-day activities and management of Allied Pediatrics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement - Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting - Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department

Health Oversight Activities - We may disclose medical information to a health oversight agency, such as the Department of Health and Human Services, for activities authorized by law. These oversight activities include for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor health care system, government programs, and compliance with civil rights laws.

Family Members - We may release medical information, including mental health information, about you to the family member who is involved in your medical care without consent or authorization if the individual's involvement is related to such information. We may also give medical information, including prescription information or information concerning your appointments to friends who are involved in your care. We may also give such information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Business Associates - We have contracted with other entities to provide services to Allied Pediatrics. When these "associates" require your personal health information in order to accomplish tasks asked of them by Allied Pediatrics It will be provided to them. Examples of business associates are: billing service, collection agency, answering service, insurance service, transcription service, and computer software/hardware provider.

Research/Teaching/Training - Your PHI can be used for the purpose of research, teaching and/or training.

Appointment Reminders - Your health information will be used by our staff to send appointment reminders to you.

Workers Compensation - We may release medical information about you for workers' compensation or similar programs without consent or authorization. These programs provide benefits for work-related injuries or illness. For example, if you are injured on the job, we may release information regarding that specific injury.

Marketing - Your health Information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you. In addition, your name and address may be used to send you a newsletter about our practice and the services we offer. You may contact our Privacy Officer to request that these materials not be sent to you.

Other uses and disclosure require your authorization - Disclosure of your health information or its uses for any other purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a release of disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights - You have certain rights under the federal privacy standards.
These include:

The right to request restrictions on the use and disclosure of your protected health information
The right to receive confidential communications concerning your medical condition and treatment
The right to inspect and copy your protected health information
The right to amend or submit corrections to your protected health
The right to receive an accounting of how and to whom your protected health information has been disclosed
The right to receive a printed copy of this notice

Allied Pediatrics' Duties - We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Changes - As permitted by law, we reserve the right to amend or notify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit unless the revisions are not significant. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information - As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the medical records department of Allied Pediatrics.

Requests for Restrictions on Protected Health Information - You have a right to request us to restrict how we use and disclose your protected health information. We are not required by law to agree with your requested restriction in certain situations. These situations include emergency treatment disclosures to the Secretary of the Department of Health and Human Services, and any uses and disclosures described on the front page of the notice. However, if we decide to grant your request, we are bound by our agreement

Complaints - If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

HIPPA Privacy Officer
Allied Pediatrics, PLLC
5564 Little Debbie Pkwy, Ste 114
Ooltewah, TN 37363

If you believe that your privacy rights have been violated, you should call the matter to our attention by calling the Privacy Officer at 423-602-9545 or by sending us a letter describing the cause of your concern to the address provided. You may also address any complaint to the United States Secretary of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint

_____ _____

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Policy for Charges Associated with Release of Protected Health Information

A signed request for the release of Protected Health Information (PHI) is required to release medical records. Due to the expenses associated with copying and mailing medical records the following charges apply per patient.

Patient and Attorney Requests

There will be a charge to patients or attorneys who request copies of medical records.

- $20.00 for pages 1-40 plus applicable postage
- $0.50 for each additional page over 40
- $20.00 for electronic copy of records on portable media plus cost of shipping

Once printed you will be pre-billed by Allied Pediatrics and your records will be sent once payment is received.

Healthcare Provider and Insurance Company Requests

- Free of charge

Immunization Records Requests

- Birth thru 12 months of age – Copies of immunization records will be provided free of charge once infants receive shots on a routine basis.
- Requests for immunizations records may take up to 72hrs to process.
- 13 months thru adulthood - One copy of an immunization record will be provided free of charge per calendar year.
- One TN or GA immunization record will be completed free of charge per calendar year.
- A $10.00 charge will apply for each copy requested thereafter in the same calendar year.

Questions Regarding Release of Immunization Records

Questions regarding release of immunization records may be directed to Allied Pediatrics at (423) 602-9545.

I understand the above information regarding the charges associated with the release of my Protected Health Information (PHI).

_____ _____

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Authorization and Consent to Participate in Telemedicine Consultation and Services

Patient Name: _____ **Date of Birth:** _____

Parent Name: _____

Purpose and Benefits: The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a health care provider at a distance. The purpose of this electronic communication is to use telemedicine to enable patients to get medical care by heath care providers without the inconvenience of traveling.

Possible Risks: As with any medical visit, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s); Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

5. I understand that telemedicine involves electronic communication and potential risk may include interruptions and technical difficulties.

6. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.

7. I understand that I will have a direct conversation with my Provider, during which I will have the opportunity to ask questions and a discussion/treatment plan will be in a language that I understand.

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Patient Consent to The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Allied Pediatrics to use telemedicine in the course of my diagnosis and treatment.

Parent Name: _____

Parent Signature: _____ **Date:** _____

ALLIED PEDIATRICS

5564 Little Debbie Pkwy Ste 114, Ooltewah, TN 37363-4356
email | info@MyAlliedPediatrics.com **web** | www.MyAlliedPediatrics.com **tel** | 423-602-9545 **fax** | 423-602-9546

Treatment Authorization Limitations

Does only **one parent** have custody rights? If so, please check this box and talk to our receptionist about these circumstances as we may need additional information from you.	☐
Does someone besides biological/adoptive parents care for or have custody rights of the patient (ex. family member, foster care)? If so, please check this box and discuss with our receptionist.	☐
Check here if **both parents** have full custody rights.	☐

Authorization for Alternate Caretakers

Allied Pediatrics understands that special circumstances may arise. If for some reason you cannot bring your child to an appointment, we allow up to 4 authorized caretakers to bring them in your place.

- _____ I understand that alternate caretakers must have a valid ID that matches the information below or we will not be able to proceed with the appointment.
- _____ I understand that alternate caretakers will have the ability to make medical decisions regarding the patient at the appointment
- _____ I understand that alternate caretakers will be responsible for making payments that are due on the day of the appointment
- _____ I understand that alternate caretakers will have the ability to make financial decisions regarding the patient's account on the day of the appointment

Patient Name: _____ Date of Birth: _____

Caretaker 1 Name: _____ Telephone #: _____

Relationship to Patient: _____

Caretaker 2 Name: _____ Telephone #: _____

Relationship to Patient: _____

Caretaker 3 Name: _____ Telephone #: _____

Relationship to Patient: _____

Parent/Guardian 1 Name: _____ Telephone #: _____

Parent/Guardian 2 Name: _____ Telephone #: _____

Signature :_____ Date: _____

ALLIED PEDIATRICS

Today's Date: _____

New Patient Health History Form

Patient Last Name _____ First Name _____ MI _____

Date of Birth _____ Sex ❑ Male ❑ Female

Parent/Guardian name _____

Marriage:

1. **Parents' marital status**:
   ❑ married ❑ unmarried ❑ divorced ❑ separated ❑ other: _____

Diet and Exercise:

1. **What type of diet is your child following?**
   ❑ Regular ❑ Vegetarian ❑ Vegan ❑ Gluten free
   ❑ Specific ❑ Carbohydrate ❑ Cardiac ❑ Diabetic
2. **What is your child's exercise level?**
   ❑ None ❑ Occasional ❑ Moderate ❑ Heavy
3. **What types of sporting activities does your child participate in?** _____

Home and Environment:

1. **Living/custody arrangements** (check all that apply)
   ❑ birth mother ❑ birth father ❑ both parents ❑ grandparent
   ❑ foster parent ❑ adoptive parents ❑ other relative ❑ other_____
2. **What type of child care do you use?**
   ❑ none ❑ relatives ❑ babysitter ❑ daycare/preschool
3. **Does your child have any siblings?** ❑ Yes ❑ No; if yes, how many? _____
4. **Do you have any pets?** ❑ Yes ❑ No
5. **Do you have moisture problems in your home?** ❑ Yes ❑ No
6. **Do you have smoke and carbon monoxide detectors in your home?** ❑ Yes ❑ No
7. **Is your child passively exposed to smoke?** ❑ Yes ❑ No
8. **Are there any guns present in your home?** ❑ Yes ❑ No

Lifestyle and Safety:

1. **Does your child wear a helmet when biking?** ❑ Yes ❑ No
2. **Does your child use a seat belt or car seat routinely?** ❑ Yes ❑ No

General Pediatric:

1. **Does your child have any accommodations for medical problems?** ❑ Yes ❑ No
2. **Has your child had a dental visit in the past 12 months?** ❑ Yes ❑ No
   Date of last visit: _____

ALLERGIES: Please list any known allergies (medications, food, bee stings, etc.) and describe the reaction.

	ALLERGY	REACTION
1.	_____	_____
2.	_____	_____
3.	_____	_____

PREFERRED PHARMACY: _____

CURRENT MEDICATIONS: Please list all medications your child is currently taking, including prescriptions, over-the-counter medications, vitamins, or inhalers.

Medication name	Dosage and frequency	Condition being treated

CHILD'S PAST MEDICAL HISTORY: Please check any medical problems your child has been diagnosed with or treated for, and provide details where applicable:

√	Diagnosis	Please explain	√	Diagnosis	Please explain
	Digestive Disorder			Recurrent ear infections	
	Endocrine Disorder			Reproductive disorder	
	Immunologic Disorder			Respiratory disorder	
	Skin disorders			Skeletal disorder	
	Lymphatic disorders			Urinary disorder	
	Musculoskeletal disease			Developmental or behavioral disorders	
	ADD/ADHD			Headaches	
	Adverse reaction to vaccines			Head injury/ concussion	
	Autism Spectrum Disorder			Depression/anxiety/ mental illness	
	Blood disease or bleeding disorders			Seizures/ epilepsy	
	Chickenpox			Other:	
	Congenital anomalies				

SURGICAL HISTORY: Please check if your child has had any of the following surgeries or procedures and include the date, if known.

√	Surgery	Date	√	Surgery	Date
	Circumcision			Tonsillectomy	
	Frenotomy			Adenoidectomy	
	Ear tubes (tympanostomy)			Hernia repair	
	Eye muscle surgery (strabismus surgery)			Other:	

BIOLOGICAL FAMILY MEDICAL HISTORY:
Please indicate if any biological family members have the following health conditions. Specify which relative (e.g., mother, brother, sister, maternal grandfather)

RELATION	Check all that apply
Father	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Mother	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Sibling 1_____	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Sibling 2 _____	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Maternal Grandmother	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Maternal Grandfather	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Paternal Grandmother	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____
Paternal Grandfather	❑ ADD/ADHD ❑ Asthma ❑ Bleeding disorder ❑ Cancer ❑ Diabetes ❑ Depression/Anxiety ❑ Genetic disease ❑ Heart disease ❑ High cholesterol ❑ Hypertension ❑ Migraines ❑ Seizures ❑ Stroke ❑ Other: _____

(ONLY) FOR PATIENTS 13 AND OLDER:

1. **Do you or have you ever smoked tobacco**? ❑ Yes ❑ No
   a. If **YES**: how many years have you smoked? _____
   b. At what age did you start smoking tobacco? _____
   c. How much tobacco do you smoke? ____ packs per day/ week

2. **Do you or have you ever used any other forms of tobacco or nicotine?** ❑ Yes ❑ No
   IF **YES,** please answer the following:
   a. Do you or have you ever used e-cigarettes or vape?
      ❑ never used ❑ former user ❑ current user
   b. Do you or have you ever used smokeless tobacco (ex. snuff, chew tobacco)?
      ❑ never used ❑ former user ❑ current user

3. **What is your level of alcohol consumption?**
   ❑ none ❑ occasional ❑ moderate ❑ heavy

4. **Do you use any illicit or recreational drugs?** ❑ Yes ❑ No
   IF **YES**:
   a. Which substance have you used? _____
      _____

5. **What is your level of caffeine consumption?**
   ❑ none ❑ occasional ❑ moderate ❑ heavy

6. **Are you sexually active?** ❑ Yes ❑ No
   IF **YES**
   a. Do you use protection during sex? ❑ always ❑ usually ❑ no