



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



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:

KIDS KARE PEDIATRICS REQUIRES THE MMR VACCINATION BETWEEN AGES 12-15 MONTHS AND SECOND DOSE BY 4-6 YEARS OF AGE. FAILURE TO COMPLY WILL RESULT IN TERMINATION FROM THE PRACTICE.

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

☐ VACCINES TO BE GIVEN IN THE PRESENCE OF PARENTS ONLY AND DISCUSSED UPON VISIT DATE

ANY EXCLUSION, WITH THE EXCEPTION OF THE MMR VACCINE LISTED ABOVE, CAN BE OVERRULED VERBALLY UPON TIME OF VISIT BY PARENTS OR LEGAL GUARDIAN.

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: _____



Kids Kare Pediatrics

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:

Signature parent or legal guardian

Relationship to child/children

Today's Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that Kids Kare Pediatrics has provided me with a copy of its HIPAA Notice of Privacy Practices.

Patient Name

Date of Birth

Signature (Individual/Personal Representative*)

Date

*If you are a personal representative signing this Acknowledgment, please provide a description of your relationship to the individual below.



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