Blackmon pediatrics

FORM #: FRM-0001
IMPLEMENTATION: 06.14.2024
UPDATED: 06.14.2024

MEDICAL RECORDS RELEASE | INCOMING

PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____

TO BE OBTAINED FROM:

_____
PROVIDER NAME | PRACTICE NAME

_____
PROVIDER | PRACTICE ADDRESS

(_____)_____-_____ (_____)_____-_____
TELEPHONE NUMBER FAX NUMBER

CONSENT | AUTHORIZATION:

"I do hereby consent and authorize Blackmon Pediatrics, PLLC to obtain copies of my medical records from the provider/practice outlined above. I further agree that a copy of this release and/or a fax of this release shall be deemed to be as valid as this original."

MEDICAL RECORDS DATE RANGE: _____/_____/_____ THRU _____/_____/_____
BEGINNING DATE OF SERVICE ENDING DATE OF SERVICE

☐ All Medical Records: to include but not limited to current & previous medical records from Blackmon Pediatrics and other providers/practices, hospitals, clinics, diagnostic services, laboratories, alcohol/drug treatment, mental health information, and HIV/STD related information which are included in this medical record."

☐ All Medical Records except the following: _____

_____

☐ Include the following Medical Records only: _____

_____

REQUESTOR SIGNATURE: _____ **DATE:** _____/_____/_____

REQUESTOR NAME: _____
PLEASE PRINT

REQUESTOR'S RELATIONSHIP TO PATIENT:

☐ PATIENT (Age 18+ or Emancipated Minor) ☐ PARENT

☐ OTHER _____ ☐ LEGAL GUARDIAN

7714 Conner Road, Suite 101 • Powell, Tennessee 37849
Phone: (865) 212-6350 • Fax: (865) 212-6446

BLACKMON PEDIATRICS

7714 Conner Road, Suite 101, Powell, TN 37849
865-212-6350

List child(s) Names	Male/Female	Date of Birth	Address same as (mom, dad, step-parent)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Patient's Address if different from parent accompanying child **City** **State** **Zip**

Parent Accompanying Child for Care

DOB: _____/_____/_____

Social Security #

Address **City** **State** **Zip**

Home Phone

Cell Phone

Employer Name

Work Phone

Other Guardian

DOB: _____/_____/_____

Social Security #

Address **City** **State** **Zip**

Home Phone

Cell Phone

Employer Name

Work Phone

Emergency Contact/Relationship to Patient

Contact #(s)

Primary Insurance

Policy ID #

Group #

Subscriber Name/Relationship to Patient

DOB: _____/_____/_____

Is Insurance Through Employer

Subscriber Address if different from patient

Subscriber Phone #(s)

Secondary Insurance

Policy ID #

Group #

Subscriber Name/Relationship to Patient

DOB: _____/_____/_____

Is Insurance Through Employer

Subscriber Address if different from patient

Subscriber Phone #(s)

I, the undersigned authorize payment of medical benefits to Blackmon Pediatrics for any services furnished to me by the provider. I understand that I am financially responsible for any amount not covered by my contract and any unpaid claims after 30 days. I also authorize you to release to my insurance company or their agent, information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Parent/Guardian Signature Date

Thank you for choosing Blackmon Pediatrics as your child(ren)'s health provider. The following is a statement of our Office Policies, which we require that you read and sign prior to any treatment.

Our Financial Policy

We participate with many HMO, PPO, and POS insurance plans. We will gladly file those claims for you. **If we do not participate with your insurance company, you will be responsible for the balance and filing the claim.**

It is your responsibility to keep your insurance information current and a copy of your card on file with us at all times. **We require knowledge of all secondary insurance policies within 30 days of service.**

Note that the parent bringing the child for the medical care is the one responsible for all fees incurred regardless of any divorce decree or court order stating otherwise.

ALL copays are due on the date services are rendered. PAYMENT IN FULL is also due on the date services are rendered for all self-paying patients. If you have a **deductible,** 10% of the lowest office visit is due at the time of service.

For your convenience, we accept VISA, MASTERCARD, and DISCOVER.

A **$25.00 service charge** will be added to any check on insufficient funds. Should you incur a balance and our payment policy cannot be followed, we will be happy to discuss monthly payment arrangements with you on an individual basis. A default in this arrangement will result in termination from the practice within 30 days and a 30% fee added to all balances at the collection agency.

Office Policies

If you should choose to terminate your patient-physician relationship with Blackmon Pediatrics, for any reason, we will no longer provide medical care for the patient(s).

This is a **NO WALK-IN** office. If you feel that your child(ren) need to be seen, please call the office to schedule an appointment or go the closest Emergency Room. **Patients arriving 15 minutes late may not be seen and asked to reschedule.**

We do request 24 hours notice to reschedule or cancel an appointment to prevent a No Show charge of $25. **If a child or family has missed 3 appointments in a 6-month period without notification, your child(ren) will be dismissed from the practice.**

There may be a **$15.00 fee** charged for all after-hour phone calls to our physicians or their representatives. This fee is not billable to your insurance company.

You understand that you have the right to a copy of your medical records after signing a release and paying **a $25 fee** for copying them.

Your signature below indicates that you have read and understand these policies. You authorize Blackmon Pediatrics to provide your child (ren) with reasonable and proper medical care by today's standards. In the event someone other than the parent brings the child(ren) for care, this authorizes care in his/her absence.

_____ _____

Parent/Guardian Signature Date