

CONFIDENTIAL COVER SHEET NEW PATIENT INFORMATION PACKET



RETURN TO: Blackmon Pediatrics Front Office Staff

Please complete and attach the following forms and requested documents (as appropriate):

- New Patient & Newborn Patient Information Form (Page 1)
- Medical Records Release Form (Page 2)
- Pediatric Demographic Form (Page 3)
- Financial Policy Acknowledgment Form (Page 4)
- Consent For Healthcare Messages (Page 5)
- Consent Form Medical Treatment & To Accompany Minor Child (Page 6)
- Copy Insurance Cards for current coverage (if applicable)
- Copy of any medical records already attained (if applicable)
- Copy of any court proceedings, orders, or documentation related to the Healthcare of the new patient or new born (if applicable)

RETURN OPTIONS:

- HAND DELIVERY** (see address at bottom of page)
- MAILED** (see address at bottom page)
- FACSIMILE** (@ 865.212.6446)
- PATIENT PORTAL UPLOAD** (please scan documents rather than photo copy)
- EMAIL** (frontdesk@blackmonpediatrics.com)



PLEASE READ CAREFULLY PRIOR TO COMPLETION OF THESE DOCUMENTS

Submission of new patient information is not a guarantee that we will be able to accept your child as a new patient with our practice. Various factors may preclude us from accepting a new patient.

The primary reason we are unable to accept a new patient is often based on our non-inclusion and/or non-participation in specific insurance plans or exclusive provider networks. Prior to the completion of this paperwork, **we strongly recommend that you contact your insurance carrier to confirm that our providers are listed as active and participating with your specific insurance plan and provider network.** Typically, the back of your insurance card and/or by logging into your insurance carrier's online portal is the best way to find this information. Below is a list of our current providers:

Abigail Blackmon, MD
Molly Marks, CPNP-PC
Cheri Tedford, CPNP-PC

Gregory Blackmon, MD
Michelle Peck, CPNP-PC
Kelli Wolfe, CPNP-PC

Blackmon Pediatrics does NOT currently participate with coverage provided by AMERICHoice, AMERIGROUP OR UNITED HEALTHCARE COMMUNITY PLAN. We are not currently able to accept new TennCare patients or any insurance plans obtained via Healthcare.gov.

We are dedicated to provide the best and most accessible care possible; therefore, not all our providers are always able to accept new patients due to patient volumes at the time of your submission. Volume fluctuations, special circumstances, specific healthcare complexities, along with other factors may allow for periodic exceptions.

BLACKMON PEDIATRIC USE ONLY

RECEIVED BY: _____

DATE: _____

REVIEWED ENTERED IN eCW

STATEMENT OF CONFIDENTIALITY: *The information contained in the pages of this information packet is privileged and confidential and intended only for the use of Blackmon Pediatrics. If the reader of this information is NOT the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited under government legislation (HIPAA). If you have received this information in error, please immediately notify us by telephone and return the original documents to us at the address listed below via US Postal Service. Thank you.*

**NEW PATIENT & NEWBORN
INFORMATION FORM**



PATIENT INFORMATION

NAME: _____ SOCIAL SECURITY NUMBER: ____-____-_____

DATE OF BIRTH: _____ GENDER: FEMALE MALE

PARENT | GUARDIAN INFORMATION (1)

NAME: _____ SOCIAL SECURITY NUMBER: ____-____-_____

DATE OF BIRTH: _____ GENDER: FEMALE MALE

CELL PHONE: (_____) _____-_____ EMAIL ADDRESS: _____

ADDRESS: _____

PARENT | GUARDIAN INFORMATION (2)

NAME: _____ SOCIAL SECURITY NUMBER: ____-____-_____

DATE OF BIRTH: _____ GENDER: FEMALE MALE

CELL PHONE: (_____) _____-_____ EMAIL ADDRESS: _____

ADDRESS: _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

MEMBER | SUBSCRIBER NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER NAME: _____ SOCIAL SECURITY NUMBER: ____-____-_____

MEDICAL RECORDS RELEASE

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



PATIENT INFORMATION

	PATIENT NAME(S)	DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER
1	_____	____/____/____	<input type="radio"/> MALE <input type="radio"/> FEMALE	____.____.____
2	_____	____/____/____	<input type="radio"/> MALE <input type="radio"/> FEMALE	____.____.____
3	_____	____/____/____	<input type="radio"/> MALE <input type="radio"/> FEMALE	____.____.____
4	_____	____/____/____	<input type="radio"/> MALE <input type="radio"/> FEMALE	____.____.____
5	_____	____/____/____	<input type="radio"/> MALE <input type="radio"/> FEMALE	____.____.____

PATIENT PORTAL INFORMATION

EMAIL ADDRESS _____ PREFERRED PHONE # FOR REMINDERS (____) ____ - ____

RESPONSIBLE PARTY INFORMATION

GUARDIAN 1

NAME: _____

DATE OF BIRTH: ____/____/____

SOCIAL SECURITY #: ____.____.____

ADDRESS: _____

PRIMARY PHONE #: (____) ____ - ____

EMPLOYER NAME: _____

WORK PHONE #: (____) ____ - ____

GUARDIAN 2

NAME: _____

DATE OF BIRTH: ____/____/____

SOCIAL SECURITY #: ____.____.____

ADDRESS: _____

PRIMARY PHONE #: (____) ____ - ____

EMPLOYER NAME: _____

WORK PHONE #: (____) ____ - ____

EMERGENCY CONTACTS

NAME: _____

RELATION: _____

PHONE #: (____) ____ - ____

NAME: _____

RELATION: _____

PHONE #: (____) ____ - ____

INSURANCE INFORMATION

PRIMARY INSURANCE NO INSURANCE COVERAGE

INSURANCE COMPANY: _____

INSURANCE ID #: _____

INSURANCE GROUP #: _____

CARDHOLDER'S NAME: _____

DATE OF BIRTH: ____/____/____

RELATION TO PATIENT: _____

SECONDARY INSURANCE NO SECONDARY POLICY

INSURANCE COMPANY: _____

INSURANCE ID #: _____

INSURANCE GROUP #: _____

CARDHOLDER'S NAME: _____

DATE OF BIRTH: ____/____/____

RELATION TO PATIENT: _____

FINANCIAL ACKNOWLEDGEMENT

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

PARENT | GUARDIAN SIGNATURE: _____ DATE: ____/____/____

PARENT | GUARDIAN NAME (PRINTED): _____

INSURANCE

Please bring your insurance card(s) with you to every appointment. It is the patient’s parent/guardian to notify the front desk staff of any changes in insurance coverage and/or when the claim should be billed to your auto insurance carrier or workers comp. We accept most insurance plans and will gladly file your claims for you. Please check with your insurance carrier to determine if our physicians/providers participate with your plan. If we do NOT participate with your insurance plan, you will be responsible for the balance and filing of the claim.

Blackmon Pediatrics does NOT currently accept the following insurance plans:
AMERICHoice, AMERIGROUP, UNITED HEALTHCARE COMMUNITY PLAN or INSURANCES via HEALTHCARE.GOV
(This is NOT a complete list, so please verify that our providers are participating with your insurance plan and network.)

FINANCIAL POLICIES

- **CO-PAYMENTS** are due on the date services are rendered.
- **SELF-PAY PATIENTS** (those not covered by an insurance plan or those opting to not bill insurance for specific charges) will be offered a pricing discount for most charges. Payment is expected on the date services are rendered unless other arrangements are made, documented, and sign by the parent/guardian and a Blackmon Pediatrics assigned agent.
- **FLEXIBLE PAYMENT PLANS** - Payment is expected within 30 days of the statement date, however, flexible monthly payment arrangements can be made for large balances on an individual case by case basis.
- **GUARANTOR INFORMATION** - any change in the guarantors address, phone number, or email address should be provided to our practice as soon as the information is available and is the responsibility of the guarantor and/or parent/guardian.
- **REFUNDS** - if an overpayment is made on your account or your account accrues a balance, the refund or statement will be issued to the address of the guarantor on file. A refund will not be issued if the guarantor/patient has any unpaid balance on the account. Refunds will be issued by request and should be processed within 30 days. Refunds not requested, will remain on the account to cover future charges.
- **RETURNED CHECKS** - any account with a returned check will be charged a \$25.00 service charge.
- **FORMS OF PAYMENT ACCEPTED** - we accept: Cash, Personal Checks, Mastercard, Discover, and Visa for your convenience.

FINANCIAL RESPONSIBILITY - belongs to the parent/guardian/guarantor that brings the child for medical care, regardless of Divorce Decrees, Court Orders, or other legal directives. Blackmon Pediatrics is equipped to provide excellent medical care to your child(ren), however, we are not equipped to deal with the myriad of legal processes that may occur. Therefore, it is our policy to not get involved with those situations, and to simply focus on the health and well-being of your child.

NO SHOW POLICY

Our office has automated methods of reminding our parents/guardian/guarantors of upcoming appointments. It is imperative that the contact information listed in the “patient portal information” on the demographic sheet is kept up to date. It is the parent/guardian/guarantors responsibility to maintain current Email address and Phone number for reminders. Failure to keep scheduled office appointments prevents other patients from receiving access to our care while also depriving those in your care from the medical assessment and care that they need. We are sensitive to the fact that unforeseen circumstances may occur that prevent you from keeping your scheduled appointment. Therefore, please notify our office 24 hours prior to your appointment to reschedule whenever possible. Any appointments canceled on the day of the appointment or any appointments that the patient fails to arrive for, will be billed a \$25 charge. Any patient that accumulates three (3) or more “no shows” in a six (6) month period, will be considered for dismissal from the practice. In addition, we are obligated under many of our managed care contracts to report patient’s who repeatedly fail to pay co-pays and deductibles as well as those who repeatedly fail to show for a scheduled appointment. If you are reported, there is a possibility your child(ren) could lose their health care benefits.

TERMINATION

Parent/Guardian termination of the patient-provider relationship with Blackmon Pediatrics, for any reason, will result in the immediate conclusion of medical care for the patient(s). Blackmon Pediatrics will be free from any responsibility to provide care, standard or emergent. A copy of your child’s medical record is available for release upon the completion of the proper release document(s). Please note, we will fax one complimentary copy of the medical record to your new provider at no cost; however, for a hard copy there is a \$20 fee for the first 5 pages, and an additional 0.50 cent fee for each page thereafter. Note: Medical records can be retrieved free of charge from the Patient Portal.

ONE TIME ACCEPTANCE & AUTHORIZATION OF CONTENT

The signature below indicates that I have read, understand, accept, and will comply with the content of this policy. I further authorize Blackmon Pediatrics to provide my child(ren) with reasonable and proper medical care as outlined by the standards of today. This further authorizes Blackmon Pediatrics to provide care to my child(ren) in the event they are brought by someone other than me, on my behalf as designated on the “Consent to Medical Treatment and to Accompany Minor Child” form.

PARENT | GUARDIAN: _____ DATE: ____/____/____
SIGNATURE

PARENT | GUARDIAN: _____ RELATION TO PATIENT: _____
PRINTED NAME

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

TEXT | VOICE MESSAGES FOR GENERAL HEALTHCARE INFORMATION

"I give permission to the physicians and their staff at Blackmon Pediatrics to":
 (Initial all approved options)

Leave TEXT MESSAGES at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my/my child's healthcare when I am not available.

Leave VOICE MESSAGES at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my/my child's healthcare when I am not available.

VOICE MESSAGES FOR PERSONAL HEALTH INFORMATION & RESULTS

Leave VOICE MESSAGES regarding my/my child's health information including test results and diagnostic information payments of balance, care plans, referrals, when I am not available.

CELL NUMBER: (____) _____ - _____

PHONE NUMBER: (____) _____ - _____

CELL NUMBER: (____) _____ - _____

PHONE NUMBER: (____) _____ - _____

SHARING OF HEALTH INFORMATION & RESULTS

Share my/my child's health information including results, diagnosis, and appointment information with the following individual(s): **NOTE: Individuals listed below will also be permitted to pick up paperwork on your behalf.**

NAME	RELATION	PHONE NUMBER
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____
_____	_____	(____) _____ - _____

PATIENT: _____
SIGNATURE | IF 18 YEARS OLD & OVER

DATE: ____/____/____

PARENT | GUARDIAN: _____
SIGNATURE

DATE: ____/____/____

PARENT | GUARDIAN: _____
PRINTED NAME

RELATION TO PATIENT: _____



CONSENT TO MEDICAL TREATMENT AND TO ACCOMPANY MINOR CHILD

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



Blackmon Pediatrics believes it is in the best interest of a minor child to be brought in for treatment by a parent and/or legal guardian. However, we are aware that there are circumstances that arise that may require a caregiver (other than a parent or legal guardian) to bring the minor child to the office for medical treatment. In those instances, we require a parent and/or legal guardian to provide their written consent for us to provide medical treatment to the individual who accompanies the minor child.

Please list below any caregiver(s) that you authorize to accompany your minor child to the office of Blackmon Pediatrics for physical examination and/or medical treatment:

NAME	RELATION	PHONE NUMBER
_____	_____	(____)____-_____
_____	_____	(____)____-_____
_____	_____	(____)____-_____
_____	_____	(____)____-_____
_____	_____	(____)____-_____



I certify that I am the parent and/or legal guardian of the minor child listed on this document and I give authority to the caregiver(s) listed above to accompany my minor child to your office for medical treatment in my absence. I further acknowledge the following:

- This consent of treatment includes but is not limited to: immunizations, prescription and over the counter medication administration, diagnostic and laboratory testing, blood draws, and any procedures that a provider of Blackmon Pediatrics deems to be medically necessary and appropriate for my minor child.
- This consent acknowledges that the caregiver(s) may have access to the minor child's written medical health care record as well as verbal discussions regarding the minor child's historical and/or current medical diagnosis and plan of care.
- As the parent and/or legal guardian, I will make every effort to be available by phone to discuss medical treatment options and/or concerns regarding the medical condition of my minor child.

PRIMARY CONTACT NUMBER: (____)____-_____ SECONDARY CONTACT NUMBER: (____)____-_____

- As the parent and/or legal guardian, I will be financially responsible for all expenses that occur due the treatment of my child, in the event that the guarantor (if not the signatory of this document) of my minor child fails to meet the financial obligations regarding any visit where a caregiver(s) accompanies my minor child in my absence.
- As the parent and/or legal guardian, I am responsible to update this consent if/when any information contained within this document changes. Furthermore, this consent will remain in effect until it is revoked in writing and/or replaced by an updated version of the form which will be determined by the most recent date listed beside the signature below.

PARENT | GUARDIAN: _____
SIGNATURE

DATE: ____/____/____

PARENT | GUARDIAN: _____
PRINTED NAME

RELATION TO PATIENT: _____