Rivergate Pediatrics, P.C.
Patient Demographics Form

Balance for this Child only: «balance» EMAIL: «Email»

Patient Name: «FirstName» «MiddleInitial» «LastName»		
Mailing Address: «MailingAddress1» «MailingAddress2»		
Home Phone: «HomePhone»	**Cell Phone:** «CellPhone»	**Work Phone:** «WorkPhone»
Okay to leave Message ☐	Okay to leave Message ☐	Okay to leave Message ☐

Date of Birth: «DOB»	**Account Number:** «PatientAcccountNumer»
Social Security Number: «SSN»	
Emergency Contact Name: «EmergencyName»	**Phone Number:**«EmergencyPhone»
Responsible Party: «GrFName» «GrLName»	**Responsible Party Date of Birth:** «GuarantorDOB»
Responsible Party Address: «GrAddr1» «GrAddr2»	**Responsible Party Social Security Number:** «GuarantorSS
Primary Insurance: «InsuranceName»	**Effective Date:**
«InsuranceAddress»	
Subscriber Name: «Subscriber»	**Date Of Birth:** «SubscriberDOB»
Subscriber ID: «subscriberno»	**Relationship to Patient:** «RelToPatient»
Group Number: «SubscriberGroupNo»	**Subscriber SS Number:**

Secondary Insurance: «InsuranceName1»	**Effective Date:**
«InsuranceAddress1»	
Subscriber Name: «Subscriber1»	**Date Of Birth:** «SubscriberDOB1»
Subscriber ID: «subscriberno1»	**Relationship to Patient:** «RelToPatient1»
Group Number: «SubscriberGroupNo1»	**Subscriber SS number:**
PCP Provider: «PcpFName» «PcpLName»	**Resource Provider:** «encDocName»
Pharmacy Name: «pharmacyName»	**Pharmacy Number:** «pharmacyPhone»

INSURANCE ASSIGNMENT OF BENEFITS

Payment for medical services is your responsibility. **All deductibles and co-payments are due at the time of service.** We will file for insurance payments from contracted plans, but be aware that not all medically necessary services are covered services and we will bill for non-covered services. If you need to set up a payment arrangement for your account, we will be happy to work with you. If we extend you credit, you agree that we, or our agent, have permission to use normal and reasonable collection procedures to collect unpaid balances.
By law, you are required to provide us with complete insurance information on primary and/or secondary coverage.
PLEASE NOTE: TENNCARE WILL ALWAYS BE SECONDARY IF YOUR CHILD HAS ANY OTHER INSURANCE COVERAGE. FAILURE TO NOTIFY TENNCARE OF OTHER INSURANCE COVERAGE IS CONSIDERED FRAUD.
I hereby assign benefits, which may be due and payable from my insurance, to Rivergate Pediatrics, P.C.

INFECTION CONTROL CONSENT

I understand and agree that it may be necessary to test my children's blood (or my blood) while they are patients at Rivergate Pediatrics. If an employee is exposed to potentially infectious materials, by needle stick, for example, blood tests will be done at no charge and results will be confidential, as provided by state law..

CONSENT FOR TREATMENT AND SHARING OF PROTECTED HEALTH INFORMATION (HIPAA)

By my signature below, I request treatment for myself or my child/children by the physicians and staff of Rivergate Pediatrics and **grant authorization for such treatment** and **I consent to release and sharing of protected health information** for the purposes of treatment, payment, and operations. I have had an opportunity to receive and review the **Notice of Privacy Practices** of Rivergate Pediatrics.

*I authorize Rivergate Pediatrics to fax immunization forms and/or a school/work excuse, including date(s) of service and restrictions, to school, daycare, preschool, or employer at my request, such authorization to remain in force until rescinded in writing. **Yes** ☐ **No** ☐

I hereby attest that all of the above information is correct to the best of my knowledge and I have also read and agree to the above statements:

____________________________ ________________________ ________

Signature of Patient or Parent/Guardian Relationship to patient Date

****Patients Over 18 Only****
I agree that Rivergate Pediatrics can continue to give medical information to my parents/Responsible party, as in the past, EXCEPT as specifically arranged with my doctor. Yes ☐ No ☐ ____________________________