PATIENT INFORMATION/CONSENT FORM

Parent/Guardian

Name:	Relationship to Pt:	
Date of Birth:	Social Security #:	
Address:		
City:	ST:	Zip:
Home #	Cell #	Work #
Can we leave a message: Home:	Cell:	Work:
Employer:		

Primary Insurance

Insured's Name:	Date of Birth:
Social Security #:	Relationship to Pt:
Name of Inurance Co:	Effective Date:
Subscriber ID:	Group #:
Employer:	Employer Phone:

Secondary Insurance

Insured's Name:	Date of Birth:
Social Security #:	Relationship to Pt:
Name of Inurance Co:	Effective Date:
Subscriber ID:	Group #:
Employer:	Employer Phone:

Parent/Guardian

Name:	Relationship to Pat:	
Date of Birth:	Social Security #:	
Address:		
City:	ST:	Zip:
Home #	Cell #	Work #
Can we leave a message: Home:	Cell:	Work:
Employer:		

Emergency Contact (Someone outside the home)

Name:	Home #:
Relationship to Pt:	Cell #:

Person Responsible for Bill:	Phone #:	
Address:	City:	
St:	Zip:	Relationship to Pt:

Pharmacy Name:	Phone #:
Address (If Known):	
Fax # (If Known):	

Names of ALL Children in family (including child being seen today)	**Sex**	**Date of Birth:**	**Social Security #:**	**Primary Dr:**

INSURANCE ASSIGNMENT OF BENEFITS

Payment for medical services is your responsibility. **All deductibles and co-payments are due at the time of service.** WE CAN NOT BILL FOR CO-PAYMENTS. We will file your 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 we extend you credit, you agree that we, or our agent, have permission to use normal and reasonable collection procedures to collect any unpaid balance. If you do not have insurance or need to set up a payment arrangement for your account, we will be happy to work with you.

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 IS COVERED UNDER ANY OTHER INSURANCE. FAILURE TO NOTIFY TENNCARE OF OTHER INSURANCE COVERAGE IS CONSIDERED FRAUD. I hereby assign benefits which may be due and payable from my insurance company 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 & 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 received a copy of the Notice of Privacy Practices of Rivergate Pediatrics.**

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 Parent/Guardian	Relationship to Patient	Date