THE CHILDRENS CLINIC OF NASHVILLE

New Patient Health History Form

BASIC INFORMATION

First Name _____ Last Name _____
Date of Birth: ____/____/____ Today's Date _____
Primary Care Physician _____ Preferred Pharmacy _____
Sex _____ Form completed by _____ Relationship to patient _____
Date of last check up _____ Grade _____

School/ Daycare (if applicable) _____ Phone number _____

HOUSEHOLD (list all people living in the child's home)

Relationship to Child	Name	Health Problems

CHILD'S LIVING SITUATION

☐ Biological Family ☐ Foster Family ☐ Single Custody

☐ Adoptive Parents ☐ Joint Custody ☐ Other (describe) _____

If one or both parents are NOT living in the home, how often does the child see the parent? _____

BIRTH HISTORY

BIRTH WEIGHT _____ LBS _____ OZ
WAS THE BABY BORN TERM (37 weeks or more)? YES / NO
How many weeks? _____
WHERE THERE ANY PRENATAL OR NEONATAL COMPLICATIONS? YES / NO If yes, explain _____

WAS THE INITIAL FEEDING: *FORMULA OR BREAST MILK*
WAS THERE A NICU STAY REQUIRED? YES / NO
If yes, explain _____

DELIVERY: *VAGINAL OR CESAREAN*

MEDICATIONS (include doses and frequency)

_____

_____

MEDICATION ALLERGIES: YES / NO / DON'T KNOW

_____

HEALTH HISTORY

DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH? YES / NO
DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITIONS? YES / NO If yes, explain _____
HAS YOUR CHILD EVER HAD SURGERY? YES / NO / DON'T KNOW If yes, explain _____
DO YOU FEEL THAT YOUR FAMILY HAS ENOUGH TO EAT? YES / NO / DON'T KNOW

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

Frequent ear infections- 6 or more in a year? Yes or No
Eye problems? Yes or No
Teeth Problems? Yes or No
Pneumonia or asthma? Yes or No
Frequent urination Yes or No
Heart Murmur Yes or No
Diarrhea or constipation Yes or No
Convulsions Yes or No

Do you have a record of your child's immunizations? Yes or No
Did you child meet milestones on time? Yes or No If no, explain _____

The Children's Clinic of Nashville, P.L.C

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, The Children's Clinic of Nashville may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to The Children's Clinic of Nashville Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review and/or obtain a copy of the Notice of Privacy Practices prior to signing this consent. The Children's Clinic of Nashville reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Children's Clinic of Nashville Privacy Officer at 4322 Harding Pike, Suite 313, Nashville, TN 37205.

With my consent, The Children's Clinic of Nashville may call my home or other designed locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to me or my child's clinical care.

I have the right to request that The Children's Clinic of Nashville restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this agreement, I am consenting to The Children's Clinic of Nashville's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Children's Clinic of Nashville may decline to provide treatment to me or my child.

_____ _____

Print Name (Parent/Self/Legal Guardian) Signature (Parent/Self/Legal Guardian)

_____ _____

Patient's Name Date

Liability Disclaimer for PATIENT PORTAL

THE CHILDREN'S CLINIC OF NASHVILLE,PLC does not provide liability insurance for the protection of individuals, groups, organizations, businesses, spectators, or others who may participate in the PATIENT PORTAL.

In consideration for your participation in the PATIENT PORTAL the individuals, groups, organizations, businesses, spectators, or other, does hereby release forever discharge THE CHILDREN'S CLINIC OF NASHVILLE,PLC, and its officers, board members, and employees, jointly and severally from any and all actions, causes of actions, claims and demands for, upon or by reason of any damage, loss of injury, which hereafter may be sustained by participating in the PATIENT PORTAL.

This release extends and applies to, and covers and includes all unknown, unforeseen, unanticipated and unsuspected injuries, damages, loss and liability and the consequences thereof, as well as those now disclosed and known to exist. The provisions of any state, federal, local or territorial law or state providing substance that releases shall not extend at this time, to the person executing such release, are hereby expressly waived.

I hereby agree on the behalf of my heirs, executors, administrators, and assigns, to indemnify THE CHILDREN'S CLINIC OF NASHVILLE, PLC and its officers, board and employees, joint and severally from any and all actions, causes of actions, claims and demands for, upon or by reason of any damage, loss or injury, which hereafter mat be sustained by participating in the PATIENT PORTAL.

It is further understood and agreed that said participation in the PATIENT PORTAL is not to be constructed as an admission of any liability and acceptance of assumption of responsibility by THE CHILDREN'S CLINIC OF NASHVILLE,PLC, its officers, board, and employees, jointly and severally, for all damages and expenses for which THE CHILDREN'S CLINIC OF NASHVILLE,PLC, , its officers, board, and employees, become liable as a result of any alleged act of the PORTAL participant.

_____ _____

Name of Parent, Guardian or Patient

Name of Patient(s) (Print name)

_____

Email for Portal sign-up

If you are 18+ and want to access to the Patient Portal given to another person on your behalf:

_____ _____

Person's name to give access

Person's email address

_____ _____

Signature

Date

Patient Portal Policy

Our patient portal will give you 24/7 access to your child's medical record. It allows you to print their medical history and immunization records. It also allows you to contact us via secure messaging for NON-CRITICAL QUESTIONS. Once you have signed up for the portal, you will receive an email with a temporary password that expires after 24 hours. Please check and update it with your new secure password so you can have access to the portal.

Terms & Conditions:

Access to the portal will automatically renew every year unless we are notified in writing to cancel, or you are transferring out of the practice. You may contact us anytime to cancel your portal access. We reserve the right to suspend your access if you are terminated from the office due to the account being sent to collections.

Please be aware of the disclaimer when entering the portal messaging center. All portal messages requiring advice or treatment will be subjected to a $40 charge. We will bill this charge to your insurance company. This charge also includes any in-depth forms or letters that require more than the standard time to do. Requests for medication refills, shot records and medical forms (requiring a signature only) will NOT incur a charge.

Secure Messaging & Disclaimer:

The Secure Messaging feature offered through the patient portal is for **NON-CRITICAL QUESTIONS ONLY.** The following are some examples of NON-Critical Questions:

- I need to make an appointment for my child's physical exam, what does my pediatrician have available next week?
- What are your hours for the Saturday walk-in?
- If you have a critical question, please contact our office during normal business hours. If this is an emergency, please call 911. All questions directed through our portal will be answered within 48-72 hours. Messages left after 4:30 P.M. CST will not be read until the next business day.

Waiver & Release Liability:

- I understand that participation in the Patient Portal is VOLUNTARY and that my consent is given considering this knowledge. I have been informed of the benefits and Terms & Conditions of the Patient Portal access that I am about to receive. I assume all responsibility for any adverse consequences as allowed by applicable law.
- The Children's Clinic of Nashville, PLC shall not, at any time, or to any extent allowable by applicable law be liable, responsible, or in any was be accountable for any loss, injury, death, or damage suffered or sustained by me or any other person at any time in connection with, or as a result of, participating in the Patient Portal being offered by The Children's Clinic of Nashville, PLC.
- I, for myself, my heirs, executors, personal representatives and assigns, hereby release The Children's Clinic of Nashville, PLC, its employees, its agents or representatives from all claims arising out of, in connection with, or in any way related to my participation in the Patient Portal offered by The Children's Clinic of Nashville, PLC as allowed by applicable law.

By signing below, I certify that the following statements are true:

- I am the patient or the patient's guardian/ personal representative signing on behalf of the patient.
- I read, understood and agree with all the statements on this form.

X_____ _____ _____

Signature of Parent, legal guardian or Patient (if 18 yrs & above) Printed Name Date

THE CHILDRENS CLINIC OF NASHVILLE

The Children's Clinic of Nashville Telemedicine Policy

The Telemedicine Services involve the use of secure interactive videoconferencing equipment and devise that enable healthcare professionals to deliver health care services to patients when face to face appointments are not available. Please review the policy below.

1. I understand that the same standard of care applies to a telemedicine visit as it applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there is potential risk to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and my refusal will be documented in my medical records. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my rights at any time by contacting The Children's Clinic of Nashville at 615-297-9541.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit purposes.
    b. I understand that I will be responsible for any out-of-pocket expenses such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become part of my medical records.

By signing this, I attest that I (1) have personally read this document (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language that I understand; and (3) I am located in the state of Tennessee and will be in Tennessee during my telemedicine visit(s).

_____ _____

Patient/Parent/ Guardian Printed Name Patient/Parent/ Guardian Signature

_____

Date

THE CHILDRENS CLINIC OF NASHVILLE

The Children's Clinic of Nashville Financial Policy

We wish to provide the best possible medical care for your family. This involves mutual understanding between the patient, doctors, and staff. We encourage you to discuss any questions you may have about this payment policy with our Billing Department.

As a courtesy to our patients, we will file your charges with your insurance company. Most insurance plans have coverage limitations, and you are responsible for understanding your coverage. If your insurance refuses payment for any service, you will have to pay in full for the services that were provided to you.

After insurance payments have been made, any unpaid or remaining balance on the account must be paid within 30 days. We ask that you provide a credit card to be on file to charge the outstanding amount to your account. Unpaid balances over 120 days will be turned over to our collection agency. You can reach out billing department anytime during normal business hours.

- If you do not have healthcare coverage, you must pay in full at the time of service.
- All charges are due within 30 days of the first billing cycle. If circumstances call for an extended payment plan, our billing department will assist you in these unusual circumstances at your request.
- An itemized statement of all medical services will be mailed to you if there is any balance that has been turned over to patient responsibility.
- There will be a fee charged for all returned checks. If there are (2) returned checks on your account, all future payments must be paid by cash or card.

MISSED APPOINTMENTS:

Our office requires 24-hour notice of cancellation. If proper notice is not given, we reserve the right to charge a $50.00 fee ($100 for Consultation) to your account. Unavoidable extenuating circumstances will be taken into consideration on a case-by-case basis.

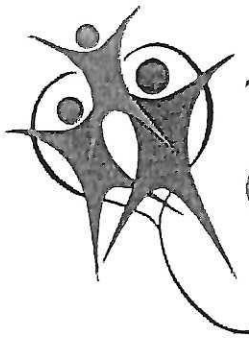
Financial Responsibility and Release of Information

1. I understand that I am financially responsible for charges not covered by my insurance policy. I also agree that should I not assume this financial responsibility, and credit action is necessary, I will pay for these costs in addition to the amount of the physician's charges.

2. I authorize The Children's Clinic of Nashville to release to the Social Security Administration or intermediaries or carriers, or other insurance companies any medical or other information needed for this or related insurance claims. A copy of this authorization may be used I place of the original.

_____ _____

DATE Signature of Patient/ Guardian



THE CHILDRENS CLINIC OF NASHVILLE

AUTHORIZATIONS FOR CREDIT/ DEBIT CARD TRANSACTIONS

Until further notice, I authorize The Children's Clinic of Nashville to charge or refund the patient responsibility balance on my account using the card I have provided.

I understand that I am responsible for updating my card information including card number and mailing address as soon as the expiration date expires or the card information changes. Any delay in updating the card information may result in additional fees for processing my payments. I am also responsible for updating my email address to receive receipts of all transactions.

Printed Name: _____

Patient(s) Name: _____

Email Address: _____

Signature: _____ Date: _____

THE CHILDRENS CLINIC OF NASHVILLE

Office Policies and Procedures

Billing Procedures:

We will verify your insurance at every visit. Whether it is a scheduled appointment or same day. If we see an issue with your insurance, we will contact you prior or make you aware at that time. We do ask that you bring us an up-to-date insurance card to all appointments. If we can not verify coverage at the time of service, we do offer a self-pay/ out of pocket option. This option requires payment at that time of service. We will refile any claims if coverage is retroactive back to that date of service and we will refund once the insurance has processed the claim.

We send patient responsibility balances at the first of the month. Any accounts that are 120 days past due must pay or set up a payment arrangement to be seen. All accounts that are not paid by 120 days will be sent to our collection agency, Fox Collections. If you are sent to collections and would like to return to the practice, we require the balance to be paid in full. Either with Fox Collections or our billing department. There is also a reinstatement fee of $40 that must be paid before your seen.

Please contact our billing team with any questions regarding your bill. We will be happy to set up payment arrangements that work for your family. We never want to lose a patient due nonpayment on an account, so if we can help in any way, please contact us in the billing department at 615-297-9541.

Credit Card on file system:

We do offer a credit card on file option for payments. This includes all copays, deductible, or non-covered services by your insurance company. We will ask you upon arrival if you would like to leave a card on file in our secure private gateway system. If you agree, we will need you to fill out a waiver stating you give us permission to use your card on file for future balances and copays. We do run a report twice a month for all personal balances owed. If you choose to have your credit card on file, you will receive a receipt by email if you are charged for a balance. If you leave an HSA card on file and need a detailed bill/receipt, please contact our billing department at 615-297-9541.

Telephone and Telemedicine Policy:

We do offer telemedicine visits, but it depends on the type of visit you are requesting. All checkups/ physicals must be performed in the office. Select sick visits can be done as telemedicine. When calling in to leave a message for a provider or nurse, please be prepared to give us as much information as possible. This will help determine how triage the call and better serve you. When requesting a refill for any medication, please have an up-to-date pharmacy number and address available. All phone calls are sent to our providers, and you will receive a call back by the end of day. Please give us time on all call backs as they are seeing patients throughout the day. If it is an urgent matter, please make the receptionist aware and they may be able to handle it promptly.

After Hours Call:

All after-hours calls will be returned by the doctor that is on call for that evening or weekend. We ask that you restrict all after-hours calls for significant or emergency illnesses. If you feel you must go to the ER, please contact the doctor on call first or our office during normal business hours. Some after-hour calls may result in a charge if treatment is involved. This charge with be determined on the time spent regarding the issue.

Portal Messaging:

When using our patient portal for medical questions or concerns please know that there will be a $40 charge that we will bill your insurance company. Any balance that is due from your deductible or not covered service will be your responsibility. The portal is not for urgent or emergency questions. Please know that the portal is only answered and checked during our normal business hours.

Form: School, Sports, Camp and Daycare:

We will provide shot records and physical forms at all check up appointments. Any additional forms needed will need to be brought to the appointment or requested at that time. Forms that are brought in after the check up appointment could result in a $10 charge per form. All patients must have an up-to-date check-up on file before we can fill out any form.

Please remember to schedule your annual check-ups for the next year before you leave your appointment.

THE CHILDREN'S CLINIC OF NASHVILLE

Patient Registration

DATE: _____

How did you hear about us?

_____ Word of mouth
_____ Internet search
_____ Referring physician

Patient's Legal Name: _____ Preferred Name: _____
Last First Middle

Sibling's: _____

DOB: _____ Sex: Male Female

Address: _____
Street Apt # City State Zip Code

Race:
____ White
_____ Asian
_____ American Indian or Alaska native
_____ Black or African American
_____ Native Hawaiian or other Pacific Islander
_____ Prefers not to answer

Ethnicity:
_____ Hispanic or Latino
_____ Not Hispanic or Latino
_____ Prefers not to answer

A.) Parent's Name: _____ Date of Birth: _____
Last First Middle

Social Security Number: _____

Address: _____
Street Apt# City State Zip Code

Home Phone: (___) _____ Cell Phone: (___) _____

Email: _____

Employed By: _____ Business Phone: (___) _____

B.) Parent's Name: _____ Date of Birth: _____
Last First Middle

Social Security Number: _____

Address: _____
Street Apt # City State Zip Code

Home Phone: (____) _____ Cell Phone: (___) _____

Email: _____

Employed By: _____ Business Phone: (___) _____

WHO CARRIES THE PRIMARY INSURANCE COVERAGE? Parent A OR Parent B
(Circle one)

Name of Nearest Relative or Friend: _____

(Not Living at Same Address) Relationship to Patient: _____ Phone: (____) _____