Knoxville Pediatric Associates, P.C. WEISGARBER OFFICE Patient Information

Child(ren):

First Name	Middle	Last	DOB	M/F	SSN#

Primary Insurance Company:_____

Policy/ID #_____**Group #**_____

Effective Date:_____

List children on this plan_____

Secondary Insurance Company:_____

Policy/ID #_____**Group #**_____

Effective Date:_____

List children on this plan_____

Child(ren) Live with: ◯ Both Parents ◯ Father ◯ Mother ◯ Other: Specify_____

Parents Marital Status: ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Single

Parent/Guardian

Relationship to Patient(s):_____

Last Name First MI

DOB_____ SSN#_____

Street Address:

City, State, Zip

Primary Phone	Work Phone	Cell Phone

Email address:_____

Employer Name:	Occupation:

Other Parent/Guardian

Relationship to Patient(s):_____

Last Name First MI

DOB_____ SSN#_____

Street Address:

City, State, Zip

Primary Phone	Work Phone	Cell Phone

Email address:_____

Employer Name:	Occupation:

Preferred Pharmacy:_____ Location:_____

-OVER-

Thank you for choosing *Knoxville Pediatric Associates* as your child(ren)'s health care provider!

OUR FINANCIAL POLICY

Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. Therefore, financial responsibility for your child(ren)'s treatment is ultimately that of the parent/guardian. Parents/Guardians are responsible for all co-pays and deductibles prior to services being rendered. You will be held responsible for the entire amount of the insurance claim if you knowingly fail to provide correct insurance information in a timely manner. If you have an insurance with which we do not participate, it is your responsibility to pay at the time of service. A service charge of $35 will be added for any checks drawn on insufficient funds. For your convenience we accept cash, check, and Visa/MasterCard/Discover credit cards or debit cards.**The parents/guardians are responsible for any bill incurred, regardless of any divorce decree or court order stating otherwise.**

OUR OFFICE POLICY

A patient that is not seen within a 3 year span will be considered a new patient and charged accordingly.

Prescription refills will only be approved during normal business hours. It is not our policy to call in medications without the child being seen first, unless it is a refill.

If 3 or more appointments are missed within a 1 year span, the **family** is subject to dismissal from KPA. Appointments that are canceled without sufficient notice are considered a missed appointment. Missed appointments are also subject to a $35 fee per appointment.

Additional charges may be incurred (or copays may be required) for additional concerns discussed at physical exams.

PERMISSION TO CONTACT

◯ Leave lab results on my answering machine

◯ Leave lab results with my family

◯ Leave general questions/medical information on my answering machine

◯ Leave general questions/medical information with a family member

◯ ONLY leave information with myself *Please note if you check here, there should be no other choices marked.*

◯ May speak with interpreter. * Please list name and phone number of interpreter. _____

The following people are authorized to bring my child for any necessary medical treatment, speak with the staff at KPA regarding my child, or sign any consent forms in my absence; or discuss the financial aspects of my child's account: (please list someone other than parent/guardian)

Name	**Relationship to Patient**	**Phone**

Emergency Contact (please list someone outside of household)

Name	**Relationship to Patient**	**Phone**

Your signature below allows us to:

1. Accept payment of benefits directly from your insurance company under the terms of your insurance. Release medical records to your insurance, hospitals, any physician, and attorneys for the purpose of determining benefits, coordination of care, or legal matters.
2. Obtain necessary information from your child(ren)'s other health care providers.
3. Allow KPA and/or its affiliates to contact you at the provided numbers regarding collection on account balances.
4. Release medical info to State Health agencies.

Your signature below also indicates your acknowledgement that you have been provided with a copy of the Notice of Privacy Practices Policy (HIPAA), that you have read and understand KPA's Financial and Office Policies as described above, and that your answers regarding contacting you regarding your child and permission for someone other than you may seek medical treatment are accurate.

Printed Name:_____ **Signature:**_____

Relationship:_____**Date:**_____