Optimum Internal Medicine & Pediatrics

Pediatric Patient Registration Form

All Fields Must Be Completed

Date

Patient's Name (First, Middle, Last) Sex: Male/Female	Date of Birth / / Social Security Number - -
Patient's Address	Telephone (Home) ( ) (Cell) ( )
City State Zip	Email address (if entered you will be emailed for appointment reminders)

Parent / Guardian Information

Mother Name / Guardian	Father's Name / Guardian
Mother's Date of Birth / / Mother's Social Security Number - -	Father's Date of Birth / / Father's Social Security Number - -
Mother's Address (if different from above)	Father's Address (if different from above)
Are there any custody issues to be noted? (if yes, Please explain)	

Type of Health Insurance: ☐Medicaid (ex: Amerigroup, United HealthCare) ☐Commercial (ex: Cigna, BCBS) ☐Other

Please complete All Insurance Information: (Please give cards to receptionists to make copies)

Primary Insurance:	Secondary Insurance: (If no secondary, please write N/A)
Policy ID # Group #	Policy ID # Group #
Effective Date:	Effective Date:

Policy Holder Information (Complete the information below if the Patient is Not the Policyholder)

Primary Policyholder's Full Name Date of Birth	Secondary Policyholder's Full Name Date of Birth
Social Security Number Sex: Male / Female	Social Security Number Sex: Male / Female
Relationship to Patient Is Address Same as Patient? If No, List Below	Relationship to Patient Is Address Same as Patient? If No, List Below

Please read the following and sign below:

I hereby authorize Optimum Internal Medicine and Pediatrics to provide any health information related to my child to their insurance company or other responsible payer, for the purposes of payment for any health care provided. I also authorize Optimum Internal Medicine and Pediatrics to provide health information to other physicians and healthcare facilities for any continuing care. I further agree that Optimum Internal Medicine and Pediatrics can use the health information for any educational needs or operations such as peer review and outcomes analysis.

Responsible Party Signature: _____ **Date**: _____

New Pediatric Patients:

All children must be accompanied by their parent / legal guardian. The parent / legal guardian must have Photo ID. If accompanied by legal guardian, you must bring in proof of guardianship at time of visit.

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Please List any Current and Past Surgeries / Hospitalizations:

Past Surgeries: _____ _____ _____
_____ _____ _____
_____ _____ _____

Past Hospitalization: _____ _____ _____
_____ _____ _____
_____ _____ _____

Medical History: Current or Past Medical Problems for Self or Family

	PATIENT	Mother	Father	Sibling	Other
Heart Disease					
Congenital / Valvular Heart Disease					
Anemia					
Endocrine disease such as Thyroid Disease					
Diabetes					
Cancer (please list which kind)					
Depression / Mental Illness / ADHD					
ENT Issues such as Ear Infections/ Sinus infections					
Asthma / Lung Problems					
Seizures / Convulsions					
Seasonal Allergies					
Kidney Disease / Bladder Disorder					
Bleeding Problems					
GI Disease such as Constipation					
Nerve / Muscle Disorder such as Cerebral Palsy					
Skin Disorders such as Eczema					

Preferred Pharmacy and Current/Past Physicians: (Please indicate the dates [month/year], if applicable)

Preferred Pharmacy Name/Phone/Address:

Past Primary Care Doctor Name/ Phone/ Address:

Current Specialists Doctor Name/ Phone/ Address:

Social History: Do you smoke or Vape? Y N Do you use alcohol? Y N Do you use Drugs? Y N
Are you sexually active? Y N Do you practice Safe Sex practices such as wearing a condom? Y N Are you depressed? Y N

Responsible Party Signature: _____ Date: _____

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Preventative Care (Please indicate dates, if known and applicable)

Last Well Child EPSDT Exam	Vaccines Up To Date for Patient: Y N U	Last Eye Exam:	Last Hearing Exam:	Last Screening Blood Work:

Allergies: Please list any allergies you may have (medications or other) and any reactions they cause

Medication / Other Type of Allergy	Reaction

Medications (Please list all Current medications that you care taking including supplements and OTC meds.)

Medication Name	**Dosage**	**Times Daily**
Example: Aspirin	*81mg*	*3 times a day (morning, noon, bedtime)*

Responsible Party Signature: _____ Date: _____

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Patient Name: _____ **DOB**: _____

In case of an Emergency, Please list who would you like us to contact:

Emergency Contact Name: _____ Phone:_____

Note: *If you would like your medical information released to your Spouse, Children, or other individual, please denote their name and relationship to you in the lines below and sign your name.*

(Any individuals you have assigned access to your health information will only be allowed information with your signed consent below.)

_____ _____

_____ _____

_____ _____

_____ _____

I hereby authorize Optimum Internal Medicine & Pediatrics the right to disclose my medical information to the above names listed. They also have the right to receive any medications, prescriptions, and paperwork on my behalf. I have the right to terminate this consent at any time by providing an updated signed change of consent form.

Medical Consent

I consent to all treatment given under the general and special instructions of the attending provider and/or his designee. Treatment may include, but not limited to, diagnostic procedures, therapeutic procedures, administration of anesthetics, use of prescribed medication, medical services, the collection and utilization of cultures and laboratory specimens, referral to specialty services for radiology, physicians consultation, and other medical services, all of which may be considered medically necessary or advisable in the judgment of the attending physicians or their designees. I also realize that certain unforeseen risks are inherent with medical treatment including but not limited to allergic reaction, adverse events, scarring, infection, and even death, and I will not hold Optimum Internal Medicine and Pediatrics responsible for any such events unless gross negligence is the cause of these events. I authorize Optimum Internal Medicine and Pediatrics to release any health information to my insurance company or other payer, for the purposes of payment for any services provided. I also authorize Optimum Internal Medicine and Pediatrics to provide health information to other physicians and healthcare facilities for any continuing care. I also acknowledge that I have been informed and am able to receive a copy of the Notice of Privacy Practices for Optimum Internal Medicine & Pediatrics at any time.

Medicare Patients

Should I be eligible for Medicare coverage, I request that payment of authorized Medicare benefits be made to Optimum Internal Medicine and Pediatrics on my behalf. I certify that the information given by me is correct. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

Protected Health Information *Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose our protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.*

Responsible Party Signature: _____ Date: _____

Optimum Internal Medicine & Pediatrics

Patient Name: _____ DOB: _____

Payment of Services *I authorize the release of any medical information necessary to process Insurance claims for my medical benefits. I authorize and assign any payment of Insurance medical benefits to Optimum Internal Medicine and Pediatrics, its successors and assigns, or any individual it may designate for the services provided. Our office will inform you of the amount due when you check out. This includes, but not limited to, Co-Payment, deductibles, etc. this amount is due at the time of service. As a courtesy to you, we will file your insurance claims if you provide us with a copy of your current insurance card. I understand that if I am self-pay, full payment is due at the time of service. I further agree to pay all costs of collection, including attorney's fees, collection agency fees, and any other fees associated with the collection of any amount due for services rendered and performed. I understand that I am financially responsible to Optimum Internal Medicine and Pediatrics, its successors and assigns and any individual it may designate for any balance not covered by insurance. If you are having laboratory and/ or diagnostic services by providers other than Optimum Internal Medicine and Pediatrics, you may be billed separately by the lab or diagnostic facility providing the service. *A $35.00 service charge will be added on all checks returned to us for insufficient funds. *$100 service fee will apply to all at home visits for a transportation and convenience fee outside of billing your insurance company for the visit **Delinquent accounts will be forwarded to a collection agency.*

No Call/No Show Policy: *Our office asks that you make every scheduled appointment. We, however, understand that missed appointments do occasionally occur. We ask that you call at least 24 hours before your scheduled appointment to cancel. If you are unable to call and cancel and you miss your appointment a $25 charge will be added to your account as a "No Cancellation Fee."*

Forms / Letters: *Forms, such as medical letters, employment paperwork, disability paperwork, DMV forms, or any other form or letter being prepared and signed by the physician requires a payment of $25.00 and must be paid before the item can be finalized and faxed, mailed, or picked up in person.*

Prescription Refills: *If you need a prescription refilled, please call your pharmacy. They will contact our office directly or by computer. We do not refill narcotics or controlled prescriptions after hours or on weekends.*

Medical Records: *There is no charge (for first copy) if records need to be sent to another doctor/clinic. After the first copy there may be a fee. Medical records less than 40 pages requires a $20 fee after a first copy is obtained and then 25 cents per page for those over page 40. If you would like your medical records saved on a disc instead of hard copy there is a $5.00 fee for this service.*

After hours phone number: *ONLY urgent calls for ill patients should use the After Hours Number. Please do not call the after-hours number for prescription refills that can be completed during office hours. Any abuse of this system will be noted on patient's chart and discussed with the patient at the next appointment. If it becomes an issue, there may be a $5.00 charge for non-urgent calls requiring our physician's time and attention.*

Assignment of Insurance Benefits and Third party Claims: *If the account is not paid at the time of service, I hereby assign to Optimum Internal Medicine and Pediatrics the proceeds from the following: TRICARE medical benefits; PIP (personal injury protection); sick benefits; physician benefits; injury benefits; any health or accident benefits of any form relating to the patient, whether insured or self-funded; proceeds of any liability settlement or judgment being paid by a third party; and any other benefits due from my insurance policy. All amounts collected will be applied to the patient's account. I understand that I am responsible for any charges not covered by insurance or other benefits and I agree to pay any fees due in full for services rendered. I further warrant and represent that any insurance or any plan that I assign is valid insurance. In the event a claim for payment submitted by Optimum Internal Medicine and Pediatrics to my insurance carrier or plan administrator is denied, I hereby authorize Optimum Internal Medicine and Pediatrics to seek an administrative review of the disputed claim in accordance with the applicable provision(s) of my plan or policy. If this review is denied or the insurance company refuses payment for any reason, I understand and accept that I am still responsible and will pay in full for all services rendered.*

Patient Photo: *I understand that a facial photo may be taken and a copy of a photo ID obtained at the first visit & periodically thereafter for identification purposes only & it will be part of my medical record and will be subject to all the protection that other personal health information receives.*

Property Liability: *I understand that certain unforeseen circumstances may lead to a possible injury on Optimum Internal Medicine & Pediatrics property, including but not limited to, falls, motor vehicle accidents, and other personal injury that are not in the control of Optimum Internal Medicine & Pediatrics. I hereby relinquish all financial or legal liability on the part of Optimum Internal Medicine & Pediatrics for any such event.* **Electronic Services:** *As of this year, Medicare and some commercial insurances cover Chronic Care Management, Remote Patient Monitoring, Telephone Interactions, Electronic (email/text), and Telemedicine services provided by my primary care provider per event or per calendar month. I understand that my primary care provider, OptimumInternal Medicine and Pediatrics, will provide such services to me if I meet criteria and if I am in need. I understand that as part of these services, I will receive a copy of my care plan or it will be made available to me on my patient portal for access 24/7 to aid me with interactions and coordination of care with other clinics, hospitals, and caregivers. I also understand that I can revoke this agreement at any time (effective at the end of the calendar month) and can choose, instead, to receive these services from another health care provider after the calendar month in which I revoke this agreement. I understand these above services are subject to the usual Medicare and other insurance deductible and co-insurance applied to medical services. My signature also authorizes my primary care provider to electronically communicate my medical information with other treating providersas part of the care coordination involved in these services.*

Responsible Party Signature: _____ Date: _____

Authorization for Release of Patient Information

I hereby authorize

_____ ____-____-_____ ____-____-_____

Doctor/Clinic Name | Telephone | Fax

to release the following health information from the records of:

_____ _____ _____-____-_____

(Patient Name) (DOB) (SSN)

Information to be released:

- ☐ Copy of complete health record
- ☐ H&P
- ☐ Recent lab-work results
- ☐ Diagnostics (x-rays, MRI results, etc.)
- ☐ Immunization Record
- ☐ Discharge summary
- ☐ Preventive care records (colonoscopy, mammogram, pap smear, PSA, smoking cessation counseling, etc.)
- ☐ Operative report
- ☐ Other: _____

Information is to be released to:

Dr. Christopher S Burress
Optimum Internal Medicine and Pediatrics
10044 Hwy 46
Bon Aqua, TN 37025
PH: (931)996-4247 FAX #: (888)814-0893
Email: christopher.burress@oimp.eclinicaldirectplus.com

Purpose for disclosure is for continuity of medical care.

Responsible Party Signature: _____ Date: _____