EAST TENNESSEE Children's Hospital

Patient Information

Patient

PCP: _____

Last Name: _____ First: _____ Mid: _____

DOB: ___/___/_____ Sex: Male/Female SSN: _____-_____-_____

Address Line 1: _____ Primary Phone: ☐ Home ☐ Cell

Address Line 2: _____ Home Phone: (____)_____-_____

City: _____ State: _____ Zip: _____ Cell Phone: (____)_____-_____

Mother/Legal Guardian

Relation: _____

Last Name: _____ First: _____ Mid: _____

DOB: ___/___/_____ Sex: Male/Female SSN: _____-_____-_____ Marital Status: _____

Address: _____ Primary Phone: ☐ Home ☐ Cell

City: _____ State: _____ Zip: _____ Home Phone: (____)_____-_____

Cell Phone: (____)_____-_____

Employer: _____ Ok to leave message: (Y / N)

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Work Phone: (____)_____-_____

Father/Legal Guardian

Relation: _____

Last Name: _____ First: _____ Mid: _____

DOB: ___/___/_____ Sex: Male/Female SSN: _____-_____-_____ Marital Status: _____

Address: _____ Primary Phone: ☐ Home ☐ Cell

City: _____ State: _____ Zip: _____ Home Phone: (____)_____-_____

Cell Phone: (____)_____-_____

Employer: _____ Ok to leave message: (Y / N)

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Work Phone: (____)_____-_____

Emergency Contact (Other than Parent or Legal Guardian)

Relation: _____

Last Name: _____ First: _____ Mid: _____

Address: _____ Home Phone: (____)_____-_____

City: _____ State: _____ Zip: _____ Cell Phone: (____)_____-_____

(Continued on back)

Patient

Race: ☐American Indian/Alaska Native ☐Asian ☐Black or African American ☐Hispanic ☐White ☐Other

Ethnicity: ☐Non-Hispanic ☐Hispanic/Latino ☐Refused to report

Preferred Language for healthcare discussion: ☐English ☐Spanish ☐Other_____

Insurance Information (Primary)

Insured's Last Name: _____ First: _____ MI: _____

Relationship to Patient:_____ DOB: ___/___/_____ SSN:_____-____-_____

Insured Address:_____ Phone: (____)_____-_____

City:_____ State: _____ Zip: _____

Insurance Name:_____ Effective Date: ___/___/_____

Employer Name:_____

Insurance Information (Secondary)

Insured's Last Name: _____ First: _____ MI: _____

Relationship to Patient:_____ DOB: ___/___/_____ SSN:_____-____-_____

Insured Address:_____ Phone: (____)_____-_____

City:_____ State: _____ Zip: _____

Insurance Name:_____ Effective Date: ___/___/_____

Employer Name:_____

Pharmacy

1) Name: _____ Phone: (____)_____-_____

Address: _____

2) Name: _____ Phone: (____)_____-_____

Address: _____

Preferred Communications

Phone call: ☐

Text messaging: ☐

Preferred Phone: (____)_____-_____

Preferred Language: ☐ English ☐ Spanish

Preferred Time to Call: ☐ Morning ☐ Afternoon ☐ Evening

Send Reminder/Follow-up Letters: ☐

Send Reminder/Follow-up Emails: ☐

Type of Reminders/Follow-up:

Select All ☐

Appointments ☐

Lab results ☐

Health Maintenance ☐

Rx Confirmation ☐

General Notification ☐

_____ _____ _____

Parent/Legal Guardian Signature **Relationship** **Date:**

East Tennessee Children's Hospital

Parent / Guardian's Consent for Treatment, Information Sharing, and Financial Agreemen

Patient Name: _____

1. The doctor and staff of this East Tennessee Children's Hospital (ETCH) Practice have my permission to give medical care to the patient.
2. I give ETCH permission to release the patient's health information to referring physicians, specialists, or other providers who may be involved in the patient's treatment. I understand that ETCH may exchange this health information electronically through the East TN Health Information Network (etHIN). I understand I can choose not to participate by completing the etHIN Exchange Opt-Out Form.
3. I understand that the patient's insurance company needs to know about the patient's visit. I allow ETCH to give necessary medical information to the patient's insurance company, any government agency, or the State of Tennessee.
4. I DO ☐ DO NOT ☐ give ETCH permission to request the patient's Medication History from other providers and from the patient's insurance company(ies).
5. I agree that insurance payments will go directly to ETCH and the physicians, and that any Medicaid or Medicare payments will go directly to ETCH. I will provide truthful information on all financial papers.
6. I understand that the patient may receive treatment from a health care provider who is not listed in the patient's insurance plan. I understand that I may receive a separate bill for the health care provider for the amount not paid by the patient's insurance.
7. I will pay the deductible and/or co-payment amounts and will pay for charges not covered by the patient's insurance. I understand that co-payments are to be made on the date of service. I understand that any unpaid account balances may be turned over to a collection agency. I realize this may affect my credit rating and I may be responsible for all collection and legal fees incurred by ETCH to collect th outstanding balance.
8. I understand that if the patient's insurance plan requires a referral from the primary care physician, the referral must be obtained before the visit to ensure the patient's maximum benefit from the insurance plan. I understand if the referral is not in place, I must take full responsibility for payment due.
9. I understand that if the patient is scheduled for a Well Check appointment and during that appointment the provider finds a condition requiring treatment (such as strep, otitis media, etc.) my insurance could require me to pay a separate co-payment.
10. I understand that if I need to cancel an appointment, I must do so at least 24 hours prior to the appointment time. I understand that the patient must come to all scheduled appointments. I understand that if the patient misses multiple appointments, the patient may be discharged from the practice.
11. I understand that a provider or employee may be exposed to the patient's blood. If that happens, I allow ETCH to test the patient's blood for Hepatitis B & C and HIV. This blood testing is free of charge and is confidential.
12. I have received a copy of ETCH's Notice of Privacy Practices. I can get another copy at any time by calling (865) 541-8053. I consent to ETCH's use of protected health information as described in the Notice. I understand that I must give a separate authorization before an other disclosures may be made.
13. I ☐ would or ☐ would not like to participate in the eClinical Works Patient Portal and authorize ETCH to use my e-mail address for purposes of participation.
14. I understand that it is this office's policy to retain a scanned copy of legal documents or guardianship papers if guardianship changes at any time. I understand that the office requires a copy of identification the first time someone presents with a patient. Insurance cards may be requested at each visit.
15. I give consent for the following individuals to bring the patient to ETCH for treatment of illnesses or injuries. I hereby give permission to ETCH to exchange information with the following individuals. This request will remain in effect until revoked by me in writing..

a) Name: _____ [relationship:_____phone:_____]
b) Name: _____ [relationship:_____phone:_____]
c) Name: _____ [relationship:_____phone:_____]
d) Name: _____ [relationship:_____phone:_____]
e) Name: _____ [relationship:_____phone:_____]

I understand this consent will be used in its entirety across all eClinicalWorks practices that are owned or affiliated with ETCH

Signed: _____ Date:_____
Printed Name: _____ Relationship to Patient:_____
Interpreter's Signature: _____ Date:_____