PEDIATRIC ASSOCIATES
OF WEST TENNESSEE, PLLC

Date: _____ _____ _____ _____ _____ _____ _____

Annual Verification/Date/Initials (Only initial and date ONCE per year)

Patient Information:

Full Legal Name: _____

Nickname: _____ SSN: _____.

Date of Birth: _____ Gender: _____ Race: _____

Guarantor (Parent/Guardian) *(Responsible for Payment)*	***Other Legal Parent/Guardian***
Full Legal Name _____	_____
Male or Female (circle one)	Male or Female (circle one)
Birthdate: _____	_____
SSN: _____	_____
Address: _____	_____
City, State, Zip: _____	_____
Cell Phone: (___) _____	(___) _____
Work Phone: (___) _____	(___) _____
Email: _____	_____
Employer: _____	_____
Occupation: _____	_____

Person Child Lives with: _____

1st Emergency Contact: _____ Relationship: _____

Emergency Contact Cell (___) _____ Other (___) _____

2nd Emergency Contact: _____ Relationship: _____

Emergency Contact Cell (___) _____ Other (___) _____

*Parents are: ___Single ___Married ___Seperated ___Divorced ___Other

-If Single, Separated or Divorced, does non-custodial parent have the right to bring the child to the doctor? **YES or NO (please circle one)**

Please list any person other than Parents/Guarantors who are allowed to bring your child to the office visit and whom you give permission to speak to the provider regarding your child's health. ****MUST BE 18 YEARS OR OLDER!****

Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____

Authorization for Consent, Payment and Financial Responsibility (Please Read and Sign):

* I consent to and authorize Pediatric Associates of West Tennessee, PLLC, its providers including physicians, nurse practitioners, technicians, nurses, and other qualified personnel to perform evaluation and treatment services and procedures as may be necessary in accordance with their professional judgment. I acknowledge that there are some risks with all medical treatments and procedures and I understand that no one can guarantee to what extent treatments or procedures will be effective.

*I agree to provide my insurance card at each visit and pay my co-pay/deductible. Co-payments, co-insurance, deductibles, and previous balances are due at the time of service by the parent who accompanies the child. I understand that fees for services rendered are my financial responsibility. I understand that unpaid claims that are not paid by my insurance company within 30 days from the date of service will be transferred to patient responsibility and will be due upon receipt of the statement. I also understand that balances for items that my insurance company deems as "non-covered services" or "not medically necessary" are also my financial responsibility. I understand that if my account is transferred to an outside collection agency I may be dismissed from the practice until the balance is paid in full. Furthermore, I understand that I will be responsible for all fees charged by the agency, including applicable attorney fees and court costs. Pediatric Associates of West Tennessee, PLLC charges $35.00 for a returned check. We require a 24 hour cancellation notice to avoid any charges. A $30.00 missed appointment fee may be charged for appointments that are missed or not canceled at least 24 hours before the scheduled appointment time.

Acknowledgement of Receipt of the Notice of Privacy Practice:

I acknowledge that I have been offered/received the Notice of Privacy Practices from Pediatric Associates of West Tennessee, PLLC. This notice describes how this office may use and disclose my protected health information. I understand that I can obtain additional copies on the website at www.kidsgetwell.com at any time or request that a copy be provided to me at any visit.

I understand that by signing below, I, as the parent/guardian authorize and agree to the terms indicated above.

_____ _____
Signature of Parent/Guardian Date

_____
Signature of PAOWT Witness