Speight Family Medical, LLC

New Pediatric Patient Information

PLEASE COMPLETE ALL BLANKS! ALL SIGNATURE/INITIAL LOCATIONS ARE HIGHLIGHTED!

Date: _____

PATIENT					
Name: Last First M.I.			Age:	Birthdate:	SS#:
Address:			City/State:		Zip:
Home Phone:		Cell Phone:		Email:	
Sex: ☐ F ☐ M Ethnicity: ☐ Declined ☐ Hispanic ☐ Non-Hispanic					
Race: ☐ Declined ☐ Caucasian ☐ African American ☐ Asian ☐ Alaskan Native ☐ Pacific Islander ☐ Other					
School Name:		City:		Grade:	

PARENT/LEGAL GUARDIAN			
Parent or Legal Guardian Name:			Relationship:
Address:	City/State:	Zip Code:	Work Phone #:
SS#:	Birthdate:	Cell Phone#:	Home Phone#:
Preferred Method Of Contact ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ By Mail		Emergency Contact:	
As responsible party, are you currently a patient in our office: ☐ Yes ☐ No			

PRIMARY INSURANCE INFORMATION			
Insurance Company:	Member ID#:		Effective Date:
Insurance Company Address:	City:	State:	Zip:
Policyholder Name:	Relationship to Patient:		Birthdate:
Policyholder Social Security #:	Policyholder Employer:		
Policyholder home phone:	Policyholder cell phone:	Policyholder work phone:	

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)			
Insurance Company:	Member ID#:		Effective Date:
Insurance Company Address:	City:	State:	Zip:
Policyholder Name:	Relationship to Patient:		Birthdate:
Policyholder Social Security #:	Policyholder Employer:		
Policyholder home phone:	Policyholder cell phone:	Policyholder work phone:	

Patient Medical History

ALLERGIES: Please list any known allergy to medications, foods, or medical products like latex, betadine, tape.
CHECK HERE IF NONE ☐ Please list any known allergy and the reaction to the allergy.

_____ _____ _____

_____ _____ _____

Please list ***ALL*** medications the patient is currently taking:
CHECK HERE IF NONE ☐

Name of Medication	Strength/mg	How often do you take it:

Pharmacy Information

_____

Pharmacy Name

_____ _____

City Phone

Personal Medical History: Please check illness or conditions the patient has or has had in the past.

	Allergies		Asthma		Depression/Anxiety
	Migraines/Frequent Headaches		Anemia		Tuberculosis
	Vision Problems (Glaucoma)		Liver Problems		Clotting Disorder
	Hearing Problems		Gallbladder Problems/Stones		Heart Murmur/Abnormal Rhythm
	Congenital Anomalies		Kidney Problems/Stones		Atrial Fibrillation
	Overweight/Obesity		Recurrent Bladder Infections		Diabetes Type I (need insulin)
	Thyroid Disease		Lupus		Diabetes Type II
	Seizure/Epilepsy		Arthritis		Anaphylactic Reaction
	ADD/ADHD		Chickenpox		Frequent ear infections
	Cancers: ***Please list all***		**Please list any other conditions:**		**Blood Transfusion: (Dates)**

Family Medical History: Please check illness or conditions any family member of the patient has or has had in the past.

Y/N	Who?		Y/N	Who?		Y/N	Who?	
		Allergies			Clotting Disorder			Thyroid Disease
		Migraines			Anemia			AIDS/HIV
		Vision Problems (Glaucoma)			Liver Problems			Heart Disease
		Hearing Problems			Seizure/Epilepsy			Depression/Anxiety
		Congenital Anomalies			ADD/ADHD			Tuberculosis
		Recurrent Bladder Infections			Anaphylactic Reaction			High Cholesterol
		Diabetes Type I (need insulin)			High Blood Pressure			Kidney Problems/Stones
		Diabetes Type II			Asthma			
		Cancers: ***Please list all***			**Please list any other conditions**			

BIRTH HISTORY		
Birth Weight:	Was deliver: ☐ Vaginal ☐ Cesarean	If cesarean, why?
Born at term? ☐ Y ☐ N	If no: ☐ Early ☐ Late	If early, How many weeks gestation?
Did mother have any illness/problems with pregnancy? ☐ Y ☐ N If yes, explain:		
During pregnancy, did mother: ☐ Smoke ☐ Drink alcohol ☐ Use non prescription drugs or medications ☐ Use prescription drugs or medications If yes, please explain:		
Did baby have any issues right after birth? ☐ Y ☐ N	Did baby leave hospital with mother? ☐ Y ☐ N If no, please explain:	Initial feeding: ☐Breast ☐Bottle

Y/N		Explain
	Do you consider your child in good health?	
	Does your child have a serious illness or medical condition?	
	Has your child has any serious injuries or accidents?	
	Has your child had surgery of any kind?	
	Has your child ever been hospitalized?	
	Are you concerned about your child's physical development?	
	Are you concerned about your child's emotional development?	
	Are you concerned about your child's attention span?	
	Is your child in school?	
	Has your child failed/repeated any grade levels?	

List ***all*** operations and the correlating dates
CHECK HERE IS NONE ☐
_____
_____
_____
_____

Please list ***any*** other Physicians seen in last 12 months
CHECK HERE IF NONE ☐
_____
_____
_____
_____

Date of last eye exam: _____ Where? _____ Does child wear glasses/contacts? ☐YES☐NO

The Following Questions are for Girls Only

Menstrual History: Age period started: _____ Date of last pap smear: _____ Where? _____
History of abnormal pap smears? ☐YES ☐ NO
Is child currently on birth control pills? ☐YES ☐ NO Does child currently have an IUD? ☐YES ☐ NO

Advance Directive: Which of the following does the patient have? Please select one:
☐ None ☐ Living Will ☐ Power of Attorney ☐ DNR ☐ Organ Donation ☐ Other

Patient Allergy Symptom Survey

PLEASE COMPLETE THE TOP TWO (2) SECTIONS ONLY!!

Patient Name DOB Today's Date

COMMON SYMPTOMS: Circle the number according to severity. 0 = NONE, 1 = MILD, 5 = VERY SEVERE

Abdominal Gas or Cramping	0 1 2 3 4 5	Hives	0 1 2 3 4 5
Arthritis or muscle pain	0 1 2 3 4 5	Hyperactivity	0 1 2 3 4 5
Asthma	0 1 2 3 4 5	Itching	0 1 2 3 4 5
Cough	0 1 2 3 4 5	Nasal Congestion	0 1 2 3 4 5
Eczema	0 1 2 3 4 5	Poor memory or concentration	0 1 2 3 4 5
Fatigue	0 1 2 3 4 5	Sneezing	0 1 2 3 4 5
Frequent colds or sore throat	0 1 2 3 4 5	Trouble breathing while sleeping	0 1 2 3 4 5
Frequent sinus or ear infection	0 1 2 3 4 5	Watery, red, itchy eyes	0 1 2 3 4 5
Headache	0 1 2 3 4 5	Wheezing	0 1 2 3 4 5

Symptom Score: _____ List any other current symptoms: _____

HISTORY:

Are there any foods that cause you any problems? _____ How? _____
Do you have a history of allergies? ☐ Yes ☐ No If yes, how long have you had allergies? _____
What season(s) do your allergies usually flare up? ☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ All year
Have you been allergy tested before? ☐ Yes ☐ No If yes, when? _____
Does any medication give you relief of your allergy symptoms? ☐ Yes ☐ No Comment: _____
Do you have pets at home? ☐ Yes ☐ No Type: _____ Do they cause symptoms? ☐ Yes ☐ No
Are you exposed to fumes or dust? ☐ Yes ☐ No Comment: _____
Do you smoke? ☐ Yes ☐ No If yes, how much? _____
Are you exposed to smoke in your environment? ☐ Yes ☐ No
Who else in your family has allergies/asthma? ☐ Mom ☐ Dad ☐ Sibling ☐ Children
Have you been diagnosed with asthma? ☐ Yes ☐ No When? _____ Severity: ☐ Mild ☐ Moderate ☐ High
Do you feel your asthma is under control? ☐ Yes ☐ No
Do you use an inhaler? ☐ Yes ☐ No If yes, how often? _____
Are you taking any sleep aids? ☐ Yes ☐ No If yes, what are you taking? _____

CONTRAINDICATIONS

Do you suffer from uncontrolled asthma or reduced lung function? ☐ Yes ☐ No
Have you ever had a severe allergic reaction? ☐ Yes ☐ No
Have you ever been hospitalized due to allergies? ☐ Yes ☐ No
Are you taking beta blockers to treat heart disease? ☐ Yes ☐ No If yes, what are you taking? _____
Have you taken any allergy, antihistamine, or cold medicine in the last 72 hours? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

CLINICAL USE ONLY

Is this patient recommended for allergy testing? ☐ Yes ☐ No Date of test: _____ ☐ Skin ☐ Blood
Refer patient to a specialist? ☐ Yes ☐ No

Reviewed By Provider Date

Revised 6/7/2019

Speight Family Medical, LLC

Office Policies

Please read the following information regarding the guidelines for our practice. Please keep in mind that some of the policies are dictated by your insurance company. If you have any questions regarding this information, please ask our office staff. If you understand this information, please sign below and return this form to our receptionist.

1. You as the patient are responsible for verifying whether we are "in-network" according to your insurance. Please be sure to bring your ***insurance card and a valid photo I.D.*** to every visit to prevent any delay of your appointment. ***Initial ___***
2. We are happy to refer you to a specialist when your provider determines that it is clinically necessary. You are responsible for verifying that the specialist to which you are referred is considered "in-network" by your insurance carrier. If you require a referral, this should be obtained prior to your visit with a specialist. ***Initial ___***
3. You are responsible for knowing which hospital your insurance carrier allows us to utilize for your procedures, tests, and admissions. ***Initial ___***
4. Please allow us one week to contact you regarding lab/test results. ***Initial ___***
5. If you have questions for the nurse or provider, we will return your call as soon as possible, giving priority to emergencies and scheduled patients in the office. At the time of your call, please let us know if you will be unavailable at a certain time & what telephone number is best. ***Initial ___***
6. School/work excuses are written ***only*** for the day you are seen in our office and for any additional days that is suggested by the provider. We are unable to write excuses for illnesses not evaluated by our office. ***Initial ___***
7. We ask that you arrive fifteen minutes prior to your appointment time in order to complete and/or review required paperwork. You must update your information on a yearly basis. ***Initial ___***
8. In order for our providers to see our patients in a timely manner, you may be asked to reschedule your appointment if you arrive 15 minutes late. ***Initial ___***
9. Patients without insurance are asked to pay the required fee prior to services being rendered and any charges occurred during your appointment will be due in full prior to leaving the office. ***Initial ___***
10. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of services (e.g., deductibles, copayments, and non-covered services. ***I understand a parent/legal guardian must accompany the child to every appointment.*** ***Initial___***
11. SFM does not provide long term pain management and we will refer the patients that require long term pain management out to a pain clinic. ***Initial ___***
12. SFM will not call in prescriptions after hours, on weekends or on holidays unless you are seen using our Telemedicine visit program. It is the patient's responsibility to manage their prescriptions and allow 24 business hours for refill requests before running out. ***Initial ___***
13. SFM will not refill pain medications that have been lost, stolen or run out early due to use other than prescribed. It is the patient's responsibility to keep up with their medications and storm them in a safe place. We check our patient's drug history on the state's control substance website regularly as required by the state and abuse of prescriptions can result in dismissal from the office or jail time. ***Initial ___***
14. SFM will randomly do drug screens on our patients that take controlled medications as required by the state. These will be done at the cost of the patient if not covered by their insurance. Our goal is to uphold correct use of prescriptions prescribed. ***Initial ___***
15. I fully understand that no services including medication refills, appointments, referrals or other services will be rendered until all balances are paid in full. SFM will not make payments arrangements. If you are a guarantor for a minor patient, please know that balances pertaining to you and all family members must be paid in full at all times to receive further services as described above. ***NO EXCEPTIONS!*** ***Initial ___***

Patient name (please print)

Parent/Guarantor Signature Date

Your Insurance Company and Our Office:
What you need to know about getting your healthcare services covered.

Many of the services provided in this office are covered by your insurance company. We gladly file claims for you as a courtesy, so that you do not have the additional worry and effort of dealing with this during a time of illness.

Unfortunately, not all services are covered by every insurance company. In cases where the services have not been covered, you will be personally responsible for the balance. Before we bill you, we will make sure that all of the information sent to your insurance company is accurate, and clearly describes the services you received.

Your Financial Responsibility:
We will file your insurance claim, but you are ultimately responsible for paying for services received in this office. Please remember that insurance companies do not pay for all medical services (including labs), even many that are especially helpful to the patient.

When a service is not covered by your insurance policy, you will be responsible for paying the bill. We cannot change the information on an insurance claim simply so that the claim will be paid. If you are not sure whether a service is covered by your plan, we will be glad to call your insurance company in advance to see if you will likely be responsible. Non-covered services are the responsibility of adult patients or the "guarantor/responsible party" for minor patients as outlined on the patient paperwork.

Insurance Filing and The Law:
Recent federal laws addressing all insurance companies require that we submit every claim accurately, reporting the exact services performed and the exact reason for performing them. We are unable to change this information simply for purposes of getting the claim covered. Our practice is committed to abiding by these laws, and will submit all claims in the appropriate manner.

Along with examinations, your provider may suggest that some "screening" test be performed to allow them to get a better picture of your health. These services may also be considered as non-covered by your insurance company. If so, you will be expected to cover the costs. Even if the results of these tests show a problem, we must submit these tests as "screening" to your insurance company, and cannot change this information simply to receive payment.

Assignment of Benefit Agreement:

I have read and do understand these policies. My permission is given for any medical treatment including, but not limited to, examination, injections, diagnostic testing or medical procedures as may be deemed advisable by members of Speight Family Medical, LLC for today and all future appointments. I hereby authorize my insurance company, including Medicare, to make payments to Speight Family Medical, LLC for medical and/or surgical services or items rendered to me or my dependent(s). I understand that if I have medical coverage, my bill will be submitted to my insurance as a courtesy to me. I fully understand that I am financially responsible for any co-pays, deductibles, percentages or denied claims that my insurance doesn't cover. Should my account become delinquent, I understand that Speight Family Medical, LLC may seek assistance from a collection agency to collect and I will be held responsible for ***a*** *collection fee up to 33.3% of the balance, court cost, and/or attorney fees that may be incurred. I certify that the information provided by me is correct and complete to the best of my knowledge and withholding information is grounds for dismissal from Speight Family Medical, LLC. It is my responsibility to update any and all personal, health and insurance information.*

Please Note: You may receive a separate bill from the lab for lab services performed in this office. ***Initial___***
Please Note: There will be a $35.00 charge for returned checks and a $25.00 appointment "no show" fee. ***Initial ___***

Patient Name (PRINT): _____

Guarantor name (PRINT): _____

What is your relationship to the minor patient? _____

Guarantor Signature: _____ Date: _____

Protected Health Information Acknowledgment Short Form

Use or Disclosure of Your Health Information
Your protected health information will be used by Speight Family Medical, LLC or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day healthcare operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may make requests on the use or disclosure of your protected health information. Speight Family Medical, LLC may or may not agree to restrict the use or disclosure of your protected health information. If Speight Family Medical, LLC agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

Revocation of Consent
You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Standards
Speight Family Medical, LLC reserves the right to modify the privacy practices outlined in the notice.

Communications with the patient should be directed to:
Patient Name: _____
Address: _____ City, State, Zip Code: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Cell Phone: (_____) _____ Alternative Phone: (_____) _____
May the Speight Family Medical, LLC staff leave messages regarding your healthcare on your voicemail or answering machine? ☐ YES ☐ NO

Who else can Speight Family Medical, LLC discuss details of your healthcare or release prescriptions to on your behalf?
Example: Mom, Dad, Legal Guardian, Grandparents, Siblings, Aunts, Uncles, etc.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____
Are there any custody issues we need to be made aware of? _____

I have reviewed this form and give permission to Speight Family Medical, LLC to use and disclose my health information in accordance with it.

Patient Name (PRINT): _____

Guarantor name (PRINT): _____

What is your relationship to the minor patient? _____

Guarantor Signature: _____ Date: _____

Authorization for Release of Protected Health Information from another facility

Patient Name:	Date of Birth:
	Social Security Number:

Person/Organization Authorized to Disclose Protected Health Information:

Address: Phone:

Fax:

Release Records to: **Speight Family Medical** Phone: 901-840-2102

76 Tabb Drive Suite E

Munford, TN 38058 Fax: 901-840-1979

Description of Information to be Used or Disclosed: **Medical Records**

Choose from the following:

☐ Entire Chart	☐ Labs (including HIV/AIDS info)	☐ Operative/Procedure Report
☐ Radiology Reports	☐ History & Physical	☐ Billing Record
☐ ER Record	☐ Pathology Reports	☐ Discharge Summary
☐ Other (please specify):		

I understand that:

1. I may revoke this authorization at any time by notifying the person/organization providing or disclosing the information in writing. However, if I revoke this authorization, it will not have any effect on any actions taken by the person/organization providing, disclosing, or receiving the information prior to receiving the revocation, nor shall it be valid to the extent that the disclosing person/organization or receiving organization has taken action in reliance on this authorization.
2. This authorization allows Speight Family Medical to obtain any and all documents in my medical record including those copies from other health care facilities and providers. I understand that the information that is released or provided may be re-disclosed and no longer protected by federal regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by the Title 42 CFR, and if there is any such information, I hereby authorize the release of this information. This authorization also includes any information related to diagnosis and/or treatment of any psychiatric and/or mental illness or any state of infection with the HIV/AIDS virus.
4. Speight Family Medical is hereby released from any liability and the undersigned will hold Speight Family Medical harmless for requesting or seeking my protected health information.
5. I understand that this authorization is voluntary and that I may refuse to sign it. Unless not allowed by law, my refusal may affect my ability to obtain treatment.
6. This authorization will expire one year from the date signed unless I provide and alternate date or event. This authorization will not apply to any dates of service that occur after the date the authorization is signed.
7. A facsimile of this authorization or a copy of this authorization shall be valid and binding with the same force as the original signature, and the person/organization releasing the information shall be entitled to enforce the same policy.

I have read and understand this entire authorization. I hereby authorize the release of the above requested medical information to Speight Family Medical from the facility named above.

_____ _____

Signature of patient or authorized Representative Date

Speight Family Medical, LLC

Controlled Substance Agreement

This is an agreement between the physician and staff of Speight Family Medical, including, but not limited to Dr. Deanna Speight, FNP and Jena Burlison, FNP, and the below signed patient regarding the use of controlled substances. These substances, such as narcotics and sedatives, have the potential for drug dependence and addiction. They require special considerations when being prescribed.

It is therefore necessary for the patient to acknowledge the following critical points by signing this agreement:

1. Narcotics are addictive.
2. You must take these medications ONLY as prescribed. It is not permissible to increase the dose without your provider's consent.
3. You are responsible for the safekeeping of your medications. You must not allow others to use your medication. Keep is well secured at all times.
4. Loss, theft, "the dog ate it", "it fell in the toilet", or any other such reason are not acceptable as a cause for early refill.
5. You cannot obtain prescriptions from other doctors or providers for any controlled substance unless approved by your provider at Speight Family Medical.
6. You must not drink alcohol or engage in recreational drug use while taking controlled substances.
7. Refills are NOT given on Fridays or outside of regular business house. NO EXCEPTIONS!
8. You agree to submit to random urine drug screens at any time at the request of your provider.
9. You agree to use one pharmacy for all controlled substance prescriptions. If you must use another pharmacy for any reason, you agree to notify the office in advance.
10. You are required to be seen in the office, with an appointment, for refills monthly until otherwise notified by your provider. The maximum time between office visits for patients taking controlled substances in three (3) months. NO EXCEPTIONS!
11. All appointments for controlled substance refills must be made at least one (1) week in advance.

At all times during the course of treatment, you are encouraged to ask questions regarding the use of addictive medication(s) and their side effects. You may choose to discontinue them at anytime. Any evidence of prescription tampering, drug diversion, selling, or any/all misbehavior involving controlled substances will result in immediate termination of all prescribing.

_____

Printed name of patient

_____

Signature of parent or authorized representative Date

_____

Pharmacy name and address

_____

Pharmacy phone number

Speight Family Medical, LLC

Acknowledgment of Receipt of Privacy Notice

By signing this form, you acknowledge that you have been given an opportunity to review Speight Family Medical, LLC's Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Patient Name	Date of Birth	Last 4 SS#
Patient Name	Date of Birth	Last 4 SS#
Patient Name	Date of Birth	Last 4 SS#
Patient Name	Date of Birth	Last 4 SS#

Check all that are true:

- □ I have received and been given an opportunity to review Speight Family Medical, LLC's Privacy Notice.
- □ SFM, LLC has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature: Parent/Legal Guardian Date

Print Name: Parent/Legal Guardian

Relationship to patient

STAFF ONLY to complete if this Acknowledgment Form is not signed:
Does patient have a copy of the Privacy Notice?

- □ Yes
- □ No

Comments: