

# Speight Family Medical, LLC

## Pediatric Patient Information

Please complete all blanks

### PATIENT

Name: Last	First	M.I.	Age:	Birthdate:	SS#:
Address:			City/State:		Zip:
Home Phone:		Cell Phone:		Email:	
Sex: <input type="checkbox"/> F <input type="checkbox"/> M	Ethnicity: <input type="checkbox"/> Declined <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic				
Race: <input type="checkbox"/> Declined <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> 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 <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> By Mail			Emergency Contact:		
As responsible party, are you currently a patient in our office: <input type="checkbox"/> Yes <input type="checkbox"/> 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:	

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

\_\_\_\_\_

\_\_\_\_\_

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: <b>Please list all</b>	<b>Please list any other conditions:</b>	<b>Blood Transfusion: (Dates)</b>

**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: <b>Please list all</b>		<b>Please list any other conditions</b>		

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**BIRTH HISTORY**

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

**Following Questions for Women 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

## 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 company. Please be sure to bring your **insurance card and a valid photo I.D.** to every visit to prevent any delay of your appointment.
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 specialist.
3. You are responsible for knowing which hospital your insurance carrier allows us to utilize for your procedures, tests, and admissions.
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.
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 store 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* \_\_\_\_\_

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Patient name (please print)

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Patient/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, 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): \_\_\_\_\_

Is Patient a Minor?  Yes  No      What is your relationship to the minor patient? \_\_\_\_\_

If a minor, guarantor name (PRINT): \_\_\_\_\_

Patient Signature (Guarantor, if minor): \_\_\_\_\_      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? Please check one: 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: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

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): \_\_\_\_\_

Is Patient a Minor?  Yes  No What is your relationship to the minor patient? \_\_\_\_\_

If a minor, Guarantor Name (Print): \_\_\_\_\_

Patient Signature (Guarantor, if minor): \_\_\_\_\_ 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:

Release Records to:	<b>Speight Family Medical</b>	Phone:	<b>901-840-2102</b>
	<b>76 Tabb Drive Suite E</b>		
	<b>Munford, TN 38058</b>	Fax:	<b>901-840-1979</b>

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

Choose from the following:

<input type="checkbox"/> Entire Chart	<input type="checkbox"/> Labs (including HIV/AIDS info)	<input type="checkbox"/> Operative/Procedure Report
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Billing Record
<input type="checkbox"/> ER Record	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> 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*  
**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 without proper documentation (ie police report).
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 hours. 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 is 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.

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Printed name of patient

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Signature of patient or authorized representative

Date

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Pharmacy name and address

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Pharmacy phone number



**Speight Family Medical, LLC**  
**76 Tabb DR STE E Munford, TN 38058**

**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.

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Patient Name	Date of Birth	Last 4 SS#
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Patient Name	Date of Birth	Last 4 SS#
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Patient Name	Date of Birth	Last 4 SS#
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Patient Name	Date of Birth	Last 4 SS#
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**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.
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Signature: Parent/Legal Guardian/Patient if over 18	Date
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Print Name: Parent/Legal Guardian/Patient if over 18

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Relationship to patient

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**STAFF ONLY** to complete if this Acknowledgment Form is not signed:

Does patient have a copy of the Privacy Notice?

- Yes
- No

Comments:

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