76 Tabb Dr #E Munford, TN 38058

403 Henslee Dr Dickson, TN 37055

Speight Family Medical, LLC

New Child Registration

Child's full name _____ DOB: _____ M / F

Additional children: (if any)

Child's full name _____ DOB: _____ M / F

Child's full name _____ DOB: _____ M / F Child's SS# _____

Child's full name _____ DOB: _____ M / F

Does child/ren live with both parents? Y / N if not, who is the legal guardian? _____

Child's Address _____ City: _____ St: _____ Zip: _____

Best Contact phone: _____ Whose number is this? _____ Alt Phone: _____

Caregiver Information: Any Custody issues? _____

Caregiver #1: Full Name: _____ DOB: _____ SS# _____

Address: _____ City: _____ St: _____ Zip: _____

Relationship to child/ren _____ Home Phone: _____ Cell#: _____

Caregiver #2: Full Name: _____ DOB: _____ SS# _____

Address: _____ City: _____ St: _____ Zip: _____

Relationship to child/ren _____ Home Phone: _____ Cell#: _____

Emergency/Insurance/Pharmacy:

Whom should we call after caregivers listed above in case of an emergency? _____

Phone #: _____ Relationship to child/ren: _____

Insurance Info: Who is the policy holder? _____ DOB: _____

Who is responsible for copays? _____ Who should receive bills? _____

Insurance Company: _____ Policy #: _____ Group #: _____

Secondary Insurance? Y / N Secondary Policy holder: _____ DOB: _____

Secondary insurance Co: _____ Policy #: _____ Group #: _____ Policy Holder SS#: _____

Pharmacy: _____ Location: _____ Phone #: _____

- It is your responsibility to pay ant deductible amount, co-insurance or any other amount not paid by your insurance.
- Charges for office visits must be paid prior to each visit.
- If this account is assigned for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. A $20.00 fee will be added to those accounts assigned to collections.
- To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records.
- I hereby assign all medical/ surgical benefits, to include major medical benefits for which I am entitled, including Medicare, Private Insurance and other health plans to Speight Family Medical, LLC (SFM).
- This assignment will remain in place until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
- I have been given the opportunity to review the Notice of Privacy practices for SFM.

Signed: _____ Date: _____

Initial History Questionnaire- New Patient

Patient Name:	Birth Date:
Age:	Gender: M F
Form Completed By:	

HOUSEHOLD - *Please list all those living in the child's home*

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their name and age and where they live._____

_____

If mother & father are not living together, or if child does not live with parents, what is the child's custody status?_____

_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in home? _____

_____

Mother's Occupation_____ Mother's Employer_____

Father's Occupation _____ Father's Employer_____

Does anyone in the home use tobacco? ☐ Yes ☐ No Are there any pets in the home? ☐ Yes ☐ No

BIRTH HISTORY

Birth Weight_____ Was delivery ☐Vaginal ☐ Cesarean?

Was the baby born at term? ☐ Yes ☐ No ☐Early ☐ Late If Cesarean, why? _____

If early, how many week's gestation?_____

Did mother have any illness/problems with pregnancy? Did your baby have any issues right after birth?

☐ Yes ☐ No Explain_____ ☐ Yes ☐ No Explain _____

_____ _____

During pregnancy, did mother Was initial feeding ☐Breast ☐Bottle

Smoke? ☐Yes ☐No Drink alcohol? ☐ Yes ☐No Did the baby go home with mother from hospital?

Use drugs or medications ☐ Yes ☐ No ☐ Yes ☐ No Explain: _____

What _____ When _____

GENERAL

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain_____
Does your child have a serious illness or medical condition?	☐ Yes	☐ No	Explain_____
Has your child had serious injuries or accidents?	☐ Yes	☐ No	Explain_____
Has your child had surgery of any kind?	☐ Yes	☐ No	Explain_____
Has your child ever been hospitalized?	☐ Yes	☐ No	Explain_____
Is your child allergic to any medicines or drugs?	☐ Yes	☐ No	Explain_____

DEVELOPMENT

Are you concerned about your child's physical development?	☐ Yes	☐ No	Explain_____
Are you concerned about your child's emotional development?	☐ Yes	☐ No	Explain_____
Are you concerned about your child's attention span?	☐ Yes	☐ No	Explain_____
Is your child in school?	☐ Yes	☐ No	Explain_____

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects?_____

Is he/she in special resource classes?_____

Please proceed to back of page

FAMILY HISTORY

Has any family member had the following:

Deafness?	☐ Yes	☐ No	Who_____	Comments _____
Nasal allergies?	☐ Yes	☐ No	Who_____	Comments _____
Asthma?	☐ Yes	☐ No	Who_____	Comments _____
Tuberculosis?	☐ Yes	☐ No	Who_____	Comments _____
Heart disease (before 50 years old)?	☐ Yes	☐ No	Who_____	Comments _____
High blood pressure (before 50 years old)?	☐ Yes	☐ No	Who_____	Comments _____
High cholesterol?	☐ Yes	☐ No	Who_____	Comments _____
Anemia?	☐ Yes	☐ No	Who_____	Comments _____
Bleeding disorder?	☐ Yes	☐ No	Who_____	Comments _____
Liver disease?	☐ Yes	☐ No	Who_____	Comments _____
Kidney disease?	☐ Yes	☐ No	Who_____	Comments _____
Diabetes (before 50 years old)?	☐ Yes	☐ No	Who_____	Comments _____
Bed-wetting (after 10 years old)?	☐ Yes	☐ No	Who_____	Comments _____
Epilepsy or convulsions?	☐ Yes	☐ No	Who_____	Comments _____
Alcohol abuse?	☐ Yes	☐ No	Who_____	Comments _____
Drug Abuse?	☐ Yes	☐ No	Who_____	Comments _____
Mental illness?	☐ Yes	☐ No	Who_____	Comments _____
Mental retardation?	☐ Yes	☐ No	Who_____	Comments _____
Immune problems, HIV or AIDS?	☐ Yes	☐ No	Who_____	Comments _____

Additional family history?

_____

_____

_____

PAST HISTORY

Does your child have, or has he/she ever had:

Chickenpox?	☐ Yes	☐ No	When _____
Frequent ear infections?	☐ Yes	☐ No	When _____
Problems with ears or hearing?	☐ Yes	☐ No	When _____
Nasal allergies?	☐ Yes	☐ No	When _____
Problems with eyes or vision?	☐ Yes	☐ No	When _____
Asthma, bronchitis, bronchiolitis or pneumonia?	☐ Yes	☐ No	When _____
Any heart problems or murmur?	☐ Yes	☐ No	When _____
Anemia or bleeding problems?	☐ Yes	☐ No	When _____
Blood transfusion?	☐ Yes	☐ No	When _____
Frequent abdominal pain?	☐ Yes	☐ No	When _____
Constipation requiring doctor visit?	☐ Yes	☐ No	When _____
Bladder or kidney infection?	☐ Yes	☐ No	When _____
Bed wetting (after 5 years old)?	☐ Yes	☐ No	When _____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When _____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	When _____
Any chronic or recurrent skin problems? (Acne, Eczema, etc)	☐ Yes	☐ No	When _____
Frequent headaches?	☐ Yes	☐ No	When _____
Convulsions or other neurological problem?	☐ Yes	☐ No	When _____
Diabetes?	☐ Yes	☐ No	When _____
Thyroid or other endocrine problem?	☐ Yes	☐ No	When _____
Any other significant problem?	☐ Yes	☐ No	When _____
Use of alcohol and abuse?	☐ Yes	☐ No	When _____

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 out 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 sub-specialist when your provider determines that it is clinically necessary. You are responsible for verifying that the sub-specialist to which you are referred is considered "in-network" by your insurance carrier. Your referral should be obtained prior to your visit to the sub-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.
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 # is best.
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.
7. We ask that you arrive fifteen minutes prior to your appointment time in order to complete and/or review required paperwork. You will be asked to 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.
9. We ask all patients that do not have insurance coverage to pay the $100 office visit before services are rendered and any charges incurred during your appointment will be paid, in full, on the date of service before leaving.
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.**
11. Speight Family Medical, LLC does not do long term pain management and we will refer the patients that require long term pain management out to a pain clinic.
12. Speight Family Medical, LLC will not call in prescriptions after hours, on weekends or on holidays. It is the patient's responsibility to manage their prescriptions and allow 24 business hours for refill requests before running out. **(INITIAL)**_____
13. Speight Family Medical, LLC will not refill pain medications that has 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. We check on our patient's drug history on the state's control substance website regularly and abuse of prescriptions can result is dismissal from our practice. **(INITIAL)**_____
14. Speight Family Medical, LLC reserves the right to randomly drug test patients at the cost of the patient, if insurance denies payment. 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 will be rendered until all balances are paid in full. Speight Family Medical, LLC will not make payment 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 service as described above – no exceptions. (INITIAL)** _____

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 wit 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 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 the 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 you 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" tests 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 test 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, not limited to, examination, injections, diagnostic testing or medical procedures as may be deemed advisable by member 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, deductible, percentages or denied claims that my insurance does not 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 ***$20.00 late fee*** *plus any collection agency fee, 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 and all person, 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 charge for returned checks and a $25 appointment "no show" fee. **(INITIAL)** _____

Patient Name (**PRINT**): _____

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

If 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 health care 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 minor, Guarantor Name **(PRINT):** _____

Patient Signature (Guarantor, if minor): _____ **Date:** _____

Authorization For Release Of Protected Health Information From Another Facility

Patient Name:	Birth Date:
	SS No.

Person/Organization Authorized to Disclose Protected Health Information:

Release Records to: **Speight Family Medical** **76 Tabb Dr. Suite E** **Munford TN 38058**	**Phone # 901-840-2102** **Fax # 901-840-1979**

Description of Information to be Used or Disclosed: Medical Records

Dates of Treatment:	Place of Treatment:

Choose From the Following:

Entire Chart	Labs (may include AIDS/HIV information)	Discharge Summary
Radiology Reports	History and Physical	Other (specify):
ER Record	Pathology Reports	
Operative/Procedure Report	Billing Record	

I understand that:

1. I may revoke this authorization in writing at any time by notifying in writing the person/organization providing or disclosing the information. 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 privacy regulations.
3. Any disclosure of records concerning diagnosis and/or treatment of alcohol and/or drug abuse is covered by Title 42 CFR, and if there is any such information, I herby authorize the release of information. This authorization also includes any information related to diagnosis and/or treatment of nay psychiatric or mental illness or any state of infection with the HIV (Aids) virus.
4. **Speight Family Medical** is herby released from any liability and the undersigned with 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 this authorization. Unless allowed by law, my refusal will affect my ability to obtain treatment, receive payment, or eligibility for benefits.
6. The authorization will expire in one year unless I provide an alternate date or event. This authorization will not apply to any dates of service that occur after the date this 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 an original signature, and the person/organization releasing the information shall be entitled to rely on the same.

I have read and understood this authorization. I herby authorize the release of the above-requested medical information about me 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 staff of Speight Family Medical, Dr. Deanna Speight, FNP, Dawn Stewart, FNP, Ruby Turner, FNP and the patient signed below 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 (such as hydroquinone, oxycodone, morphine, and fentanyl) are addictive.
2. You must take these medications 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 other to use your medication. Keep it well secured at all times.
4. Loss, theft, the dog ate it, it fell in the toilet or other such stories are not acceptable as cause for early refill.
5. You cannot obtain prescriptions from other doctors or providers for controlled substances unless approved by your provider at Speight Family Medical.
6. You must not drink alcohol or engage in recreational drug use while taking prescriptions for controlled substances.
7. Refills are NOT given on Fridays or after regular business hours.
8. You agree to submit to urine drug screens at any time.
9. You agree to use one pharmacy for all prescriptions. You may change pharmacies if we are informed.
10. You are required to be seen in the office, with an appointment, for refills MONTHLY until the provider approves any scheduling changes. NO EXCEPTIONS!
11. All appointments for controlled substances must be made at least a week in advance for refills.

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

Signed_____

My pharmacy name & location_____

My pharmacy number_____

Speight Family Medical, LLC
Parental Consent for Treatment for Minor

Please furnish the following information. The information will be used in strict confidence in your child's chart.

Caretaker Full Name: _____

Caretaker Full Name: _____

Caretaker Full Name: _____

The above listed person(s) has my permission to sign for treatment and/or receive protected health information for the following children:

Child's Name_____ Date of Birth _____

Child's Name_____ Date of Birth _____

Child's Name_____ Date of Birth _____

Child's Name_____ Date of Birth _____

PIN: _____

Please choose a Caretaker PIN code, usually four digits or letters long. We will only discuss protected health information with individuals who have a PIN code. Parent and caretakers need individual pin codes to distinguish whom we are speaking with.

The above listed person has my permission to sign for treatment and/or receive protected health information for the above listed children. I assume responsibility for providing insurance information for these children for office visits when taken to Speight Family Medical, LLC by this Caretaker, or for paying balances not covered by insurance for these visits. This permission is in effect until revoked by a Legal Guardian.

SIGNATURE OF LEGAL GUARDIAN: _____ DATE _____

PRINTED NAME: _____

RELATIONSHIP TO PATIENT: _____

Speight Family Medical, LLC

76 Tabb DR STE E Munford, TN 38058
403 Henslee Dr Dickson, TN 37055

Privacy Notice Acknowledgement

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/Patient if over 18

Print Name: Parent/Legal Guardian/Patient if over 18

Relationship to Patient

Date

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

- ☐ Yes
- ☐ No

Comments: