

KNOXVILLE PEDIATRIC ASSOCIATES, P.C.
RECORDS RELEASE AUTHORIZATION

2201 Clinch Avenue
Knoxville, TN. 37916
Phone (865) 525-0228
Fax (865) 525-0285

AND

9017 Cross Park Drive, Suite 200
Knoxville, TN. 37923
Phone (865) 690-1161
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There is a fee of \$20 for the first forty (40) pages or less of the medical record and a per page charge of 25¢ for all pages thereafter. There is NOT a charge to release records directly to another physician.

Release records to (name, address, phone):

Release records from (name, address, phone):

Please release records on the following patient(s):

Name(s) _____ **Date of Birth** _____

Reason for records release (please check):

Moving
 Graduated from pediatrics
 Insurance
 Wait times specify (waiting room, in room, nurse line, appt line)
 Other _____

Dissatisfied with physician
 Dissatisfied with staff:
 Front office _____ Nurse _____ Business Dept _____
(comments) _____

*****It is our goal to improve our practice and better serve our patients so any comments are appreciated*****

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND SPECIFY BELOW THE INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR COMPLETE RECORDS WILL BE RELEASED.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of substance abuse, psychological or psychiatric conditions, AIDS/HIV, etc, please specify) _____

Expiration or revocation of authorization - I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Treatment, payment, enrollment, or eligibility of benefits-Is not conditioned on signing the authorization or a description of the consequences to the patient if he or she refuses to sign the authorization.

Information- Once the information is used or disclosed, it may no longer be protected.

Use of copies - A copy of this authorization may be utilized with the same effectiveness as an original.

My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.

Signature _____ **Date** _____

Office Use Only

(Driver's License/photo ID must be presented)

Driver's License number/ID number of individual records released to: _____

Date records released: _____ Relationship to patient: _____

Amount charged for records: _____ Employee Initials: _____

PATIENT INFORMATION

CHART NAME
OR
CHART # _____

DATE _____

Please use black ink only.

Knoxville Pediatric Associates, P.C.

| | | | | | |
|---|---------------------------------------|------------------|----------------|-----------------|----------------|
| P A R E N T I N F O | PARENT (GUARDIAN) PROVIDING INSURANCE | | FIRST | MIDDLE (MAIDEN) | LAST |
| | HOME ADDRESS | STREET NAME | APT. # | | CITY/STATE/ZIP |
| | SOCIAL SECURITY # | DATE OF BIRTH | E-MAIL ADDRESS | HOME PHONE # | CELL PHONE # |
| | EMPLOYER NAME | EMPLOYER ADDRESS | WORK PHONE # | OCCUPATION | |
| | OTHER PARENT NAME | | FIRST | MIDDLE (MAIDEN) | LAST |
| | HOME ADDRESS | STREET NAME | APT. # | | CITY/STATE/ZIP |
| | SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE # | CELL PHONE # | |
| | EMPLOYER NAME | EMPLOYER ADDRESS | WORK PHONE # | OCCUPATION | |

THE FOLLOWING QUESTION IS OPTIONAL BUT BENEFICIAL TO THE PHYSICIAN IN MANY CIRCUMSTANCES.

FAMILY RELIGION (optional)

ETHNIC ORIGIN OF PARENTS (optional)

| | | | | | | |
|--|-------------------|--------|------|-----|---------------|-------------------|
| C H I L D R E N | CHILDREN (S) NAME | | | | | |
| | FIRST | MIDDLE | LAST | SEX | DATE OF BIRTH | SOCIAL SECURITY # |
| | FIRST | MIDDLE | LAST | SEX | DATE OF BIRTH | SOCIAL SECURITY # |
| | FIRST | MIDDLE | LAST | SEX | DATE OF BIRTH | SOCIAL SECURITY # |
| | FIRST | MIDDLE | LAST | SEX | DATE OF BIRTH | SOCIAL SECURITY # |
| | FIRST | MIDDLE | LAST | SEX | DATE OF BIRTH | SOCIAL SECURITY # |
| | FIRST | MIDDLE | LAST | SEX | DATE OF BIRTH | SOCIAL SECURITY # |

IN CASE OF EMERGENCY CALL (List someone other than parents)

| | | | |
|------|---------|--------------|-------------------|
| NAME | ADDRESS | RELATIONSHIP | CELL # PHONE # |
|------|---------|--------------|-------------------|

DO HAVE TENNCARE NOW? (CIRCLE ONE) **Y** **N**
 IF SO, WHICH PLAN? (PHP, TENNCARE, BLUECARE, JOHN DEERE TENNCARE, ACCESS MED PLUS, OTHER)

| | | | |
|--|---|-------------------------|----------------|
| P R I M A R Y | PRIMARY INSURANCE INFORMATION (We require a copy of your ID card) | | |
| | INSURANCE COMPANY NAME | PHONE # | |
| | INSURED'S NAME | RELATIONSHIP TO PATIENT | |
| | ID NUMBER | GROUP NAME/NUMBER | EFFECTIVE DATE |
| S E C O N D A R Y | SECONDARY INSURANCE INFORMATION (We require a copy of your ID card) | | |
| | INSURANCE COMPANY NAME | PHONE # | |
| | INSURED'S NAME | RELATIONSHIP TO PATIENT | |
| | ID NUMBER | GROUP NAME/NUMBER | EFFECTIVE DATE |

Thank you for choosing Knoxville Pediatric Associates as your child(ren)'s health care provider. We require that you read and sign the following prior to any treatment.

OUR FINANCIAL POLICY

Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. Therefore, financial responsibility for your child(ren)'s treatment ultimately is yours. You are responsible for all copays and deductible prior to services being rendered. If you have an insurance which we do not participate with, it will be your responsibility to pay at the time of service unless payment arrangements have been made. Any account that is referred to a collection agency will have a service charge added. A service charge of \$20.00 will be added for any checks drawn on insufficient funds. We accept Visa, MasterCard and Discover credit cards.

****The parent/guardian are responsible for the bill incurred, regardless of any divorce decree or court order stating otherwise****

OUR OFFICE POLICY

A patient that is not seen within a 3 year span will be considered a new patient and be charged accordingly.

Prescription refills will only be approved during normal business hours. It is not our policy to call medications without the child being seen first, unless it is a refill.

We require 24 hours notice to reschedule or cancel an appointment. If scheduled appointments are missed on a continual basis without notification of cancellation this may result in the termination of care for your child(ren).

Your signature below allows us to: accept payment of benefits directly from your insurance company under the terms of your insurance release to your insurance, hospitals, and any physician, and attorneys all information regarding your medical care for the purpose of determining benefits, coordination of your care, legal matters, obtain necessary information from your child(ren)'s other health care providers, and the acknowledgment that you have been provided with a copy of the notice of privacy practices.

- Please mark all that apply:
- Leave appointment reminders on my answering machine.
- Leave appointment reminders with a family member.
- Mail appointment reminders on postcards to my home address.
- Leave lab results on my answering machine.
- Leave lab results with my family.
- Leave general questions/medical information on my answering machine.
- Send questions/medical information to my email address. (KPA uses a secure server)
- Leave general questions/medical information with a family member.
- ONLY** leave information with myself. (Please note if you check here there should be no other choices marked)

The following person(s) may bring my child for treatment: _____ & _____

DATE: _____ SIGNATURE: _____ RELATIONSHIP: _____