Maryland Farms Pediatrics Patient Portal Access Form

I. Patient Information:

* Patient Name/Children's Names:

_____ _____
(Last Name, First Name) / (DOB) (Last Name, First Name) / (DOB)

_____ _____
(Last Name, First Name) / (DOB) (Last Name, First Name) / (DOB)

Address: _____
Street Address/City/State/Zip code

Patient Email Address (if 18 or over): _____

Phone Number: _____ - _____ - _____ Patient Cell Phone (if 18 or over): _____ - _____ - _____

X _____ Date: _____
Patient Signature (if 18 or over)

II. Proxy Information: (Proxy is the person who will have access to view records on the Patient Portal)

*Proxy Guardian: _____
(Last Name, First Name)
Sex: _____
DOB: _____

Social Security Number: _____ - ___ - _____

Email Address: _____

Phone Number: _____ - _____ - _____

Proxy Guardian: _____
(Last Name, First Name)
Sex: _____
DOB: _____

Social Security Number: _____ - ___ - _____

Email Address: _____

Phone Number: _____ - _____ - _____

Address: _____
Street Address/City/State/ Zip Code (if different from above)

*note: Legal Guardians must attach a copy of the court order appointing guardian and/or letters of guardianship verifying the Proxy's status as legal guardian of the patient.

If you are email/faxing this form, please attach a copy of your valid photo ID.

III. Signature:

By signing below, I acknowledge and agree that I will comply with the Patient Portal Terms and Conditions.
If I am a proxy for a patient over 18, I understand that the patient can cancel my access to his/her Maryland Farms Pediatrics Patient Portal at any time.

X _____ Date: _____ X _____ Date: _____
Proxy Signature Proxy Signature

Patient Signature (if 18 or older): _____ Date: _____
(**by signing you acknowledge and agree to allow access to the Proxy listed above**)

Maryland Farms Pediatrics Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.

Payment is required at the time of service. We accept cash, check, or credit card (Visa, Discover, or MasterCard).

For patients with no insurance or no well child or immunization coverage, full payment is required at the time of service.

For patients with an HMO plan, co-payment is required at the time of service. The amount of co-payment varies with different plans. You are responsible for knowing the co-payment amount and primary care physician listed on each child's card.

For patients with a PPO plan, we will submit your claim to insurance. Once your insurance processes the claim, we will submit a bill to you. You may also be asked to pay any previous claim balances at the time of your service.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility.

Bills unpaid for more than 90 days may be turned over to a collection agency unless other arrangements have been made. Accounts that are turned over to collections may result in dismissal from the practice.

If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our business office manager.

No shows or same day cancellations for check-ups, consultations, or chronic problem follow up (ADHD, asthma, etc.) will result in a $25.00 charge per child. Please help us serve you better by keeping scheduled appointments. Multiple missed appointments may result in dismissal from the practice.

The transfer of records (10 pages or more) will be $10.00 per child. You can pick up the records in the office at no cost. We can email or fax under 10 pages at no additional charge.

I have read the above financial policy, and I understand and agree to abide by it.

_____	_____
Legal Guardian (print)	Legal Guardian (print)
_____	_____
(signature/date)	(signature/date)

MARYLAND FARMS PEDIATRICS
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Maryland Farms Pediatrics to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Maryland Farms Pediatrics describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Maryland Farms Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lenore Kinkade, 5056 Thoroughbred Lane, Brentwood TN 37027

With this consent, Maryland Farms Pediatrics may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Maryland Farms Pediatrics may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Maryland Farms Pediatrics may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Maryland Farms Pediatrics restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Consent to Wireless Telephone Calls: If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including services and collection agents, of each of them regarding the hospitalization, the services rendered or my related financial obligations.

By signing this form, I am consenting to allow Maryland Farms Pediatrics to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Maryland Farms Pediatrics may decline to provide treatment to me.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN PRINT LEGAL GUARDIAN NAME

_____ _____
PRINT PATIENT'S NAME DATE

MARYLAND FARMS PEDIATRICS MEDICAL HISTORY FORM

Name of patient_____ Date of birth_____
Brothers/Sisters_____

FAMILY MEDICAL HISTORY

Please indicate if any Family Members have any of these conditions:

Diabetes_____
Cancer_____
Tuberculosis_____
Seizures_____
Heart Disease_____
Kidney Disease_____
Lung Disease_____
Blood Disease_____

Mental Retardation_____
Mental Illness_____
Eczema_____
Hay Fever_____
Asthma_____
Inherited Disease_____
High Blood Pressure_____
Birth Defects_____

Significant Social History (Divorce, Relocation, Family Deaths, Family Stress)
_____

PREGNANCY AND BIRTH

Due Date_____ Birth Weight_____ OB doctor_____
Problems during pregnancy or
delivery_____
_____
During Pregnancy-Medications taken_____ Alcohol_____

PAST MEDICAL HISTORY

Prior Pediatrician_____
Current Medical
Problems_____
_____
CurrentMedications_____
_____

Past Hospitalizations_____
Past Surgery_____
Allergies to Medications_____

MARYLAND FARMS PEDIATRICS CONSENT

CONSENT FOR TREATMENT:
This is to certify that I, the parent/legal guardian, request treatment of my minor child by the physicians and/or staff of Maryland Farms Pediatrics Authorization is hereby granted for such treatment.

Parent/Legal Guardian Signature _____ Date_____
Witness Signature: _____ Date_____

INFECTION CONTROL CONSENT
To protect employees against possible transmission of blood borne disease, such as hepatitis B human Immunodeficiency Virus(HIV), by signing below I understand it may be necessary for my child's blood to be tested if any employee is exposed by needle stick or any other method of exposure. The results are confidential and the testing is at no cost to the patient or responsible party.

INSURANCE BENEFIT ASSIGNMENT
As a courtesy to our patients, we will file your insurance if you are covered under a plan that we participate with. By singing below, I hereby assign insurance benefits to Maryland Farms Pediatrics. I also authorize MFP to release any information necessary for payment of the claim to my insurance carrier at their request. I also understand that I am fully responsible for payment of this account if my insurance information is incorrect or if my insurance doses not pay in a timely manner.

PAYMENT OF ACCOUNT
As stated above, payment is due at the time of service. All co-pays are to be paid at the time of service. Please make checks payable to Maryland Farms Pediatrics. Your child's health is important to us. If you encounter a hardship in payment of your account, please call Lenore Kinkade at (615)-373-3337. We will attempt to make payment arrangements so there is no interruption in your child's health care or well visits. If your account becomes past due, we will send your account to collections. If your account goes to court, you will be responsible for all court cost and attorney fees. By signing below, I am stating that I understand the payment policies of Maryland Farms Pediatrics.

CONSENT TO WIRELESS TELEPHONE CALLS
If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls (including autodialed calls and prerecorded messages) at that wireless number from the hospital, its successors and assigns, and the affiliates, agents and independent contractors, including servicers and collection agents, of each of them regarding the hospitalization, the services rendered, or my related financial obligations.

_____

PARENT/GUARDIAN

_____ _____

DATE WITNESS

Authorization to Treat an Un-emancipated Minor

Patient Name_____

Date of Birth_____

I, _____, am the parent or legal guardian of the above named patient. I agree for the patient to be examined and treated at Maryland Farms Pediatrics in my absence. I realize that, in case of questions, I must be able to be reached by telephone during the time of the exam, and based on the significance of the exam, my presence may be required.

I may be reached at telephone number_____

Printed name of Parent or Legal Guardian_____

Signature of Parent or Legal Guardian_____

Today's Date_____

TREATMENT AUTHORIZATION

I, _____ authorize the following
(Parent/Guardian name)
Individual(s) below to participate in the discussion and treatment of
_____ with the physician/nurse of Maryland Farms Pediatrics.
(Patient Name)

Name of authorized parties (parties must be 18yrs or older)

_____

_____

_____

Anyone not listed above is required to bring written permission from Parent/Legal Guardian before treatment*

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is way for doctors to send an accurate, error free, and understandable electronic prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

• **Formulary and benefit transactions** - Gives the health care provider information about which drugs are covered by your drug benefit plan.

• **Medication history transactions** - Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

Consent

By signing this consent form, you are agreeing that your provider may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Maryland Farms Pediatrics to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient Name Patient DOB

_____ _____
Signature of Patient or Guardian Today's Date

_____
Relationship to Patient