TERRACE PEDIATRIC GROUP

342 21st AVE. NORTH
NASHVILLE, TN 37203
TEL: (615) 327-9371 • FAX: (615) 329-6652

RALPH M. GREENBAUM, M.D.
JAMES S. PRICE, M.D.
WILLIAM A. SANDERS, M.D.

JULIE T. PEEK, M.D.
BRAD A. GREENBAUM, M.D.

We would like to welcome you and your family to Terrace Pediatric Group.

We want you to know that we appreciate the opportunity to take care of your child. Thank you for selecting us as your child's physicians and we look forward to serving you both. Your child's health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We treat a full spectrum of both acute illnesses and chronic conditions and offer a wide variety of services and preventive programs to address your child's physical and mental well being. **"We Strive to Empower Wellness."**

In order to expedite the new patient registration process, we ask that you arrive 10-15 minutes early for your appointment and bring the following ***completed*** forms with you:

1. **PATIENT REGISTRATION**
2. **CONSENT FOR TREATMENT AND ASSIGNMENT OF BENEFITS**
3. **MEDICAL HEALTH HISTORY**
4. **OFFICE POLICY NOTICE TO PATIENTS**
5. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

In addition to completing these forms, we ask that you ***read*** the documents containing information on Terrace Pediatric Group's **PRIVACY PRACTICES**.

Again, thank you for choosing us. We look forward to seeing you at our clinic and well do our best to make your visit as pleasant, efficient and complete as possible.

Sincerely,
Terrace Pediatric Group's Staff

Terrace Pediatric Group

Patient Information

Child's First Name: _____

Child's Last Name: _____

Child's Date of Birth: _____

Address: _____

Mother's Name: _____

Mother's SS#: _____ DOB: _____

Mother's employer: _____

Telephone # Home: _____

Business_____

Father's Name: _____

Father's SS#: _____ DOB: _____

Father's Address: _____

Father's employer: _____

Telephone # Home: _____

Business_____

Emergency Contact: _____

Phone: _____

Primary Insurance Name: _____

Insured Name:_____ Insured Date of Birth:_____

Member ID: _____ Group #: _____

Second Insurance Name: _____

Insured Name:_____ Insured Date of Birth:_____

Member ID: _____ Group #: _____

Source of Information: _____

Referred by: _____

Obstetrician: _____

Hospital: _____

Pediatrician: _____

TERRACE PEDIATRIC GROUP

Patient consent for Use and Disclosure of Protected Health Information

With your consent, Terrace Pediatric Group may use and disclose protected health information (PHI) about your child to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for more complete description of such uses and disclosures. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 342 21st Avenue North, Nashville, TN 37203.

With your consent, Terrace Pediatric Group may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to your clinical care.

With your consent, Terrace Pediatric Group may mail to your home or office any items that assist the practice in carrying out TPO, such as appointment reminder cards, insurance information, and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for your child.

Recognizing that it may be necessary for someone other than yourself to bring your child to see the doctor, or call pertaining to other protected health information; do your authorize Terrace Pediatric Group to release protected health information concerning your child to these people for treatment, payment, and health care operations?

YES NO

Information described above may be disclosed to:

_____

Name of person relationship

_____

Name of person relationship

You may revoke or terminate this authorization by submitting a written revocation to Sherese Collins, Privacy Officer, Terrace Pediatric Group, 342 21st Ave. N., Nashville, TN 37203.

Acknowledgement of Receipt of the Notice of Privacy Practice

I acknowledge & signed that Terrace Pediatric Group's Notice of Privacy Practices was made available to me. This notice describes how this office may use and disclose my protected health information. Patients requesting a Restricted Visit must submit the request in writing and pay at the time of service. I understand that I can obtain a complete copy by requesting that a copy be provided to me at the visit.

Print Name of Patient _____ Birthdate _____

Print Name of Parent or Legal Guardian _____

_____

Signature of person giving authorization Relationship to patient

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Dear Parent:

This letter is for informational purposes only. In the event that your child/children need to be seen by our doctors, and they have no insurance at the time of service, a partial payment will need to be paid prior to services being rendered. If the child is coming in for a sick visit, the amount due will be $90. If they are coming for a well-care visit, the amount due will be between $115 to $150, depending on the age of the child. If additional charges are added to the visit, we will bill you, if necessary. Payment in full is expected within 30 days.

Thank you,

Terrace Pediatric Group

By signing this form, you are acknowledging that you have been given this information.

Child's name _____ d.o.b. _____

Parent or Guardian Signature _____

Date _____

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Dear Parent,

Congratulations on your new born baby!

We understand that there are a lot of responsibilities that come along with having a baby, and it can all be very overwhelming.

Here at Terrace Pediatric Group we are striving to make your office visit as easy as possible; and there are a few things that you can do to assist us in our efforts.

In most cases your baby is covered under your insurance for the first 30 days of his/her life. After this time your baby could possibly be without insurance; therefore it is very important that you take the necessary measures to ensure that your child is covered by an insurance carrier prior to their 2 month visit.

Please notify our office as soon as possible upon receipt of any and all proof of coverage through an insurance carrier.

If for any reasons your child is not covered by an insurance carrier at the time of this visit, please understand that you will be required to either pay for the visit, at the time of service or reschedule your appointment for a later date.

We appreciate your continued cooperation in this matter.

Listed below are a few contacts that you may find helpful.

Thank you for choosing Terrace Pediatric Group for the health care needs of your child.

Department of Human Services	TN Care Bureau	TN Care Solutions
615-532-4000	1-800-852-2683	1-800-878-3192
www.tn.gov/humanserv		

By signing this form, you acknowledge that you have read it and you understand the information that it contains.

Child's name_____ D.O.B._____

Parent or Guardian Signature_____Date_____

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Financial Agreement

(Both sections are to be signed and dated)

I understand that I am obligated to report/disclose all medical insurance coverage for each of my children under the care of Terrace Pediatric Group. I further understand that my failure to disclose current or proper insurance coverage in a timely manner could result in charges that will be my full responsibility.

I also understand that I am responsible for charges that my insurance does not pay.

_____ _____

Customer Signature Date

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that Terrace Pediatric Group and/or their Third Party Collections may contact me/us as described above.

_____ _____

Customer Signature Date

(Rev. 6/2013)

Terrace Pediatric Group

Name: _____ DOB: _____

Authorization to Release Information

I hereby authorize the Physicians of Terrace Pediatric Group to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Authorization to Treat

I hereby authorize the Physicians of terrace Pediatric Group to render medical care to the patient named below.

A photocopy of these assignments shall be as valid as the original.

Patient _____ Date _____

Parent /Guardian (please print) _____

Parent / Guardian (signature) _____

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Immunization Records Request
And
Release of Other Medical Information

Patient(s) Names:_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

_____ DOB:_____

Please check and/or add any other entities that are OK to release your child's information to:

____WIC ____DHS ____Child's School ____Child's Daycare/Childcare Center

____(Other)_____ ____(Other)_____

____(Other)_____ ____(Other)_____

_____

Parent or Legal Guardian Signature Relationship to Patient(s) Date

Thank you,
Medical Records Department

(Rev. 6/2013)