Lloyd D. Franklin, M.D.
James H. Batson, M.D.
Leslie Treece, M.D.
Mary C. Loghry, M.D.

Cookeville Pediatric Associates

www.cookevillepediatrics.com

Kassie Barnes, PNP
Julie Smith, FNP
Lauren Grizzard, FNP
Dawn Johnson, FNP
Brooke Hewett, FNP

Please fill out completely and neatly, do not put "SAME", if we are unable to read the form or if information is not sufficient you will be asked to fill out another one at your next visit.

Child's Legal Name: _____ **SS #** _____

Name the Child goes by: _____ **DOB:** ___/___/___ **Sex:** _____

Preferred Language: _____ **Race:** _____ **Ethnicity:** _____

Mailing Address: _____ **City:** _____ **ST** _____ **Zip** _____

Mother's Name: _____ **Mother's DOB** _____ **Home Phone ( )** _____

Email Address: _____ **Cell Phone ( )** _____

Employment: _____ **SS#** _____ **Work Phone #** _____

Father's Name: _____ **Father's DOB** _____ **Home Phone ( )** _____

Email Address: _____ **Cell Phone ( )** _____

Employment: _____ **SS#** _____ **Work Phone #** _____

Relative/Friend (Emergency): _____ **Phone #** _____

Primary Insurance: _____ **ID #** _____

Subscriber's Name: _____ **DOB** _____ **Group #** _____

Ins. Company's Address: _____ **City:** _____ **ST** _____ **Zip** _____

Secondary Insurance: _____ **ID #** _____

Subscriber's Name: _____ **DOB** _____ **Group #** _____

Ins. Company's Address: _____ **City:** _____ **ST** _____ **Zip** _____

Are there any other family members seen at this facility? If so, please give the following information:

	Name	**DOB**	**Health Problems**
Brother/Sister:			
Brother/Sister:			
Brother/Sister:			

Patient Authorization

I request that payment of authorized benefits be made on my behalf to Cookeville Pediatric Associates or any services furnished me by these physician/suppliers. I authorize any holder of medical information about my child to release to my insurance agents any information needed to determine these benefits or the benefits payable to related services. I understand that I am responsible for any remaining amount not reimbursed by my insurance company. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Parent or Guardian Signature: _____ **Date:** _____

COOKEVILLE PEDIATRIC ASSOCIATES
150 NORTH WILLOW AVENUE
COOKEVILLE, TN 38501
PHONE (931) 528-1485
FAX (931) 526-4233

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations.

- PATIENT NAME:_____DOB_____SSN_____
- INFORMATION SENT FROM:

_____
_____
_____

INFORMATION SENT TO:

_____
_____
_____

- INFORMATION TO BE RELEASED: (please specify one)

1.ALL RECORDS GENERATED BY THIS FACILITY: _____
Are there any portions of your record in which you do not want released: Psychological _____, Substance abuse_____, AIDS/HIV_____, Other_____. (Please specify)

2.A PORTION OF RECORDS (specify dates or illnesses) : _____

_____

_____

3.ONLY IMMUNIZATION RECORD: _____

- PURPOSE OF THE USE OR DISCLOSURE: _____

_____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for the disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

- Parent's initials _____

A copy of this form will be provided if requested.
Cookeville Pediatrics will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
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:

- Parent's Name (please print) _____
- Parent's Signature_____
- Relationship to patient _____Date_____

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Thank you for choosing Cookeville Pediatric Associates for your pediatric medical needs. Please take a moment to review and acknowledge our office policies regarding the following:

VACCINES

We follow the American Academy of Pediatrics Bright Futures guidelines for all vaccines.

We firmly believe:

- in the effectiveness of vaccines to prevent serious illness and to save lives.
- in the safety of all vaccines.
- that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control, the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.
- based on all available literature, evidence and current studies, that vaccines do not cause autism or other developmental disabilities.
- that vaccinating children and young adults may be the single most important health promoting intervention we perform as health care providers, and that you can perform as parents/caregivers.

These things being said we recognize that there is controversy surrounding vaccinations and the choice may be very emotional for some parents. We will do everything we can to help you understand the importance of your child receiving all recommended vaccines. As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

Should you absolutely refuse to vaccinate your child despite all of our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend them. Please understand that by not vaccinating your child you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

APPOINTMENTS

We now offer walk-in sick appointments Monday-Friday from 8:30 AM until 11:00 AM and 1:00 PM until 4:00 PM. Our Saturday walk-in clinic offers walk-in sick appointments as well from 8:00 AM until 1:00 PM. We cannot guarantee which provider will be available for these visits. If you require a certain provider you will need to call in advance. Physicals and chronic condition appointments will still be by appointment only and also need to be scheduled in advance. We ask that you arrive 15 minutes prior to any scheduled appointment to allow for paperwork and insurance updates. Patients arriving more than 15 minutes late for scheduled appointments will be asked to reschedule. We also ask you call in advance if you are unable to keep your scheduled appointment. Failure to do so will cause you to be marked as a "no show." Repeated "no shows" may result in your child being terminated from our practice.

INSURANCE/ BILLING

It is extremely important that you provide us with accurate insurance information at each visit. We only have a certain period of time to file claims to your insurance company, after that time claims are denied and billed directly to you. If you receive a bill that you believe is in error, this is an indication that there is a problem with your insurance. We ask you to call us immediately, as we are working within your insurance company's time constraints. Failure by you to notify us or to handle the problem with your insurance company will leave us no option but to bill you directly for all charges you have incurred.

Well-Child check-ups, immunizations and other routine services may not be covered by some insurance plans. It is your responsibility to be aware of what your co-payments and benefits are. Please check with your insurance carrier about plan benefits prior to your appointment. All non-covered services are your responsibility to pay and will be billed accordingly. **ALL CO-PAYMENTS MUST BE PAID AT THE TIME OF SERVICE.**

If you do not have insurance coverage or if you have a lapse in insurance coverage, we will see your child, however, all charges must be paid prior to being seen by a provider. We will not bill any of these charges and the charges will be collected at check in.

In the case of divorce or separation, the parent authorizing treatment for the child/children will be the parent responsible for all subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

PRIVACY

For the privacy and protection of our patients and to prevent any HIPPA or ethics violations photo, video/audio or electronic recording of any kind can only be done with the expressed consent of the provider you are seeing that day and in the privacy of the examination room provided. Inappropriate or disrespectful use of social media to promote slanderous or harmful information regarding our patients or practice will not be allowed. We are required under law to protect the privacy and identity of each patient so any violation of this policy will result in an immediate termination from our practice.

I have read, understood, and agreed to the above policies of Cookeville Pediatric Associates.

_____ _____

Signature of Parent/Guardian Date

_____

Please list all children's names and dates of birth.

Revision effective 5/7/15

COOKEVILLE PEDIATRIC ASSOCIATES, P.C.
PAST MEDICAL HISTORY FORM

PHYSICIAN CHILD WILL SEE:_____ DATE: ___/___/___

PATIENT:_____RESPONSIBLE PARTY_____
CHILD'S DOB: ____/____/____

CHILD'S BIRTH HISTORY (IF KNOWN):
Type of delivery (check one) Vaginal ____ C-Section ____
Premature birth? Yes ____ No ____
How many weeks at delivery _____ Birth weight _____ (pounds)
Did the mother have any complications during pregnancy? Yes ____ No ____
Did the mother have any complications during or around the birth? Yes ____ No ____

CHILD'S PAST MEDICAL HISTORY:
Any significant past medical history Yes _____ No _____
Previous hospitalizations? Yes _____ No _____
If yes, explain: _____

Attention Deficit Disorder	Yes ____ No ____	Fracture	Yes ____ No ____
Allergies	Yes ____ No ____	Acid Reflux	Yes ____ No ____
Anemia	Yes ____ No ____	Headache	Yes ____ No ____
Asthma	Yes ____ No ____	Psychiatric Disorders	Yes ____ No ____
Blood disorders	Yes ____ No ____	Migraine	Yes ____ No ____
Bronchiolitis	Yes ____ No ____	Ear infections	Yes ____ No ____
Chickenpox	Yes ____ No ____	Pneumonia	Yes ____ No ____
Chronic illness	Yes ____ No ____	Recurrent colds	Yes ____ No ____
Heart defect	Yes ____ No ____	Sinus infections	Yes ____ No ____
Concussion	Yes ____ No ____	Seizure disorder	Yes ____ No ____
Delayed Developmental Milestones	Yes ____ No ____	Thyroid disorder	Yes ____ No ____
Diabetes Mellitus	Yes ____ No ____	Tonsillitis	Yes ____ No ____
Eczema/Rash	Yes ____ No ____	Trauma	Yes ____ No ____

CHILD'S SURGERY HISTORY:
Significant surgeries Yes ____ if yes, what surgeries:_____
No ____

Appendix removal	Yes ____ No ____
Hernia repair	Yes ____ No ____
Tonsils removed	Yes ____ No ____
Ear tubes	Yes ____ No ____

FAMILY HISTORY:

Alcoholism	Yes ____ No ____	High blood pressure	Yes ____ No ____
Asthma	Yes ____ No ____	Juvenile Rheumatoid Arthritis	Yes ____ No ____
Birth defects	Yes ____ No ____	Kidney disease	Yes ____ No ____
Cancer	Yes ____ No ____	Mental illness	Yes ____ No ____
Crohn's Disease	Yes ____ No ____	Mental retardation	Yes ____ No ____
Diabetes	Yes ____ No ____	Migraine	Yes ____ No ____
Drug use	Yes ____ No ____	Stroke	Yes ____ No ____
Epilepsy	Yes ____ No ____	Systemic Lupus	Yes ____ No ____
Heart disease	Yes ____ No ____	Tuberculosis	Yes ____ No ____
High cholesterol	Yes ____ No ____		

CHILD'S SOCIAL HISTORY:

Exposure to cigarette smoke at home	Yes ____ No ____
Living with parents	Yes ____ No ____
Recent contact with pets/animals	Yes ____ No ____
Child enrolled in day-care	Yes ____ No ____
Living in a foster home	Yes ____ No ____
Tobacco use	Yes ____ No ____
Alcohol	Yes ____ No ____
Drug use	Yes ____ No ____

OTHER:

Is there any additional information we may need to know? _____

_____