7693 Rhea Co Hwy Ste 1
Dayton, TN 37321
(423) 594-8700

18 and Over Demographic Form

Patient Information

_____ _____ ☐ Male ☐ Female
Last Name First Name MI Preferred Name

_____ _____-_____-_____ Visually Impaired ☐ Yes ☐ No Hearing Impaired ☐ Yes ☐ No
Date of Birth Social Security Number

Language Preference: ☐ English ☐ Spanish ☐ Other _____ Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ I Decline to Answer

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ White ☐ Hawaiian/Pacific Islander ☐ I Decline to Answer

_____
Mailing Address City State Zip

Primary Contact Number _____ ☐ Land ☐ Cell Belongs to? _____
2ndary Contact Number _____ ☐ Land ☐ Cell Belongs to? _____

Emergency Contact

Name: _____ Number: _____ ☐ Land ☐ Cell

Insurance Information

Primary Insurance Company: _____

Secondary Insurance Company: _____

Your privacy is very important to us. There are times that we will reach out to you to follow up with you regarding your treatment, payment and healthcare operations, appointment reminders, insurance questions, patient statements and other items pertaining to your care. For convenience sake, we offer email and text messaging reminders and notifications. We will not send sensitive issues via these routes, nor on voicemail, but a follow up call might be necessary to share the pertinent information. Please check any of the following ways you would like us to communicate with you. If you have any questions or needs, please contact Allyson Blaylock, Practice Administrator at (423) 594-8700 ext. 7120 or via email at blaylock@fireflypediatrics.org

Please list any restrictions to how we may contact you (ex: you may not leave messages on voicemail):

_____

☐ You may leave messages (with a person or voicemail) at _____ or _____

☐ You may text me at the following cell phone number(s) _____

☐ Please sign me up for the Patient Portal and informational email messages. The e-mail address I would like to use is:

_____

(Continued on back side)

General Agreement (sign and initial next to each statement)

_____ I have received, read, and understand the Firefly Pediatrics Patient Information brochure. I understand the stated policies of this practice and I agree to be bound by their terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ I have received and reviewed a copy of Firefly Pediatrics' Notice of Privacy Practices, which describes how patient health information may be used and disclosed. I understand that Plateau 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 *Firefly Pediatrics, Privacy Officer, 7693 Rhea Co Hwy, Suite 1 Dayton, Tn 37321*. The most up-to-date Notice of Privacy Practices is also located on the practice website at *www.fireflypediatrics.org*. If I have a complaint regarding privacy or other issues, I understand that I may complain to the HIPAA Privacy Officer.

_____ I authorize Firefly Pediatrics, its clinicians, and its employees to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). If I do not sign this consent, Firefly Pediatrics may decline to provide treatment.

_____ I have the right to request that Firefly Pediatrics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____ I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ I authorize Firefly Pediatrics to process my insurance claims and understand they may use a photocopy of my signature for this purpose. I authorize Firefly Pediatrics to release any medical or other information necessary to my insurance carrier. If I am covered by or eligible for TennCare, Firefly Pediatrics may release protected health information to the Bureau of TennCare. I authorize and direct my carrier to issue payment check(s) directly to Firefly Pediatrics. Regardless of my insurance benefits, I understand that I am fully financially responsible for any and all fees incurred, and I agree to pay such fees in full when permitted by my insurance carrier. I agree to pay all collection costs, court costs, and attorney fees incurred to collect my account.

_____ The insurance information I have provided represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose any and all plans to which I subscribe may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

_____ If my address, telephone number, or insurance changes for any reason, I agree to let Firefly Pediatrics know immediately.

Payment Agreement (sign and initial next to each statement)

_____Copayments are due at the time of the visit. If the copayment is not paid in full on the day of the visit, or a copay agreement is not signed, an additional $10.00 service charge will be added to the patient balance for the date of the visit.

_____If your commercial insurance does not have a set copayment amount, a payment of $20 will be collected towards the coinsurance or deductible amount prior to being seen.

_____If the bank returns a check for insufficient funds or if you give our office a credit card to charge as part of a payment plan agreement and it is declined, a $25.00 service charge will be added to the patient balance for the date of the visit.

_____If a patient does not have insurance, payment must be paid in full at the time of service.

_____If a patient has a balance due, payment will be required within 30 days of your first statement. If the balance cannot be paid in full within that time period, a signed payment agreement must be completed with a credit card kept on file, to be charged monthly. Balances that are not paid and/or a payment agreement is not made at 60 days from the statement date will be assessed a late fee.

_____ If a payment plan must be executed for an outstanding balance, all future appointments must be paid on the date of service, prior to being seen. The payment amount will be assessed according to your specific insurance plan's copayment, coinsurance and deductible amounts.

_____If Firefly Pediatrics finds it necessary to take steps to collect a past-due balance, the patient is responsible for all costs involved in collection, including court costs.

_____If a patient files bankruptcy, future appointments must be paid prior to being seen. The amount will be assessed according to your copayment, coinsurance and deductible amounts. Patients with current, active Medicaid (TennCare) are excluded from this policy.

Signed: _____ Date: _____