Plateau Pediatrics
3234 Miller Ave
Crossville, TN 38555
(931) 707-8700

Out of Town Family Demographic and Consent Form

Patient Information – Please include each child that will be a visiting patient (If you have more than 4 children please ask for a 2nd Demographic Form)

Child No. 1 _____ _____ _____
Last Name First Name MI Preferred Name Social Security Number

☐ Male ☐ Female Date of Birth _____

Child No. 2 _____ _____ _____
Last Name First Name MI Preferred Name Social Security Number

☐ Male ☐ Female Date of Birth _____

Child No. 3 _____ _____ _____
Last Name First Name MI Preferred Name Social Security Number

☐ Male ☐ Female Date of Birth _____

Child No. 4 _____ _____ _____
Last Name First Name MI Preferred Name Social Security Number

☐ Male ☐ Female Date of Birth _____

Home Address

_____
Street or PO Box City State Zip

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

Parent/ Legal Guardian No. 1

_____ _____ _____
Last Name First Name MI Date of Birth Social Security Number

Parent/ Legal Guardian No. 2

_____ _____ _____
Last Name First Name MI Date of Birth Social Security Number

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 Villa Edwards, Practice Administrator at (931) 707-8700 ext. 7239 or via email at edwards@plateaupediatrics.com.

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:

_____ and belongs to ☐ Mom ☐ Dad ☐ Legal Guardian

Family Doctor

Please list the patient's regular physician so we may send note to them about today's visit.

_____

Physician Name Address Telephone

I give consent for the physicians of Plateau Pediatrics to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures upon my prior consent. I understand that I have the right to request restrictions, but Plateau Pediatrics is not required to agree with the request. If I do not sign this consent, Plateau Pediatrics may decline to provide treatment.

I authorize Plateau Pediatrics to process my insurance claims. I allow a photocopy of my signature to be used to process my insurance claims. I authorize Plateau Pediatrics to release any medical or other information necessary to my insurance carrier and authorize and direct my carrier to issue payment check(s) directly to Plateau 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. **Depending on my insurance coverage, the doctor visit may not be a covered benefit. I understand I may be fully responsible for payment at the time of the visit. If the insurance covers the doctor visit, I will be reimbursed.**

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 pre-certification/second opinion requirements for any and all plans to which I subscribe may cause me to insure full liability for professional charges, as a result of non-payment by any carrier.

If my address, telephone number, insurance, or legal custody status changes for any reason, I agree to let Plateau Pediatrics know immediately.

Plateau Pediatrics is committed to adhering to privacy practices as set forth in the Notice of Information Practices. The Notice of Information Practices provides further details of how my protected health information may be used and disclosed. If I have a complaint regarding privacy or other issues, I understand that I may complain to the HIPAA Privacy Officer.

Parent/guardian's name: _____

Signature: _____ Date: _____