Spring Creek Pediatrics
929 Spring Creek Road, Suite 206
Chattanooga, TN 37412
Phone (423) 892-3400
Fax (423) 892-8266 or (423) 648-2692
Stephanie A. Stegall, M.D. ***Summer R. Ross, M.D.*** ***Jessica R. Claridge, M.D.***
Jana S. Watters, FNP-BC ***John Appel, PA-C***

Adult Patient Demographic Sheet

FULL NAME ________________________________

DATE OF BIRTH ___/____/____

GENDER M / F/ Other

Phone Number: (____) __________________________

Address: ______________________________________

Email: ____

City: _____________ **State:** _______ **Zip :** _________

SSN: ________________________ *(This is REQUIRED for Insurance Purposes)*

Current School: ______________________________ **and/or Employer:** ______________________________

PRIMARY INSURANCE

Policy Holder Name: ________________________

Policy Holder Birth Day: ___/____/____

Holder SSN: __________________________

(This is REQUIRED for Insurance Purposes)

Employer: _________________________________

Insurance Company: ________________________

Policy/Member ID #: ________________________

Group ID #: ______________________________

Effective Coverage Date: ___________________

SECONDARY INSURANCE (If applicable)

Policy Holder Name: ___________________________

Policy Holder Birth Day: ___/____/____

Policy Holder SSN: _____________________________

(This is REQUIRED for Insurance Purposes)

Employer: ____________________________________

Insurance Company: ___________________________

Policy/Member ID #: ________________________

Group ID #: _______________________________

Effective Coverage Date: ____________________

EMERGENCY CONTACT

Name: ___________________________________

Relation: ________________________

Phone Number: (______) ________________

PHARMACY INFO

Pharmacy Name: __________________________

Pharmacy Address: ________________________

City: ________________ **State:** _______ **Zip:** ________

Pharmacy Phone Number: (______) _______________

NOTICE OF PRIVACY

By my signature, I have been made aware of the SPRING CREEK PEDIATRICS' HIPAA Privacy Regulations. A synopsis of the manual is posted and available upon written request. A copy of the Federal Laws Governing the Protected Health Information (PHI) may be downloaded by going to https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

CONSENT TO USE & DISCLOSE HEALTH INFORMATION

I understand that as part of my care, SPRING CREEK PEDIATRICS originates and maintains paper and/or electronic records describing my health history, symptoms, exams, test results, diagnosis, treatments, and plans for future care or treatment.
I Authorize the release of any office notes and results of images in the event it is needed to help with the diagnosis and plan of care for further treatment in coordination of care. I permit a copy of this information to be used in place of the original.

Who is allowed access to personal health information? *(make appts, pick up prescriptions, samples, letters etc.)*

Name: ____ **Relation:** ________________________________

Name: ____ **Relation:** ________________________________

I AUTHORIZE SPRING CREEK PEDIATRICS AND ITS STAFF TO DISCUSS MY MEDICAL INFORMATION WITH PARENT(S) ***Initial below***

- I allow access to my **diagnosis and treatment information** ____
- I allow my **immunizations records** to be released by fax or mailed:_______________ _
- I allow my **treatment plans** (i.e.: medication, asthma, epi-pens, etc.) to be disclose _____________
- I allow my **office visits** to be accessed: ________
- I allow my **labs** to be released: ________
- With my consent, I allow any **“confidential information”** including results of STD testing, HIV, AIDS, and Pregnancy testing to be shared with ______Parents _______ Self Only

ACCOUNT INFORMATION

- For financial purposes, I allow **my parent(s)** access to discuss **my account**. _________ *(Initial)*

We are committed to providing the best care possible. Understanding your financial responsibility is considered part of your medical management. This Financial Policy is an agreement between you and the providers of SPRING CREEK PEDIATRICS. Your understanding is important to our professional relationship.

Though you may still be covered under your parent's insurance, **YOU**, as an adult, are solely financially responsible for any and all payments: copay, coinsurance or deductible that your insurance deems as your responsibility. You may meet with our Business Office for payment options and account changes.

It is your responsibly to provide SPRING CREEK PEDIATRICS with **accurate** and **timely** insurance information. Inaccurate or untimely information that results in denial or non-coverage by your insurance company will be your responsibly.

I acknowledge that during my wellness visit, there may be a problem-oriented service performed by SPRING CREEK PEDIATRICS provider. In this case, I understand that two separate charges may be submitted to my insurance and that when applicable, a copay/deductible/co insurance may be required for charges generated pertaining to problem-oriented services. Alternatively, I understand I may choose to return for a separate visit to address problem-oriented issues, at which time, my copay /deductible would still apply.

NON-EMERGENCY APPOINTMENTS may be rescheduled if your account has an outstanding balance(s) or if a co-payment is not paid at time of service. We accept cash, checks, MasterCard, AmEx, Visa, or Discover.

Outstanding balances are due within 30 days, unless prior arrangements have been made with SPRING CREEK PEDIATRICS' BUSINESS OFFICE.

CONTACT INFORMATION

May we leave a message on your voice mail or text your cell phone regarding your appointments reminders, any test results, referrals, account information etc. **Y / N**

My signature below indicates I am the patient listed above, that I have provided accurate information to the best of my knowledge and I understand and agree to the provision above.

X ____
Signature

____
Print Name **Date:** __________________

****This form must be completed in FULL****