TLC Pediatrics
22335 U.S. Hwy 72 East, Ste C, Athens, AL 35613
256-870-4111

Patient Information

Patient's Name_____ Name child goes by:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth: _____ Sex: M F Preferred Language:_____

Cell Phone:_____ Home Phone:_____

Race: American Indian or Alaskan White Black Asian Hispanic Native Hawaiian Unknown

Ethnicity: Hispanic Origin Not of Hispanic Origin Refused by patient

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Parent's Name:_____ Second Parent's Name:_____

DOB:_____ DOB:_____

Work #:_____ Cell#:_____ Work #:_____Cell#:_____

Email:_____ Email:_____

Emergency Contact:_____ Relationship to patient:_____

Home #_____Cell #_____ Work #_____

Siblings that we see:_____

Insurance Information

Primary Insurance **Secondary Insurance**

Policy Holder Name:_____ Policy Holder Name:_____

Insurance Company:_____ Insurance Company:_____

Policy #_____ Policy #_____

Group # _____ DOB:_____ Group # _____DOB:_____

Signature: _____Date:_____

Insurance Release: I hereby authorize TLC Pediatrics to furnish the above named insurance company all the information they may Request concerning the patient's present illness or injury. I hereby assign to TLC Pediatrics all benefit for service rendered.

TLC Pediatrics

New Patient Registration Form 2 of 4

Pediatric or Minor Patient

I,_____, parent/legal guardian/legal custodian/caretaker of
(your name)
_____, date of birth ____/____/_____ give permission for my minor
(Child's name)
_____, date of birth ____/____/_____ give permission for my minor
(Child's name)
_____, date of birth ____/____/_____ give permission for my minor
(Child's name)
child to receive health-related services such as a physical examinations, immunizations, prescriptions, referrals, and other services as indicated. I understand that the child's medical records are strictly confidential. I hereby authorize use of these records by all persons within TLC Pediatrics office (such as physicians, nurses, and other providers) participating in the provision of my health-related services.

I release TLC Pediatrics and their health officers, employees and agents from my liability resulting from their use of this form. I hereby authorize payment of insurance benefits to the above-named clinic to release any information acquired during the examination or treatment so that the insurance benefits may be promptly and correctly filed.

Furthermore, I authorized the following individuals who are listed below (1) to sign any necessary papers on subsequent visits, (2) t read and sign the information statements required before immunizations can be administered, and (3) to advise the nurse of any conditions following previous treatments or immunizations which would prevent my child's receiving further treatments or immunizations on a subsequent visit which my be made in my absence. Information given to the persons listed below and signature made by them will have the same effect as if I had personally received the information and signed by name on any documents on behalf of my child.

Persons authorized to bring my child to TLC Pediatrics for services and sign papers on my behalf:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of TLC Pediatrics notice of privacy practices.

I, _____, authorize TLC Pediatrics to release any information acquired in the course of my child's examination or treatment. I also authorize any insurance payment directly to TLC Pediatrics for medical benefits. I understand any monies received from the insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges and will be responsible for any collection fees, attorney fees, or court costs should my account become delinquent. I understand that all payments for services rendered are expected at the time of service.

_____ _____

Signature of Parent/Guardian **Date**

TLC Pediatrics

New Patient Registration Form 3 of 4

Patient Eligibility Screening Record

Alabama Vaccines for Children Program

Child's Name:_____ DOB:_____

Parent/Guardian/Individual of Record Name: _____

This child qualifies for vaccinations through the VFC program (please circle on if applicable) because he/she

A. Is enrolled in Medicaid
B. Does not have Health Insurance
C. Is American Indian or Native Alaskan
D. Do Not have Medicaid (skip to EPSDT Child Health Medical Record)

Medicaid Program Release of Information

I, _____, _____, of _____

Name **Relationship** **Child's Name**

A qualified participant in the Alabama Medicaid Program, hereby agree to the release of my child's records to the Alabama Medicaid Agency and to any participating contractors or subcontractors with his/her medical care and follow-up. I also agree to the release of any program records pertaining to my child.

_____ _____

Parent/Guardian or Custodian Signature Date

_____ _____

Witness Date

EPSDT Child Health Medical Record

I give permission for the child whose name is on this record to receive services at TLC Pediatrics. I understand that he/she will receive test, immunizations, and exams including physicals/screenings. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me.

_____ _____ _____

Signature Relationship Date

TLC Pediatrics

New Patient Registration Form 4 of 4

After Hour Calls

I,_____, parent/legal guardian/legal custodian/caretaker of
(your name)
_____, date of birth ____/____/_____
(Child's name)
_____, date of birth ____/____/_____
(Child's name)
_____, date of birth ____/____/_____ understand that After Hour
(Child's name)

Calls are for Emergency. All After Hour Calls are subject to a $10 charge.

If you need the after hours please call, we are here for you, but do note that after hours calls are not for:

- Refill on medication
- Request an appointment
- Request Blue card

Medication will only be called in after hours on a case to case bases.

_____ _____

Signature of Parent/Guardian **Date**

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Preferred Pharmacy

Please list below your Main pharmacy and then if you have 2 others or mail in please list those as well.

Patient Name:_____

Preferred Pharmacy:_____ Road Names:_____

2nd Pharmacy:_____ Road Names:_____

3rd Pharmacy:_____ Road Names:_____

Mail in Pharmacy:_____

TLC Pediatrics

Patients Name:_____ Date of Birth:

Patients Name:_____ Date of Birth:

Patients Name:_____ Date of Birth:

We understand things come up. However, please respect our time as well. A simple call, text, or email could let us know you are unable to make your appointment time. If you do not contact our office prior to your appointment to reschedule you may be subject to a No Call/ No Show fee. First time fee will be $15.00, second time to No Show/ No call fee is $30.00 and third time to No Show/ No Call you may be subject to being discharged as a patient.

Parent Signature:_____ Date: