PENTA
pediatric ear nose and throat associates
Joe A. Graves, M.D & Katrina Rouse FNP
2100 W. Clinch Ave. Ste 330
Knoxville, TN 37916
865-673-8229/865-673-8893 (fax)
www.penta-knox.com

We wish to inform you of your child's appointment on _____arrive at _____.

Your child will be seeing **Dr. Graves** _____ **Nurse Practitioner** _____ **Audiologist** _____.

In order to assist us during your initial consultation, please read and complete ALL enclosed questionnaires. Please bring **EVERY PAGE** in the packet with you for your child's appointment.

- IMPORTANT : A parent and/or legal guardian **MUST** accompany the child at **ALL** appointments. Please ensure that you bring all legal guardianship paperwork **(UP TO DATE)** with you to the visit. (This is for your child's safety & protection) Should someone other than a parent or legal guardian accompany your child to the initial visit, the appointment **WILL** be rescheduled.
- Persons under the age of 18yo **MUST** be accompanied by a parent or legal guardian to **EVERY** appointment.
- If necessary, your child may require further diagnostic testing. Please be prepared to be in the office at least one(1) hour.

Referral/Insurance Information:

- Our office is a specialty care facility. You may need to contact your Primary Care Physician(PCP) or your insurance carrier to find out if your insurance requires a referral to see a specialist.
- If you **DO need a referral**, please remember it is your responsibility to obtain this for every visit in our office.
- Please ensure that you provide **ALL** insurance information at the time of your visit. Some patients have a primary and secondary insurance. You are required and responsible to provide all insurance information at the time of visit. **Please note: if information is NOT provided within timely filing period, you will be responsible for balance.**

PLEASE BRING VALID INSURANCE CARD/CARDS & PHOTO ID WITH YOU TO ALL APPOINTMENTS.
PLEASE FILL OUT PAPERWORK WITH BLACK INK

****ALL PAPERWORK MUST BE COMPLETED BEFORE YOU ARRIVE TO APPOINTMENT. IF NOT YOUR APPOINTMENT WILL BE RESCHEDULED.**

WE DO NOT VALIDATE PARKING, it is $2 charge, no matter how long you are in the building.

Please initial that you have read & understand the information above: _____.

Parental Consent Protocol

- It is the policy of Pediatric Ear Nose & Throat Associates P.C. that each patient is to be accompanied to all appointments in our office by their **parent or legal guardian.** (if legal guardian brings child in, they **MUST** present appropriate legal paperwork).

- Should the patient be an established patient of PENTA yet their chart be in storage, this will make the patient a NEW patient and they **MUST** be accompanied by their parent or guardian to their NEW patient appointment.

- Should the patient be an established patient of PENTA and be coming into the office for a NEW problem, they **MUST** be accompanied by their parent or legal guardian. (see below)

- If the patient is an established patient of Pediatric Ear, Nose & Throat Associates, and P.C. and is coming for a routine recheck appointment or Post op appointment with our office, they can be accompanied to the office, **WITH** consent of parent or legal guardian, by grandparent, emergency contact or whomever the parent/legal guardian deems responsible. ****Note: Whoever is accompanying the patient into PENTA must present notarized paperwork stating that they have been given permission for said person to accompany the patient into the office. (we will need to obtain photo ID from the person that has accompanied the patient)**

PLEASE BE ADVISED: PARENTS & GUARDIANS ASKING IF SOMEONE ELSE CAN BRING THEIR CHILD TO RECHECK APPOINTMENTS: ANY PROCEDURES, SURGERIES, CT SCANS, ETC. **CANNOT AND WILL NOT** BE SCHEDULED UNLESS THE PARENT OR LEGAL GUARDIAN ARE PRESENT AT THE APPOINTMENT.

****PLEASE NOTE THAT YOUR EMERGENCY CONTACT AND OR HIPAA CONTACT DO NOT QUALIFY AS LEGAL GUARDIANS FOR APPOINTMENTS! ****

Please sign below that you have read and understand this consent form.

Signature Of Parent or Legal Guardian:_____

Date: _____

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PATIENT REGISTRATION

PATIENT NAME_____
(LAST NAME) (FIRST NAME) (MIDDLE NAME) (CALLED BY)

ADDRESS_____APT#_____

CITY:_____STATE:_____ZIP CODE_____

HOME PHONE# (____)_____SOCIAL SECURITY #_____

PATIENT'S DATE OF BIRTH _____/_____/_____ CURRENT AGE_____ SEX: MALE / FEMALE

**RELIGIOUS PREFERENCE (OPTIONAL) _____

****PREFERRED LANGUAGE AT HOME** _____**DO YOU NEED AN INTERPRETER YES / NO**

EMERGENCY CONTACT NAME (NOT LIVING IN YOUR HOME) _____

EMERGENCY CONTACT PHONE # _____RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ SECONDARY INSURANCE_____

SUBSCRIBER NAME_____ SUBSCRIBER NAME_____

POLICY/MEMBER ID# _____ POLICY/MEMBER ID#_____

RELATIONSHIP TO INSURED_____ RELATIONSHIP TO INSURED_____

PARENT/GUARDIAN/RESPONSIBLE PARTY

MOTHER'S NAME_____SOCIAL SECURITY #_____

RELATIONSHIP TO PATIENT - BIOLOGICAL/ADOPTIVE MOM? STEPMOM? FOSTER MOM? GUARDIAN? OTHER? (CIRCLE ONE PLEASE)

ADDRESS _____CITY_____ST_____ZIPCODE_____

DATE OF BIRTH ____/____/____ CURRENT AGE_____ CELL PHONE # (____)_____

EMPLOYER_____PHONE#_____

FATHER'S NAME_____SOCIAL SECURITY #_____

RELATIONSHIP TO PATIENT - BIOLOGICAL /ADOPTIVE DAD? STEPDAD? FOSTER DAD? GUARDIAN? OTHER? (CIRCLE ONE PLEASE)

ADDRESS _____CITY_____ST_____ZIPCODE_____

DATE OF BIRTH ____/____/____ CURRENT AGE_____ CELL PHONE # (____)_____

EMPLOYER_____PHONE#_____

I HEREBY AUTHORIZE PENTA TO FURNISH INFORMATION TO OBTAIN INFORMATION FROM INSURANCE CARRIERS & OTHER HEALTHCARE PROVIDERS/FACILITIES CONCERNING MY CHILD'S ILLNESS AND TREATMENT

SIGNATURE_____**TODAY'S DATE**_____

Pediatric Ear, Nose & Throat Associates, P.C.

Joe A. Graves, M.D.

MEDICAL INFORMATION

Patient Name _____
(Last) (First) (M) (Called by)

Referring Physician _____ Phone(_____)_____

Address _____ City_____ST_____ Zip_____

Primary Care Physician_____ Phone(_____) _____

Address _____ City_____ST_____ Zip_____

***Please include for referral purposes**

General Medical Information:

Was the patient delivered(born) prematurely? Y N How early _____ # of weeks _____
Was the patient admitted to the Neonatal ICU? Y N Length of stay_____ # of weeks _
Does the patient have Heart Disease? (e.g **heart murmur**) Y N _____
Does the patient have Lung Disease? (e.g. **asthma**) Y N _____
Does the patient have Liver Disease? (e.g. **hepatitis**) Y N _____
Does the patient have Diabetes? Y N _____
Does the patient have High Blood Pressure? Y N _____
Does the patient have a history of Seizures? (e.g. **epilepsy**) Y N _____
Does the patient have a Bleeding Disorder? (e.g. **hemophilia**) Y N _____
Other Medical Problems: _____
_____

Past Surgical History:

List the patient's previous surgeries and date(s) of surgery: _____
_____
_____
Has the patient ever had his/her Spleen removed? Y N _____

Social History:

Does the patient attend school or daycare? Y N Year? _____
Name of School _____ Full-Time or Part-Time
How many children in household? _____ Age of other children? _____
Are there any family pets? Y N Indoor / Outdoor Type? _____
Does anyone in the family smoke? ( ) Y ( ) N ( ) Outside Only

Medications:

List current medications and dosage

_____
_____

******MEDICATION ALLERGIES******

_____
_____
_____

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2100 W. Clinch Avenue, Suite 330
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(865) 673-8229 Office
(865) 673-8893 Fax

Thank you for choosing us as our pediatric ear, nose & throat specialists. Please read our Payment Policy below, ask any questions, and sign in the space provided.

Co-payments and deductibles are due prior to your appointment. Failure to pay your co-payment and / or deductible will result in the rescheduling of your appointment.

50% of the patient responsibility will be collected prior to the date of any surgery.

Self-pay patients are responsible for paying the full amount the date the service is rendered.

Any additional patient responsibility must be paid in full b the timeline shown below:

Balances:	**Payment Terms:**
$0.00 - $250.00	**0 days – 30 days from date of service**
$251.00 - $$400.00	**0 days – 60 days from date of service**
$401.00 & over	**0 days – 90 days from date of service**

Should you have questions regarding our payment policy or if extenuating circumstances do not allow you to adhere to the terms above, please contact us. We will be happy to discuss payment options with you on an individual basis.

I have read and understand the Payment Policy for Pediatric Ear, Nose & Throat Associates, P.C., which I do hereby acknowledge and agree to abide by.

_____
Patient Name

_____ _____
Parent / Legal Guardian / Guarantor Signature Date

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One Time Authorization Form

Patient's Name: _____ **Date:** _____

Assumption of Responsibility: I agree that in consultation of services to be rendered, I obligate myself to assume financial responsibility and agree to pay upon demand to above named PROVIDER's all charges for such services and incidentals incurred. Should the account be referred to an attorney for collection, I shall pay reasonable attorney fees and collection expenses. Even though insurance may be filed, I understand that all bills are payable upon receipt and that I and not the insurance company, am responsible for payment of all services.

Initials: _____

Responsibility of Co-Pay Amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of physician's visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have been paid.

Initial: _____

Assumption of Referrals: I understand that if I have insurance coverage, which requires a referral from a Primary Care Physician, it must be received in order to receive maximum benefits from my insurance company. I further understand that it is my responsibility to obtain a hardcopy referral from my PCP. I have been given the opportunity by the above said provider to obtain a referral or reschedule my appointment. I understand that it is my responsibility to obtain any and all needed referrals for any and all appointments. I understand that if I refuse that I am taking full responsibility for payment.

Initial: _____

Assignment of Insurance Benefits: I hereby assign direct payment of any hospital insurance benefits, medical insurance benefits including Medicare, Medigap, major medical benefits, insurance disability benefits, or injury benefits payable because of liability of third party or organization, and so forth, payable to or above said patient until account paid in full.

Initial: _____

Acknowledgement of Receipt of HIPAA notice: I acknowledge receiving today a copy of PROVIDER's notice of privacy policies. I consent to the PROVIDER's use of protected health information as described in the notice of treatment, payment or healthcare operations. I understand that I must provide a separate authorization before any other disclosures may be aware.

Signature: _____ **Date**: _____

Authorization for Release: I authorize my protected health information to be disclosed to the following:

_____

Signature: _____ **Date**: _____

Request for restrictions: I request that my health information not to be disclosed to the following:

_____

Signature: _____ **Date**: _____

Office Policies for Cancelations and Rescheduled appointments: If a patient has missed/canceled/rescheduled three (3) appointments, they will be subject to possible discharge from PENTA.

Signature: _____ **Date**: _____

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MEDICAL RECORDS RELEASE

(Physician's Office Form)

Please complete the following information:

Patient Name:_____Date of Birth:_____

Address:_____

_____

Phone:_____

I, _____, authorize the release of all medical records, pertaining to the treatment of any ear, nose, and throat condition, for the patient mentioned above. This release will give PENTA permission to obtain medical records from any office that might have protected health information that will help in treating the patient mentioned above, regarding any ear, nose, and throat condition.

If there are any records you would like to restrict an office from sending, please list those records, and which office the records would be coming from:

_____

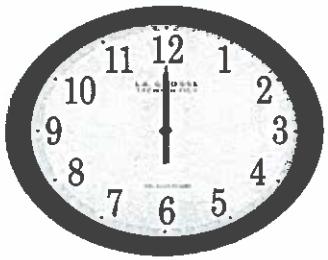
_____

_____ _____

Signature of Parent or authorized representative Date

_____ _____

Printed name of authorized representative Witness



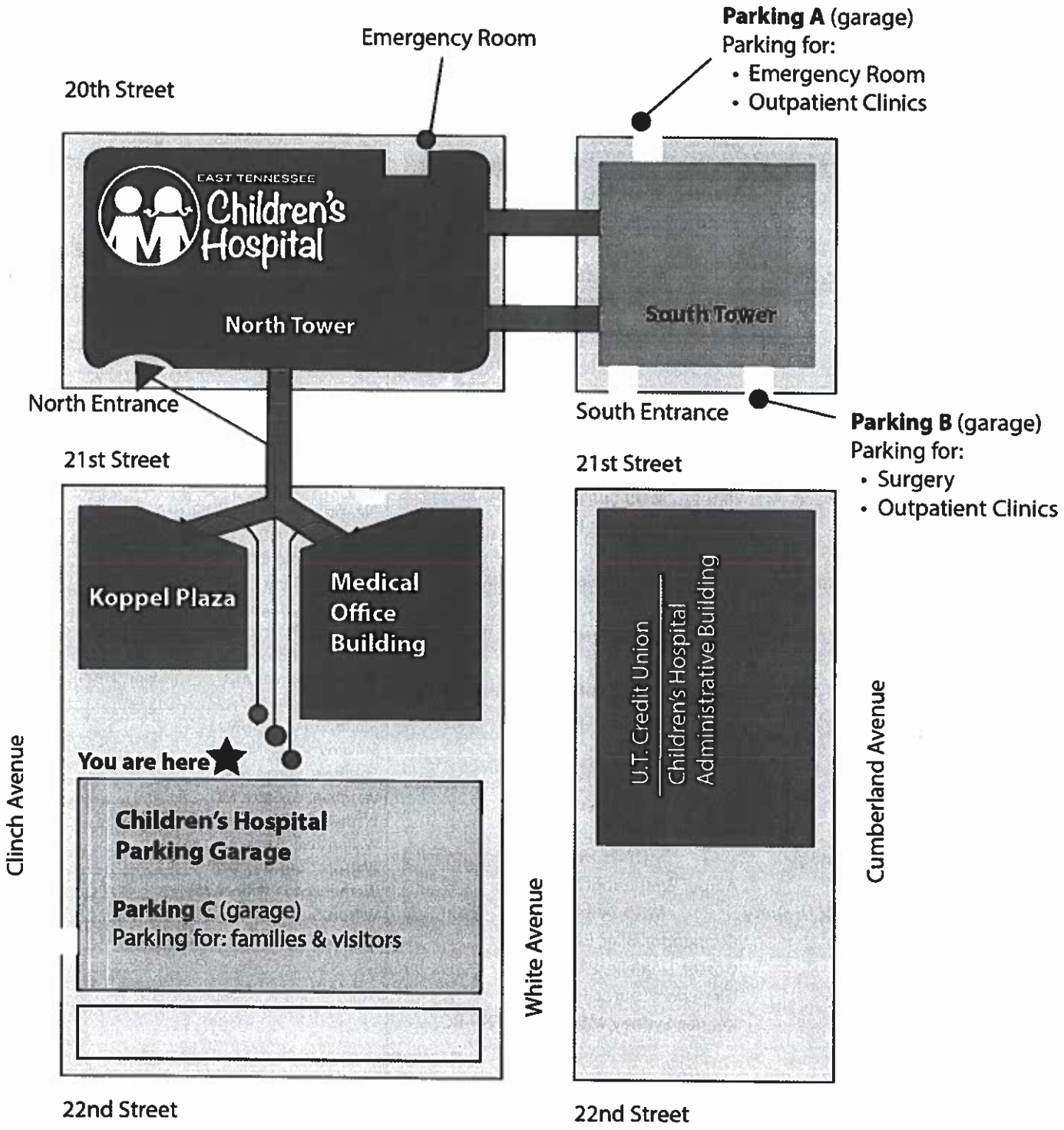
Effective Immediately!

You Will Be Rescheduled If…

- You Are **15** Minutes Late For Your Appointment
- You Have **NOT** Completed Your New Patient Packet
- You Do **NOT** Have Your Insurance Card

Thank You For Your Cooperation!

Physician Offices of the Koppel Plaza and the Medical Office Building
Map and Physician list by name and group



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Directions:

From Interstate 40 East or West:

Take 17th Street Exit and turn **RIGHT** onto 17th Street

Cross over the top of the hill (there will be 2-3 red lights you will go through)

At the stop sign, turn **RIGHT** onto Clinch Ave.

Go (3) three blocks, the Children's Medical Office Building and ETCH will be on the **LEFT**

Parking for the Medical Office Building is located at the corner of Clinch Ave & 22nd Street (if you went to the stop sign, you've went too far) in the Children's Parking Garage C.

Exit out of the parking garage on the 2nd floor and we will be in the brick building on the right of the breeze way. There is a flat rate of $2 for the parking garage & we do not validate parking.

From Alcoa Hwy(US 129):

Exit Alcoa Hwy @ Kingston Pk onto Cumberland Ave.

Turn **RIGHT** at light onto Kingston Pk./Cumberland Ave.

Merge IMMEDIATELY into the **LEFT** ln.

Travel under railroad trestle.

Turn **LEFT** at the 2nd red light at 22nd St (beside Cookout)

Travel (2)two blocks and turn **RIGHT** onto Clinch Ave.

You will immediately turn **RIGHT** into the Children's Parking Garage C.

Exit out of the parking garage on the 2nd floor and we will be in the brick building on the right of the breeze way. There is a flat rate of $2 for the parking garage & we do not validate parking.