Endo For Kids

Pediatric Endocrinology Services
1975 Town Center Blvd · Knoxville, TN 37922
Phone (865) 546-3998 · Fax (865) 546-1123 · www.endoforkids.com

Patient Information

Date _____

Last Name _____

First Name _____ Middle _____

Sex _____ Date of Birth _____ SS# _____

Street Address _____

City _____ State _____ Zip Code _____

Primary Phone _____

Race: ☐ Asian ☐ Biracial ☐ Black or African American

☐ American Indian or Alaska Native ☐ Caucasian/White

☐Native Hawaiian or Other Pacific Islander

Other: _____ ☐ Prefer not to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Preferred Language for Healthcare Discussion _____

Physician Information

Referring Doctor _____

Reason for Visit _____

Primary Care Provider _____

Primary Provider Phone _____

Mother/Guardian Information

Last Name _____

First Name _____ Middle _____

Street Address _____

City _____ State _____ Zip Code _____

Primary Phone _____

Secondary Phone _____

Work Phone _____

SS# _____ DOB _____

Email Address _____

Employer _____

Marital Status *(Check one of the following)*

☐Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

Pharmacy/Portal Information

Preferred Pharmacy _____

Pharmacy Phone _____

Preferred Email(s) for Patient Portal _____

_____

Emergency Contact

Please list the name of a relative or friend that does not live with you and can be contacted in case of an emergency.

Name _____

Relationship to Patient _____

Phone _____

Insurance Information

Primary Insurance _____

Who carries the insurance on the patient?

Name _____ DOB _____

Relationship to Patient _____

Effective date: _____

Policy # _____ Group# _____

Secondary Insurance _____

Who carries the insurance on the patient?

Name _____ DOB _____

Relationship to Patient _____

Effective date: _____

Policy # _____ Group# _____

Father/Guardian Information

Last Name _____

First Name _____ Middle _____

Street Address _____

City _____ State _____ Zip Code _____

Primary Phone _____

Secondary Phone _____

Work Phone _____

SS# _____ DOB _____

Email Address _____

Employer _____

Marital Status *(Check one of the following)*

☐Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

PLEASE COMPLETE REVERSE SIDE

Agreement and Consent

I hereby give consent for the following individuals to bring my child to Endo For Kids, for treatment and to exchange necessary information with Endo For Kids. This request will remain in effect until revoked by me in writing.

_____/ _____

_____/ _____

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1. I am the parent or legal guardian authorized to act on the patient's behalf. I hereby authorize medical services to be provided to the patient by the MDs, mid-level providers, dietitians, and medical staff of Endo For Kids as necessary.

2. Acknowledgment of Receipt of Privacy Notice: I acknowledge receiving upon request, a copy of the 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 health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

3. Referrals: I understand that if the patient's insurance plan requires a referral from the primary care physician, the referral must be obtained prior to the visit in order to ensure the patient's maximum benefit from the insurance plan. I further understand if the referral is not in place, I agree to sign a waiver taking full responsibility for payment due for services rendered by Endo For Kids.

4. Providers may use an AI tool that listens during the consultation and generates a written summary or "note" based on that conversation. This tool allows the provider to focus more on the patient and less on the computer. This allows us to provide the best care possible. The summary note is reviewed and approved by the provider. This tool adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secure and protected. Only the healthcare professionals involved in your care will have access to these notes.

5. I understand that all services may not be covered by the patient's insurance plan. I understand that I am responsible for paying for all services rendered not covered by the patient's insurance. I understand that any unpaid account balance owed to Endo For Kids by me, may be turned over to a collection agency that will include collection agency fees and may affect my credit rating.

6. I hereby authorize Endo For Kids, to release information to referring providers, insurance companies, government agencies, etc., as necessary, for Endo For Kids to obtain payment for services rendered.

7. I authorize and request payment to be made directly to Endo For Kids for insurance benefits payable for services provided by Endo For Kids. This authorization expressly includes benefits that are provided by Medicaid and/or any other public or private insurance plans.

8. Reminder/Notification: I grant Endo For Kids permission to leave a message regarding appointments, discussion of treatment plan, etc. at the phone numbers I listed on the registration form.

9. I grant permission for the patient's photo to be taken and retained in his/her personal medical chart or file for identification purposes only.

10. Arriving 15 minutes late or more for a scheduled appointment may result in the appointment needing to be rescheduled. If you need to reschedule or cancel your appointment, please call our office prior to your appointment. Otherwise, it will be marked as a no-show. After 3 no-show appointments, the patient may be dismissed from our practice at our discretion.

Patient's Name _____

Signature of Parent/Legal Guardian _____

Relationship to Patient _____

Date ____/____/_____

*Endo For Kids is a division of GI For Kids, PLLC