Barbara Kaczmarska, MD FAAP
880 Colloredo Blvd.
Shelbyville, TN 37160

Phone 931.685.8111
Fax 877.801.2703

Finest Comprehensive Care with a Personal Touch

PATIENT DATA SHEET

Patient Information

Last Name _____ First _____ Middle_____

Address_____ Apt # _____

City _____ State _____Zip _____

Social Security Number _____ Birth Date____/____/____ Sex ☐ Male ☐ Female

Race: ☐ African American ☐ American Indian ☐ Asian ☐ White ☐ Decline Ethnicity: ☐ Hispanic ☐ Not Hispanic

Parent/Legal Guardian

☐ Father
Name: _____
Home Phone: _____ Cell: _____
Address: _____
City, State, and Zip: _____
SSN: _____ DOB:_____
Employer:_____
Employment Address: _____
Employment Phone: _____
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Email:_____

☐ Mother
Name:_____
Home Phone: _____ Cell: _____
Address:_____
City, State, and Zip: _____
SSN: _____ DOB:_____
Employer: _____
Employment Address: _____
Employment Phone: _____
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Email:_____

Local Emergency Contact (other than Responsible Party):

Name_____ Phone #_____

Relationship to Patient _____ Cell # _____

Insurance Information

	Primary	Secondary
Insurance Company:	_____	_____
Policy Holder:	_____	_____
Policy Holder's Date of Birth:	_____	_____
Policy ID #:	_____	_____
Relationship to Patient	_____	_____

Signature of Responsible Party

I consent to medical treatment of this patient which includes routine diagnostic procedures and may include blood tests. I authorize the release of information concerning this patient's health, care, advice and treatment given in order to evaluate and process insurance claims for the services provided. I have read and understand the HIPAA Notice of Privacy Practices on the back of this sheet.

I authorize insurance benefits, which are otherwise payable to me, to be paid directly to the doctor. If the patient is under 18 years of age, I, as the legal guardian, authorize treatment of the minor without my presence, if accompanied by one of the individuals named in the *Delegation of Authority* form. Should this account become delinquent, I accept responsibility for all collection, attorney, and court costs.

To the best of my knowledge, the information provided in this document is true and accurate. I understand that not giving complete and accurate information may be dangerous to the patient's health.

_____ _____ _____ _____

Parent/Legal Guardian Signature Date Witness Signature Date

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Use and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care service to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities included, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donations: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by Law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information. *You have the right to inspect and copy your protected health information*: Under federal law, however, you may not inspect or copy the following records, psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

This notice was published and becomes effective on/or before April 14, 2003.

I have read the foregoing HIPAA notice; been offered a copy as desired for my records; and asked questions as desired regarding the notice.

_____ _____

Signature Date Witness Date

Barbara Kaczmarska, MD FAAP
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ACKNOWLEDGMENT of FINANCIAL RESPONSIBILITY of CO-PAYS, DEDUCTIBLES and NON-COVERED SERVICES

Dr. Kaczmarska and her staff strive to interpret your medical health insurance plan to the best of our ability in order to advise you of covered and non-covered services that may be performed during the course of a routine well child exam. However, you are ultimately responsible for understanding your own benefit plan. We encourage you to review your plan and contact your benefits coordinator for any questions or clarifications you may require.

Acknowledgment of Financial Responsibility:

I agree to pay the co-pay due on the date service is rendered unless none is required by my insurance policy.

For insurance plans that have **deductibles and/or co-insurance**, we will estimate the balance due to the best of our ability. **That estimated balance will be due on the date of service**. After the claim has been filed and payment has been received by Dr. Kaczmarska, if there is a balance due from you, it must be paid in full before your child is seen for another visit.

I acknowledge that some services performed during the course of a routine well child exam may not be covered by my medical health insurance plan. These services include, but are not limited to, vision exams, hearing screenings and immunizations. I understand that I am financially responsible for payment of all non-covered services and agree to pay for them on the date service is rendered.

I acknowledge that I will not be asked to pay any contractual write-off amounts agreed to by Dr. Kaczmarska and my insurance company.

I understand that I may elect to decline any covered, or non-covered, services by advising Dr. Kaczmarska, Jean, or the nursing staff prior to the examination. By doing so, I acknowledge that this may be against Dr. Kaczmarska's advise and her desire to provide my child with the most thorough examination possible.

Patient's Name:_____

Parent/Legal Guardian Signature: _____ **Date:** _____

Do you have, or have you applied for, TennCare coverage? ☐ Yes ☐ No

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KIDS ARE SPECIAL

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DELEGATION OF AUTHORITY

Date: _____

In my absence, the following person(s) have permission to obtain medical care for my child. I understand that I am responsible for all expenses incurred for my child's treatment. Dr. Barbara Kaczmarska or her delegate(s) may discuss my child's medical status with the designated person(s).

Child's Name: _____

Date of Birth: _____

Designated Person(s):	**Relationship to Child:**	**Phone Number:**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

_____ _____

Parent/Legal Guardian Signature **Date**

PATIENT ELIGIBILITY SCREENING RECORD
Vaccines for Children (VFC) Program

Provider: Barbara F. Kaczmarska, MD

This child qualifies for vaccination through the VFC program because he / she:

(mark *one* box only)

a. is enrolled in / eligible for TennCare ☐

b. does not have health insurance ☐

c. is American Indian or Alaskan Native ☐

None of the above ☐

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RECORDS RELEASE REQUEST

Date: _____

Previous Doctor: _____

_____

Hospital of birth: _____

I hereby authorize the release of medical and immunization records for:

Patient Name: _____

Date of Birth: _____

Home Address: _____

_____

Purpose of Disclosure: _____Changing Doctors _____Moving_____Other _____

In compliance with HIPPA Privacy Policies and Procedures, I am advised that this release may include information regarding communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), psychiatry, drug, and/or alcohol abuse, unless specifically requested to omit. The requested medical records will be released in their entirety unless otherwise noted here_____

_____

I ask that these records be released to:

Kids Are Special
880 Colloredo Boulevard
Shelbyville, TN 37160

I have the authority to request this information by virtue of being the patient's parent/legal guardian and have signed the release form below.

_____ _____

Parent/Legal Guardian Signature Date

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HEALTH ASSESSMENT

Patient Information

Last Name _____ First _____ Middle_____ Nickname _____

Nationality: _____ Birth Date____/____/____ Sex ☐ Male ☐ Female

Are Immunizations current? ☐ Yes ☐ No Attached? ☐ Yes ☐ No Last Well Child Exam Date ____/____/____

Birth History

State/Country of Birth _____ Pregnancy/Delivery Problems_____

Delivery Type_____ Postpartum Complications _____

Was baby discharged with mother?_____ If no, why not? _____

Birth Weight _____lbs _____oz Apgar _____ Length of Baby's Hospital Stay _____

Results of hospital nursery hearing screening _____

OB GYN_____ Former Pediatrician_____

Medical History

Disease / Illnesses Currently Being Treated	Describe	
Present Medications	Prescription	OTC
Allergies	Food / Environment / Medications	
Hospitalizations	Describe	Date
Surgeries	Describe	Date
Injuries / Accidents	Describe	Date
Significant Illnesses	Describe	Date
Sexually Active	☐ Yes ☐ No	If yes, method of contraception:
Sexually Transmitted Diseases	☐ Yes ☐ No	If yes, describe:

Does patient have now, or has patient ever had, any of the following conditions?

- ☐ ADHD / ADD
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chicken Pox –Age _____
- ☐ Cold Sores/Blisters
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Hay Fever
- ☐ Hearing Problems
- ☐ Heart Murmur
- ☐ Heart Trouble/Disease
- ☐ Hepatitis A, B, C
- ☐ High/Low Blood Pressure
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Joint Disorders
- ☐ Kidney/Bladder Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Mitral Valve Prolapsed
- ☐ Mumps – Age _____
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sickle Cell Disease / Trait
- ☐ Sinus Trouble
- ☐ Skin Problems/Eczema
- ☐ Stomach/Intestinal Disease
- ☐ Thyroid Disease

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HEALTH ASSESSMENT

Lab Tests (if applicable)

☐ Blood Lead Test	Date:_____	☐ Newborn Metabolic Screen	Date:_____
☐ Blood hgb/hct	Date:_____	☐ Urinalysis	Date:_____
☐ Cholesterol	Date:_____	☐ Pap Test	Date:_____

Family Medical History

☐ Alcoholism	☐ Drug Addiction	☐ Mental Retardation
☐ Anemia	☐ Eczema	☐ Obesity
☐ Asthma	☐ Hay Fever	☐ Seizures
☐ Birth Defects	☐ Heart Disease	☐ Sickle Cell Disease / Trait
☐ Cancer	☐ High / Low Blood Pressure	☐ Stroke
☐ Deafness	☐ Kidney / Bladder Disease	☐ Thyroid Problems
☐ Depression	☐ Leaming Disability	☐ Tuberculosis
☐ Diabetes	☐ Other _____	

Social / Cultural History

School Name _____ Grade Level_____

Language Spoken at Home_____ # of Family Members Living in Same House _____

Primary Caretaker of Patient _____ Relationship _____

	Name	Occupation	Age
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Other			
Other			

Environmental History

☐ Alcohol Use	☐ Yes	☐ No	☐ Tobacco Use	☐ Yes	☐ No
☐ Drug Use	☐ Yes	☐ No	☐ Exposure to Tobacco Smoke	☐ Yes	☐ No
☐ Cat	☐ Yes	☐ No	☐ Other Pets	☐ Yes	☐ No
☐ Dog	☐ Yes	☐ No	What kind _____		

Provider Comments

_____

_____

_____

_____ _____

Provider Signature Date