Dear New Patient:

We would like to welcome you to Shults Pediatrics. You have chosen us to provide what we consider one the most important services you will need, and that is to help your child grow into a healthy adult. The desire of everyone at Shults Pediatrics is to develop a relationship with you and your child that will produce the best healthcare for your child.

The health of your child always comes first at Shults Pediatrics. We continually strive to develop an environment that provides the highest quality of pediatrics while also offering services our patients need in a platform they request. We encourage your input and suggestions (good and bad). At this time we would like to share our procedures as well as several of our expectations of you to maintain a relationship that is essential to the highest quality of healthcare.

Office and Appointments

The office hours are:

7:00am – 6:00pm	Monday, Tuesday, Wednesday and Thursday
9:00am – 5:00pm	Friday
8:00am – 12:00pm	Sat.

1. Office staff will begin answering telephones fifteen (15) minutes before the office opens each day.
2. Please call the office to schedule an appointment and the office staff will work with you to provide a time that is best suited for the needs of your child.
3. You should always call for an appointment unless you have an emergency and we are the closest healthcare facility.
4. If you require a nurse to return your call we ask for your patience. We do our best to return all calls in an expeditious manner on the same day.

Medical Protocol

1. Medication questions should be dealt with during office hours.
2. Dr. Shults feels that if a child is sick enough to require antibiotics then they need to be seen by a physician. Dr. Shults is very diligent in providing quality care without promoting bacterial resistance.
3. The after hours phone number on the answering machine is for emergencies only. Dr. Shults, Dr. Bullen or Sarah Jones, CPNP will answer all after hour emergency calls.
4. We are pleased to provide a secure patient portal through our web-site **www.shultspediatrics.com.** Many non-emergent questions can be communicated to our staff as well as obtaining much of your child's information online. Please ask or visit our web-site for more information.
5. In the event Dr. Shults schedules time out of the office; Dr. Bullen or Sarah Jones, board certified pediatric nurse practitioner, will be in the office to provide your child with quality pediatric care.

Insurance, Financial and Family Information

1. You are responsible for providing the office with any changes in family information (address, telephone, insurance, etc.) as soon as possible.
2. The guardian is responsible for knowing and providing the office with patient insurance plan details
3. The office strives to ensure the confidentiality of your child's medical information. You must provide written information to us of all persons allowed to seek medical attention and/or medical information for your child.
4. The person presenting the patient for medical care must be prepared to pay the visit co-pay or charges.
5. Patient account statements are mailed monthly. Payment is expected within fifteen (15) days of the statement date. If you are unable to pay off account balances you are responsible for contacting the office to make payment arrangements.
6. If you are unable to make an appointment that is scheduled please call our office to cancel and reschedule. If you do not give advance notice of a missed appointment there will be a No Show Fee applied to your account.

We want to thank you for choosing Dr. Shults and everyone at Shults Pediatrics for the healthcare of your child. We look forward to a long healthy relationship together.

Sincerely,

Dr. Shults

Shults Pediatrics Staff

Shults Pediatrics, PC
Newborn Questionnaire

Child's Name:

Birth Date: _____

Labor

Gestational Age: _____ Spontaneous or Induced: _____
Length of Labor: _____
Medications: _____
Complications (for mother or child): _____
Group B Strep positive or negative? _____

Delivery

Vaginal or Cesarean? _____
If Cesarean, why? _____
Anesthesia: _____
Head first or breach delivery? _____
Were forceps or vacuum extractor used?
_____

Baby's Condition at Birth

Weight: _____ Length: _____ APGARS: _____
Resuscitation: _____
Any feeding problems in the nursery? _____
Jaundice? _____
Other problems: _____
_____
Were any vaccinations given? _____
Was neonatal screen drawn? _____
Other information regarding your child's health we may need to know: _____
_____
_____

Shults Pediatrics, PC
Prenatal Questionnaire

Date: _____ Due Date: _____

Mother's Name: _____ Father's Name: _____
Address: _____ Telephone: _____

Father's Occupation: _____ Work Phone: _____
Mother's Occupation: _____ Work Phone: _____
Insurance: _____

Child's Birth Order: _____
Siblings: Name (age): _____ _____
_____ _____
Who referred you to Shults Pediatrics, P.C.? _____
Delivery Hospital: _____ OB Doctor: _____

Family History

Allergies: _____

Circle those that apply: Diabetes Birth defects Bleeding disorders Seizures
Kidney stones Heart disease High blood pressure Obesity

Mother's History

Age: _____ Blood Type: _____ Allergies: _____
Past Medical Problems: _____
Past Surgeries: _____
Do you smoke? _____ Attend prenatal classes? _____
Are you planning to breastfeed or bottle-feed? _____
Will you have help at home after the baby is born? _____
Do you have relatives close? _____

Previous Pregnancies

Miscarriages: _____ Premature Deliveries: _____
Newborn diseases/Birth defects: _____
Breastfeeding Problems: _____

Current Pregnancy

Illnesses: _____
Medications: _____
Special testing during pregnancy: _____

SHULTS PEDIATRICS
Stephanie Shults, MD
Phone: (865) 670-1560
Fax: (865) 670-1862

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT: _____

DATE OF BIRTH: _____

PARENT OR GUARDIAN: _____

MOTHER SOCIAL SECURITY NUMBER:_____

PHYSICIAN WITH RECORDS: TN State Dept. of Health
Laboratory Services
Attn: Mitzi Lamberth, RN

I hereby request that my medical records be released to:

Shults Pediatrics
Stephanie Shults, MD
9142 S. Northshore Drive
Knoxville, TN 37922

SIGNATURE: _____

DATE: _____

Date: _____ **SHULTS PEDIATRICS, P.C.** Acc#: _____

PATIENT INFORMATION

Patient Name:_____
Last First Middle Nickname

Address: _____
Street Address PO Box

_____
City State Zip Code

Home Phone: (_____)_____ Birth Date:_____ Age: _____

Social Security #: _____ Patient Gender: male female

Main Language:_____ Race:_____

Ethnicity (circle one): Hispanic or Latino Origin Not Hispanic or Latino Origin Decline to Answer

How did you hear about us?_____

SIBLING(S) – PATIENTS AT SHULTSPEDIATRICS, PC

1_____AGE_____ 2_____AGE_____

3_____AGE_____ 4_____AGE_____

5_____AGE_____ 6_____AGE_____

RESPONSIBLE PARTY INFORMATION

MOTHER/FATHER: (CIRCLE ONE)

Name: _____
Address: _____
_____
Home Phone: _____
Employer: _____
Work Phone: _____
Mobile Phone: _____
e-mail address: _____
Soc. Sec. No.: _____
Date of Birth: _____

MOTHER/FATHER: (CIRCLE ONE)

Name: _____
Address:_____
_____
Home Phone:_____
Employer: _____
Work Phone: _____
Mobile Phone:_____
e-mail address_____
Soc. Sec. No.: _____
Date of Birth: _____

EMERGENCY CONTACTS

Name: _____ Relation to Patient: _____
Phone #: _____
Name: _____ Relation to Patient: _____
Phone #: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Employer Name: _____

Cardholder's Name: _____ DOB: _____

Relation to Patient: _____ Childs Primary Care Physician: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Employer Name: _____

Cardholder's Name: _____ DOB: _____

Relation to Patient: _____

Financial Information

- Insurance co-payments are required at the time of the visit.
- Our office staff will file your insurance claims for you unless you instruct us otherwise.
- A **$39.00** service charge will be added for all returned check by PayTek Solutions.
- We accept VISA, MasterCard, Discover, and Debt Cards for your convenience.
- Statements are mailed daily. Payment is expected within 15 days of the statement.
- If you encounter financial difficulties, contact our office to arrange a payment plan before legal a collection agency is involved. Once the collection agency is involved, we are not at liberty to arrange a payment plan with you.

Accounts will be turned over to a collection agency if there is no effort toward payment within a reasonable time period. Notification will be sent to you prior to the account being turned over to collections.

In order to bill your insurance carrier appropriately, we need your current insurance coverage information, as well as your personal address and phone number. It is your responsibility to keep this information current.

One Time Authorization

By signing below, I hereby authorize Shults Pediatrics to treat my child and release any necessary medical information pertaining to such treatment to the appropriate insurance company. I guarantee payment of all charges pertaining to treatment of my child. I understand that I am responsible for all fees, regardless of insurance coverage. I have read and understand the above financial guidelines.

Date: _____

Responsible Party Print Name: _____

Responsible Party Signature: _____

Relation to Patient: _____

Shults Pediatrics

One Time Authorization Form

Patient's Name_____ **Date**_____ **Pt#**_____
(Please Print)

Assumption of Responsibility: I agree that in consideration of services to be rendered, I obligate myself, assume financial responsibility and agree to pay upon demand to above named PROVIDER 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 the payment of all services. A service charge will be added for all returned checks. We accept Visa, MC, Discover and Debt Cards for your convenience.

Responsibility for Co-pay Amounts: I agree to be fully responsible for paying co-pays of set amounts at the time of physicians visit. Further, I understand that if my co-pay is a percentage, I will be responsible for payment immediately after insurance benefits have paid. This meaning that any bill received once insurance is paid, will be due upon receipt. I understand that it is my responsibility to know my co-pay, deductible and any other medical service(s) that are not covered by my insurance company as well as the yearly limits that are my responsibility.

Assumption of Referrals: I understand that it is my responsibility to obtain a referral from the above said provider or to reschedule my appointment. I understand that if I refuse that I am taking full responsibility for payment.

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 a third party or organization, and so forth, payable to or for the above said patient until account is paid in full.

Acknowledgement of Receipt of Privacy Notice: I acknowledge receiving today 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 for treatment, payment, or health care operations. I understand that I must provide a separate authorization before any other disclosures may be made.

Authorization for release: By signing below I am authorizing the practice to disclose my child's protected health information about current health conditions to the following:

☐ spouse ☐ parents ☐ children ☐ clergy ☐ other (list names)_____

_____

I understand my rights and how to revoke this permission as described in the Notice of Privacy Practices given to me by the practice.

Office Visits: The following individuals are authorized to seek medical attention for my child in my absence:

_____

_____

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

_____

_____

By signing below I have read and understand all the information described above.
Signature: _____ **Date:** _____