Dear Caregiver,

Thank you for choosing Siskin Children's Institute to be a partner in your child's care. Our team is committed to providing high-quality care in a family-centered environment to ensure you and your child are comfortable and enjoy your visit(s).

To help us better serve you and your child, we ask that you arrive at least **30 minutes prior** to your scheduled appointment to allow time for parking and the check-in process.

Additionally, we strongly encourage you to complete the attached new patient registration forms and bring them with you to your appointment, along with your:

- Current insurance card(s)
- Your child's current medication list (prescriptions, over the counter, and supplements)
- Hearing and vision evaluations, educational/school testing, and any other relevant testing results
- A copy of IEP, IFSP, or other therapy notes, such as OT, PT, or Speech
- Any co-pays, deductibles, or other out-of-pocket expenses

Please feel free to contact our office at 423-490-7710 if you have any questions, need additional information, or need to reschedule your appointment.

Thank you for selecting our practice! We look forward to serving you!

IMPORTANT APOINTMENT INFORMATION

- The initial appointment may take up to 2 hours. This gives our team the opportunity to understand your concerns, your child's developmental history, and evaluate your child. Please consider making alternative arrangements for siblings, if possible.
- Due to the complexity of patient appointments, we are unable to accommodate late arrivals. **If you are more than 10 minutes late, you will be asked to reschedule.**

CHATTANOOGA
1101 CARTER STREET, CHATTANOOGA 37402
PHONE: 423.490.7710 FAX: 423.490.7750
HOURS: MONDAY – FRIDAY 8AM – 3PM
FRIDAY 8AM – 3PM

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NASHVILLE
2201 MURPHY AVE. SUITE 306, NASHVILLE 37203
PHONE: 615.730.8095 FAX: 615.730.9135
HOURS: MONDAY – THURSDAY 8AM-6PM

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Attendance Policy

At the Center for Developmental Pediatrics at Siskin Children's Institute we care about the children and families we serve across our region. We are here to effectively work together in a collaborative manner to achieve the best developmental outcomes for your child. Due to the high volume of patients needing our specialized services, please be advised of the following **attendance policy** for our center.

By signing this agreement, you are acknowledging the following practices:

- All patients must be brought to our center by the **parent or legal guardian**. We must have written legal documentation to support the legal guardian's right to seek care for the patient. An adult must remain in the building for the duration of the medical or therapy visit.
- To decrease the spread of illness, if your child is sick with fever, vomiting/diarrhea, respiratory problems, infection, or other communicable condition (e.g., lice, pink eye, ringworm, chicken pox, etc.) within 24 hours of the appointment, we ask that you reschedule the visit.
- **Initial Medical Appointment**: Please arrive 30 minutes before your initial appointment to allow the check-in process to go smoothly and complete the appropriate paperwork.
- **Follow-Up Medical or Therapy Appointment(s):** Please arrive 15 minutes before your appointment time to allow the check-in process to go smoothly and complete any additional paperwork.
- **Late Arrival for Medical or Therapy Appointment(s)**: If you arrive 10 minutes **after** your scheduled medical or therapy appointment, you will be asked to reschedule your appointment for another day.
- **Cancellations for Medical or Therapy Appointment(s)**: Please notify our center of cancellations at least 48 hours before the scheduled appointment time. This allows the office to schedule another patient in need of an appointment.
- **Missed Medical Appointments:** If the patient **misses 3 medical appointments** within 12 months, you will be asked to find another provider for services.
- **Missed Therapy Appointments:** We ask that your child attends **10 out of 12 appointments.** If there are more than 2 unplanned/non-sick absences within the 12-visit period, we will contact you and may suggest your child be placed on the waitlist.

We appreciate your cooperation, and we look forward to serving your family.

_____ Signature

_____ Date

_____ Printed Name

_____ Patient's Name and Date of Birth

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Family Confidentiality Policy

To ensure a safe and respectful environment for all patients, caregivers, and staff, this policy is established regarding family confidentiality during clinic visits.

While engaging with children and their families in the clinic setting, patients and caregivers may be exposed to confidential information. This information is shared solely for the purpose of providing effective care and support. All participants – patients, caregivers, staff, and any other individuals involved – are expected to always respect the privacy and confidentiality of others.

We ask that patients, caregivers, and others who participate or observe clinic activities focus their attention and questions solely on the patient(s) they are present with, maintaining respect for the privacy of others. Discussions regarding any other children, families, or staff members should be limited and treated with the utmost confidentiality.

Policy Expectations:

- **Participants must refrain from sharing any personal identifying information about other individuals or families that may be observed or discussed during clinic visits.**
- **All participants are encouraged to maintain confidentiality in all exchanges.**
- **Video recording, photography, and any form of recording other than for the explicit purposes of the clinic are prohibited at all times.**
- **All who participate in clinic activities are asked to commit to protecting the rights and privacy of all patients, families, and staff present.**

By signing below, I acknowledge that I have read and understand the Family Confidentiality Policy and agree to abide by its guidelines. I also acknowledge that by signing below, failure to comply with these guidelines may result in being asked to leave the premises.

_____ _____

Signature Date

_____ _____

Printed Name Patient's Name and Date of Birth

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AUTHORIZATION FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

Consent to Treat:

_____**(Initial)** I am the parent or legal guardian of the patient named below, and I give consent to Siskin Children's Institute, its staff, physicians, and other practitioners to provider and perform medical care, tests, screenings, and other services that are deemed necessary or beneficial by the practice for my child's health and well-being.

Financial Agreement:

_____**(Initial)** I agree that in consideration for the services rendered to my child, I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance. I understand that to the extent permitted by law, where insurance or other third-party benefits are insufficient to pay for the services rendered, I will be responsible for payment of any balances due. I understand that if I have not provided Siskin Children's Institute with accurate and current information regarding my insurer at the time of services rendered, I will be responsible for the costs of all care for that date of service. I agree to pay all bills when presented with a statement.

Release of Information:

_____**(Initial)** I understand that Siskin Children's Institute will release my child's health information, medical records, treatment plans, evaluations, and other relevant information with healthcare providers involved in my child's care. This includes, but is not limited to, primary care physicians, specialists, therapists, and other medical professionals. We may also share necessary information, such as diagnosis codes, treatment plans, and services rendered, with your health insurance provider(s) or third-party payers for the purpose of billing, payment, and reimbursement. We may be required to share certain information with governmental agencies, accrediting bodies, or other entities as part of our legal obligations or to comply with regulatory requirements.

Consent to Text/Email:

Text and email communication that occur outside of a secure electronic medical record, patient portal, or otherwise encrypted source may be less secure and have an increased risk of sharing your information with a third-party. As such, we will limit the amount and type of information shared via unencrypted text and email. I am giving permission to receive text and email communication for scheduling information such as making, rescheduling, and cancelling appointments; appointment reminders; links to secure virtual appointment portals; inclement weather office closures; and links to recruit your anonymous feedback in the form of consumer feedback surveys.

Text Communications:

- ☐ I accept
- ☐ I decline

Email Communications:

- ☐ I accept
- ☐ I decline

Consent for Use of AI During Visit:

_____**(Initial)** To provide your child with the best care and attention, our providers will be using a service called Freed that transcribes conversations and helps with their notes. Your child's information is private and secure using encryption technology and protected by law under HIPAA. After the visit, our providers will review the content for accuracy.

Acknowledgement of Medical and Ancillary Services:

_____**(Initial)** I understand that my child is here to receive medical services today and that the medical provider may refer my child for additional services such as Occupational Therapy, Speech Therapy, or Applied Behavior Analysis (ABA). I acknowledge that while Siskin Children's Institute offers these services, I have the option to seek these services at other organizations.

_____ _____

Signature _ Date

_____ _____

Printed Name _ Patient's Name and Date of Birth

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Authorization for the Release of Protected Health Information and Consent to Bring

I hereby authorize the providers and medical personnel of Siskin Children's Institute to discuss and/or release my child's protected health information (PHI) to the following individuals or entities as allowed under the Health Insurance Portability and Accountability Act (HIPAA). I also consent to allowing these individuals to bring my child to all appointments at Siskin Children's Institute and to receive protected health information related to those appointments.

Please list all individuals to whom you authorize the release or discussion of your child's PHI. **If the patient is a minor, each parent or guardian must be listed.**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that I may revoke this authorization at any time by providing a written notice to Siskin Children's Institute. I understand that the revocation of this authorization will not apply to any actions taken prior to receiving the written revocation.

By signing below, I confirm that I have read and understand this Authorization for the Release of Protected Health Information and Consent to Bring, and I authorize as outlined above.

_____ _____

Signature Date

_____ _____

Printed Name Patient's Name and Date of Birth

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PATIENT INFORMATION (PLEASE FILL IN **ALL** INFORMATION)

PATIENT NAME: _____ DOB: _____ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER: _____

PATIENT ADDRESS (MAILING): _____ CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE #: _____ SECONDARY PHONE #: _____

PRIMARY EMAIL ADDRESS: _____

ETHNICITY: ☐ NOT HISPANIC/LATINO ☐ HISPANIC/LATINO

RACE: ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ 2 OR MORE RACES ☐ OTHER: _____

COUNTRY OF ORIGIN: _____ ☐ PREFER NOT TO RESPOND

LANGUAGE USED IN THE HOME: _____ INTERPRETER NEEDED? ☐ YES ☐ NO

GUARANTOR INFORMATION (THIS IS THE PERSON RESPONSIBLE FOR PAYMENT)

NAME: _____ DOB: _____

PRIMARY INSURANCE INFORMATION
(PLEASE FILL IN **ALL** INFORMATION)

INSURANCE NAME: _____

POLICY #: _____

GROUP #: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

RELATIONSHIP: _____

SECONDARY INSURANCE INFORMATION
(PLEASE FILL IN **ALL** INFORMATION)

INSURANCE NAME: _____

POLICY #: _____

GROUP #: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

RELATIONSHIP: _____

EMERGENCY CONTACT:

NAME: _____ PHONE #: _____

RELATIONSHIP: _____ MAY WE LEAVE A MESSAGE? YES ☐ NO ☐

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Transition of Care for Treatment Management Based on Age

Effective Date: 10/01/2024

Purpose:

To establish a standardized process for the appropriate and timely transitioning of patients from Developmental Behavioral Pediatrics (DBP) to Primary Care Providers (PCP) or Psychiatry based on medication management or treatment needs, while ensuring optimal care and safety.

Policy:

Patient Eligibility:

- **Transition Protocols for Patients Aged 6 Years and Above:**
  - Patients on **Stimulants for ADHD and SSRIs:**
    - If the patient is stable on their current medication regimen, they will transition to their Primary Care Provider (PCP) for ongoing management.
  - Patients on **Antipsychotics:**
    - Patients requiring antipsychotic medication will transition to Psychiatry for specialized care and ongoing medication management due to the complexity of treatment.
- **Transition Protocols for Patients Aged 3 Years and Above:**
  - Patients on **Guanfacine and Clonidine:**
    - If the patient is stable on their current medication regimen, they will transition to their Primary Care Provider (PCP) for ongoing management.
- **Transition Protocols for All Ages:**
  - Patients with **medications and cases beyond Developmental Behavioral Pediatrician (DBP) expertise:**
    - If a patient has medication or treatment management needs that exceed the capabilities of Developmental Behavioral Pediatrics, they will be transitioned to Psychiatry for specialized care.

Implementation:

- **Assessment:**
  - Prior to transition, a comprehensive assessment will be conducted to determine medication stability and ongoing care needs.
- **Communication:**
  - The transition will be communicated to both the patient and their caregivers, ensuring they understand the reasons for the transition and the next steps.
- **Documentation:**
  - All transitions will be documented in the patient's medical record, including the rationale for the transition, the date, and the receiving provider's information
- **Follow-Up:**
  - Follow-up appointments will be coordinated with the receiving provider to ensure continuity of care

_____ _____

Signature Date

_____ _____

Printed Name Patient's Name and Date of Birth

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Credit Card/Debit Card Pre-Authorization Consent and Acknowledgement

Siskin Children's Institute is committed to providing our patients with high-quality, compassionate medical care. Our credit card pre-authorization process facilitates smoother transactions and faster processing.

If you have insurance contracted with Siskin Children's Institute, we will submit your claim as usual. At this time, we request authorization to bill the balance to a major credit card or debit card to cover amounts determined by your insurance company to be your responsibility.

Upon receipt of an Explanation of Benefits (EOB) from your insurance company, any unpaid portion of your claim will be billed to your credit card or debit card up to, but not exceeding the practice's pre-established threshold of $250. Should your insurance pay the claim in full, your account will not be charged. If you have a balance due, we will send you an email notifying you that your card will be charged that amount within 7 days.

All credit card/debit card information will remain confidential and securely stored within Athena and/or Central Reach. Siskin Children's Institute will not store any banking account data.

By signing below, I hereby authorize Siskin Children's Institute to securely store my credit card/debit card information within Athena and/or Central Reach and to charge my credit card/debit card for any outstanding balance due after my insurance company processes the claim and issues an Explanation of Benefits (EOB). I understand that:

1. I will be notified of any balance due via email, including the amount and EOB details, prior to my card being charged.
2. If the outstanding balance exceeds the threshold of $250, I will be contacted for confirmation prior to processing the payment.
3. In the event of a declined or insufficient funds transaction, I will be contacted to provide an alternative payment method or make other payment arrangements.
4. I have the right to dispute any charges by contacting the billing department for review of the EOB and any associated charges.
5. Charge Frequency:
    - Medical Services are billed monthly.
    - Therapy Services (Speech Therapy, Occupational Therapy, and/or ABA) are billed weekly.

I have read and understand the above terms regarding credit card/debit card preauthorization. I acknowledge that I have had the opportunity to ask questions and that I voluntarily agree to the terms outlined in this policy. I understand that this authorization is valid until I revoke it in writing. I agree to notify Siskin Children's Institute of any changes to my credit card/debit card information.

_____ _____

Cardholder's Name (Printed) Date

_____ _____

Cardholder's Signature Patient's Name and Date of Birth