Texoma Pediatrics

# NEW PATIENT REGISTRATION FORM

## CHILD'S INFORMATION – SEPARATE FORMS MUST BE COMPLETED FOR EACH CHILD IN A FAMILY

| CHILD'S FULL NAME (FIRST, MIDDLE, LAST) | | | CHILD'S GENDER ☐ MALE ☐ FEMALE | CHILD'S PRIMARY LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER _____ | CHILD'S DATE OF BIRTH |
|---|---|---|---|---|---|
| MAILING ADDRESS | | | PHYSICAL ADDRESS | | |
| CITY | STATE | ZIP | CHILD'S ETHNICITY ☐ DECLINE ☐ NON-HISPANIC ☐ HISPANIC | | CHILD'S RACE ☐ DECLINE ☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIN OR PACIFIC ISLANDER ☐ WHITE ☐ OTHER _____ |
| PRIMARY HOME PHONE | PRIMARY CELL PHONE | | HOW DID YOU HEAR ABOUT US? | | |

## MOTHER or LEGAL GUARDIAN'S INFORMATION

## FATHER or OTHER LEGAL GUARDIAN'S INFORMATION

| MOTHER/GUARDIAN'S FULL NAME | | | FATHER/GUARDIAN'S FULL NAME | | |
|---|---|---|---|---|---|
| MOTHER/GUARDIAN'S SOCIAL SECURITY # | MOTHER'S MAIDEN NAME OR GUARDIAN'S RELATION TO THE PATIENT *(IF APPLICABLE)* | | FATHER/GUARDIAN'S SOCIAL SECURITY # | CHILD LIVES WITH *(CHECK ONE)* ☐ MOTHER ☐ FATHER ☐ BOTH ☐ OTHER _____ | |
| MOTHER/GUARDIAN'S DATE OF BIRTH | MOTHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED | | FATHER/GUARDIAN'S DATE OF BIRTH | FATHER/GUARDIAN'S MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ SEPERATED ☐ DIVORCED ☐ WIDOWED | |
| MOTHER/GUARDIAN'S MAILING ADDRESS ☐ *(CHECK IF SAME AS CHILD)* | | | FATHER/GUARDIAN'S MAILING ADDRESS ☐ *(CHECK IF SAME AS CHILD)* | | |
| CITY | STATE | ZIP | CITY | STATE | ZIP |
| MOTHER/GUARDIAN'S HOME PHONE | MOTHER/GUARDIAN'S CELL PHONE | | FATHER/GUARDIAN'S HOME PHONE | FATHER/GUARDIAN'S CELL PHONE | |
| MOTHER/GUARDIAN'S EMPLOYER | MOTHER/GUARDIAN'S WORK PHONE | | FATHER/GUARDIAN'S EMPLOYER | FATHER/GUARDIAN'S WORK PHONE | |
| MOTHER/GUARDIAN'S EMAIL ADDRESS | | | FATHER/GUARDIAN'S EMAIL ADDRESS | | |

## INSURANCE INFORMATION – PLEASE PROVIDE A COPY OF THE INSURANCE CARD AT CHECK-IN

| PRIMARY INSURANCE COMPANY NAME | SUBSCRIBER'S NAME | SUBSCRIBER'S DATE OF BIRTH | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ OTHER _____ |
|---|---|---|---|
| SECONDAY INSURANCE COMPANY NAME | SUBSCRIBER'S NAME | SUBSCRIBER'S DATE OF BIRTH | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ CHILD ☐ SELF ☐ OTHER _____ |

**PREFERRED METHOD OF CONTACT (appt. reminders will be text unless otherwise stated) PHONE E-MAIL TEXT MAIL**

*1415 W. Main St. Suite 300, Durant, OK 74701/Phone: (580) 920-1980/Fax: (580) 920-9937*

Texoma Pediatrics

# NEW PATIENT HISTORY

Patient's Name _____
Date of Birth_____
Your Relationship to Child _____
Present Health Concerns _____
_____
_____
_____
Current Medications _____
_____
_____

## CHILD'S BIRTH HISTORY

Hospital of Birth_____
Number of Previous Pregnancies _____
Birth Weight_____
Premature _____ Full Term _____
Problems with this pregnancy, labor or delivery?_____
_____
Problems in the nursery_____
_____

## CHILD'S PAST MEDICAL HISTORY

Illnesses_____
_____
Hospitalizations _____
_____
Surgeries_____
_____
Injuries_____
_____
Serious Infections_____
_____
Other Medical Problems_____
_____
Developmental Problems _____
_____
_____
_____

School Problems _____
_____
_____
Allergies: _____
_____
_____

## OTHER CHILDREN IN FAMILY

| Name | Age | Medical Problems |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Children not living _____
Cause of death _____

## FAMILY HISTORY

Birth Defects _____
Bleeding Problems _____
Juvenile Diabetes _____
Seizures _____
Heart Disease (note approx age of onset) _____
_____
High Blood Pressure _____
Stroke_____
Allergies _____
Asthma _____
Mental Illness _____
Attention Deficit Disorder _____
Learning Problems _____
Alcohol or Drug Abuse _____
Genetic Diseases _____
Migraines _____
Obesity _____
Kidney Disease/Urinary Reflux_____
Thyroid Problems _____
Other _____
_____

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# Consent for Services

**Patient Name**_____ **Date of Birth**_____

**AUTHORIZATION FOR TREATMENT:**
I authorize Texoma Pediatrics, PLLC to provide treatment to myself or the above named patient.

**NOTICE OF PRIVACY PRACTICES:**
I have been given a copy of Texoma Pediatrics, PLLC Privacy Practices in compliance with HIPAA legislation.

**ASSIGNMENT OF BENEFITS:**
I authorize my insurance company to pay and hereby assign directly to Texoma Pediatrics, PLLC, all benefits, if any, otherwise payable to me for services. This authorization may be revoked by either me or my insurance company at any time in writing.

**REFERENCE LABORATORY SERVICES:**
I understand that Texoma Pediatrics, PLLC utilizes the services of an outside lab to perform some of the lab tests requested by its physicians. I further understand that the Reference Laboratory will bill separately for its services. I consent to Texoma Pediatrics providing demographic information as necessary for billing purposes.

**CANCELLATION OF APPOINTMENTS**
I understand that I must give a 24 hour notice to cancel my appointment. I further understand that future services may be denied if I fail to keep my scheduled appointments.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:**
I authorize release of copies of pertinent medical records to providers outside of Texoma Pediatrics, PLLC who are being consulted with and/or I am being referred to in connection with my current treatment, to insurance companies for the purpose of determining benefits for services provided, and to reference laboratories for billing purposes.

**FINANCIAL POLICY/PAYMENT AGREEMENT/COLLECTION POLICY:**
I, the undersigned, do hereby expressly guarantee payment of all charges for medical services rendered, or to be rendered by Texoma Pediatrics, PLLC. I understand that it is my responsibility to provide Texoma Pediatrics with current insurance information. I will be responsible for the balance due, plus any costs that are incurred by Texoma Pediatrics, PLLC in collecting my account.

**USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION**
My insurer may share my past, current and future health and account records with Texoma Pediatrics, PLLC about services I've received from Texoma Pediatrics, PLLC and other care providers unrelated to Texoma Pediatrics, PLLC. These records may be used by Texoma Pediatrics, PLLC as needed to manage or coordinate my care and to improve the quality of that care.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

| _____ | _____ | _____ |
|---|---|---|
| Date | Signature Patient (if 18 yr.) / Parent / Legal Guardian | Relationship to Patient |

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## Medical Authorization for Minors/Emergency Contacts

Printed Name of Child: _____

Child's Date of Birth: _____

We (I) hereby authorize the following persons to be listed as emergency contacts, authorize medical treatment, call to request medical information, and/or sign for immunizations for the above named child:

| Person | Phone Number | Relationship to Child |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date: _____

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## Records Release Form

**IF RECORDS ARE OVER 30 PAGES, PLEASE MAIL.**

I, _____ (Name), _____ (Relationship), of:

Patient's Name:_____

Date of Birth: _____

Home Address: _____

_____

Home Phone #:_____

Hereby authorize the release if his/her medical records from:

Name of Provider/Institution:_____

Address: _____

_____

Phone #: _____

Fax #: _____

To be forwarded directly to:

**Texoma Pediatrics, PLLC**
**1415 W. Main St., Suite 300**
**Durant, OK 74701**
**Phone: (580) 920-1980**
**Fax: (580) 920-9937**

I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

_____ _____

Parent/Guardian Signature Date

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# Financial Policy

**Patients with Insurance**

Parents/Guardians of patients are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Co-payments and anticipated coinsurance amounts will be collected at the time of check-in and will be expected prior to services being rendered. When there is a known deductible, payment will be expected at the end of treatment. If a parent/guardian is unaware of their deductible or coinsurance amount, we will bill the insurance company as a courtesy. Any remaining balance should be taken care of within one (1) month's notice from the insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit, or your family has an outstanding balance, you must notify the office to make arrangements in advance of each office visit.

**Patients without Insurance**

Parents/Guardians of patients are responsible for making payment for care at each patient visit. If payment cannot be made at each visit, you must notify the office to make arrangements in advance of each office visit.

**Patients without their Insurance Card or New Insurance**

Parents/Guardians of patients are responsible for making payment for care at each patient visit if the insurance cannot be verified with your insurance company before leaving the office. You must present your card at each visit per your insurance company and you must notify us promptly of any change in you or your child's insurance status.

**Missed Appointments/Medical Records Transfer/Shot Record Fee**

Patients who fail to show for any appointment or do not give 24 hrs advance notice of cancellation will be charged $25. We reserve the right to discharge you from the practice for continued missed appointments. There is a $0.30 charge per page (up to $200 plus cost of mailing) to transfer medical records to another physician's office or to obtain a copy of the medical records. There will be a $2.00 charge for printing shot record and will be available next day.

| _____ | _____ | _____ |
|---|---|---|
| Date | Signature Patient (if 18 yr.) / Parent / Legal Guardian | Relationship to Patient |

Texoma Pediatrics

# Notice of Privacy Practices

This notice describes how your personal healthcare information may be disclosed or used by this office. Please read this notice carefully. If you have any questions, please contact our Privacy Officer. After reviewing this document, you will be asked to sign that you have received this notice.

This office is required to abide by the terms of this Notice of Privacy Practices. The terms may change at any time and the revised notice will apply to all protected health information maintained at that time. The revised notice will be posted in our office. You may request a revised copy of this notice by also calling our office.

This office has taken reasonable steps to safeguard the privacy and confidentiality of your Protected Health Information (PHI). The staff of this office will only use your health information for the intended patient care purpose. Conversations among staff members that reference your information will be conducted on a confidential and professional manner.

## 1. Uses and Disclosures of Protected Health Information for TPO

This office will need to access your protected health information for purposes of treatment, payment and operations (TPO) in accordance with State and Federal Law.

- **Using & Disclosing Information For Treatment Purposes**

  To maintain high quality healthcare, it will be necessary to share protected health information with all members of your treatment team. This can include employees in this office as well as other providers.

- **Using & Disclosing Information For Payment Purposes**

  Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for our internal billing personnel to have access to protected health information to carry out their job functions.

- **Using & Disclosing Information For Operations Purposes**

  Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, and compliance with all federal and state laws.

## 2. Specific Authorization Required for Other Uses and Disclosures

Other uses and disclosures of your protected health information will only be made with your written authorization. This authorization will only allow the use or disclosure of the specific information detailed on the authorization form. Some examples include but are not limited to: some marketing activities, the use or disclosure of psychotherapy records in our possession and in some instances for research purposes.

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## 3. Other uses and disclosures without your authorization

The following are situations where this office may use or disclose your protected health information without your consent or authorization:

- **Uses and disclosures of protected health information (PHI) as required by law, court orders, a legal process, or government agencies.**
- **Uses and disclosures of PHI for matters of public health for the purpose of controlling disease as dictated by law.**
- **Uses and disclosures to government oversight agencies for the purpose of health and privacy audits or investigations.**
- **Uses and disclosures may be made to public health authorities in situations of suspected abuse or neglect.**
- **Uses and disclosures to Institutional Review Boards for the purpose of medical research.**

## 4. Patient Privacy Rights effective April 14, 2003

- **In general you will have the right to review and copy your protected health information as well as amend your record. Some exceptions include, but are not limited to: psychotherapy notes, information compiled for use in a civil, criminal or administrative proceeding.**
- **You have the right to request a restriction of the disclosure of your protected health information for treatment, payment or operation. This office is not required to agree to the request, but will do so at our discretion.**
- **You have the right to request to receive confidential communications from us by alternative means or to an alternative location. We will make every effort to honor reasonable requests.**
- **You have the right to request an accounting of the disclosures made of your protected health information by this office (after April 14, 2003). This only applies to disclosures made for purposes other than treatment, payment or operations.**

## 5. Privacy Officer & Complaints

**Should you have any concerns you may contact our Privacy Officer who is responsible for the privacy and confidentiality of your information in accordance with state and federal law. Any complaints or issues you have regarding the privacy or confidentiality of your information should be directed to the privacy officer.**

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## Medical Home Agreement

**This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.**

**As your Medical Home Primary Care Provider (PCP), we agree to:**

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ongoing, quality and safe medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed medically necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed medically necessary by your PCP.

**As a Medical Home Patient, your responsibility is the following:**

1. Work with us, as your PCP, to meet all of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report any changes related to your health, treatments, medications, etc.
   - This includes use of **all medications** - prescription, over-the-counter, herbal and street drugs.
   - This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us before going to the Emergency Room, unless it is life threatening.
5. Notify us after any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including follow-up appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call before your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

**Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.**

_____ _____

Patient or Guardian Date

_____ _____

Provider Signature Date

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