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

430 Bryan Dr, 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 _____
_____
Pharmacy_____

CHILD'S BIRTH HISTORY

Hospital of Birth_____
Number of Previous Pregnancies _____
Birth Weight_____ SVD/C-SECTION
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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Texoma Pediatrics

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.

VACCINE POLICY
I am aware of Texoma Pediatrics Vaccine Policy and a copy has been given to me.

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 and that future services may be denied if I fail to keep my scheduled appointments. I have been given a copy of the Medical Home Agreement that fully explains terms and conditions.

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. I have been given a copy of the Financial Policy that fully explains terms and conditions.

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 agreeing to the above 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: **OTHER THAN BIOLOGICAL MOTHER/FATHER OR LEGAL GUARDIAN.**

Person	Phone Number	Relationship to Child

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date: _____

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Texoma Pediatrics

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____**DOB**: _____

I hereby authorize

_____

Name of Person/Organization Disclosing PHI to release the following information to

_____

Name and Address of Person/Organization Receiving PHI

Information to be shared:

□ Psychotherapy Notes (**if checking this box, no other boxes may be checked**)
□ Entire Medical Record
□ Billing Information for_____
□Mental Health Records
□ Substance Abuse Records
□ Medical information compiled between_____ and _____
□ Other:_____

The information may be disclosed for the following purpose(s) only:

□ Insurance □ Continued Treatment □ Legal □ At my or my representative's request
□ Other:_____

I understand that by voluntarily signing this authorization:

• I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
• I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
• I have the right to receive a copy of this authorization.
• I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
• My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
• I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
• I understand I cannot restrict information that may have already been shared based on this authorization.
• Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____

Signature of Patient or Legal Representative Date

_____ _____

Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)

Texoma Pediatrics

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 PHYSICIAN.

_____ _____

Patient or Guardian Date

_____ _____

Physician Signature Date

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Texoma Pediatrics

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) months' 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. (Medicaid/Sooner Care patients are subject to dismissal). 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.

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.

Texoma Pediatrics

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.

Texoma Pediatrics

Vaccine Policy

An open letter to all our valued families:

The physicians of Texoma Pediatrics care deeply about the health and safety of the children in our care. One of the most vital steps in keeping them healthy is to be current with their childhood vaccines. Our clinic follows the recommendations of the American Academy of Pediatrics and the Centers for Disease Control and Prevention by encouraging our patients to be immunized according to their published schedule. Unvaccinated children are at higher risk for becoming ill with a host of preventable diseases, that can have very serious and sometimes devastating consequences. In addition, unvaccinated children can potentially spread a preventable disease to another child who may be too young to be vaccinated or whose medical condition prevents them from receiving immunizations. The vaccines our children receive have each been thoroughly tested for safety and effectiveness and we have given them to our own children.

With those important issues in mind, and for the safety of all the children in our care, we are providing our families with the Texoma Pediatrics statement regarding vaccine status:

Effective immediately, Texoma Pediatrics will no longer accept new patients who are unvaccinated or on an alternative vaccine schedule. Parents who would like to start immunizations, are encouraged to discuss catch-up immunizations for their child. Additionally, we discourage adoption of alternative vaccine schedules for our patients. Parents who choose to use an alternative schedule, are asked to have vaccines completed within the recommended time ranged specified by the American Academy of Pediatrics and CDC.

In addition to our new vaccine policy, we want to point out and make very clear that for those children in our care who have medical conditions, severe documented reactions, or treatments that preclude them from receiving vaccines, Texoma Pediatrics will exclude them from this policy until they are medically eligible to obtain vaccines.

We will try to address any questions and concerns you may have. We will also be happy to provide you with the current AAP/CDC recommended vaccine schedule. We at Texoma Pediatrics look forward to providing your children with the best possible medical care and guidance, and we value your trust and confidence.

Sincerely,

Jamie Akin, DO
Michael Simulescu, DO

430 Bryan Dr, Durant, OK 74701/Phone: (580) 920-1980/Fax: (580) 920-9937