**NEW PATIENT REGISTRATION FORM**

**CHILD’S INFORMATION – SEPARATE FROMS MUST BE COMPLETED FOR EACH CHILD IN FAMILY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CHILD’S FULL NAME (FIRST, MIDDLE, LAST)** | | | **GENDER**  **MALE**  **FEMALE** | **CHILD’S PRIMARY LANGUAGE**  **ENGLISH**  **SPANISH**  **OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **CHILD’S DATE OF BIRTH** |
| **MAILING ADDRESS** | | | **CHILD’S SOCIAL SECURITY NUMBER** | | | **PREFERRED PHARMACY** | |
| **CITY** | **STATE** | **ZIP** | **CHILD’S ETHNICITY**  **NON-HISPANIC**  **HISPANIC** | | **CHILD’S RACE**  **AMERICAN INDIAN OR ALASKAN NATIVE**  **ASIAN**  **BLACK OR AFRICAN AMERICAN**  **NATIVE HAWAIAN OR PACIFIC ISLANDER**  **WHITE**  **OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **PRIMARY PHONE** | **WORK PHONE** | | **HOW DID YOU HEAR ABOUT US?** | |

**MOTHER OR LEGAL GUARDIAN’S INFORMATION FATHER OR LEGAL GUARDIAN’S INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MOTHER/ GUARDIAN’S FULL NAME** | | | **FATHER/ GUARDIAN’S FULL NAME** | | |
| **MOTHER/ GUARDIAN’S SOCIAL SECURITY NUMBER** | **MOTHER’S MAIDEN NAME** | | **FATHER/ GUARDIAN’S SOCIAL SECURITY NUMBER** | **CHILD LIVES WITH (CHECK ONE)**  **MOTHER**  **FATHER**  **OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| **MOTHER/ GUARDIAN DATE OF BIRTH** | **MOTHER/ GUARDIAN’S MARTIAL STATUS**  **MARRIED SINGLE**  **SEPERATED DIVORICED**  **WIDOWED** | | **FATHER/ GUARDIAN’S DATE OF BIRTH** | **FATHER/ GUARDIAN’S MARTIAL STATUS**  **MARRIED SINGLE**  **SEPERATED DIVORICED**  **WIDOWED** | |
| **MOTHER/ GUARDIAN’S MAILING ADDRESS** | | | **FATHER/ GUARDIAN’S MAILING ADDRESS** | | |
| **CITY** | **STATE** | **ZIP** | **CITY** | **STATE** | **ZIP** |
| **MOTHER/ GUARDIAN’S PHONE** | | | **MOTHER/ GUARDIAN’S EMPLOYER AND PHONE NUMBER** | | |
| **FATHER/ GUARDIAN’S PHONE** | | | **FATHER/ GUARDIAN’S EMPLOYER AND PHONE NUMBER** | | |
| **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 DOB**  **SUBSCRIBER’S SOCIAL SECURITY NUMBER** | **PATIENT’S RELATION TO SUBSCRIBER** |
| **SECONDARY INSURANCE COMPANY NAME** | **SUBSCRIBER’S NAME** | **SUBSCRIBER’S DOB**  **SUBSCRIBER’S SOCIAL SECURITY NUMBER** | **PATIENT’S RELATION TO SUBSCRIBER** |

**Consent for Services**

**AUTHORIZATION FOR TREATMENT:**

I have the right, as a patient, to be informed about my condition and the recommended surgical, medical or diagnostic procedure to be used so that I may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in my care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By my verbal consent, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked. I have the right at any time to discontinue services.

I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have any concerns regarding any test or treatment recommend by my health care provider, I am encouraged to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

To better serve the needs of people in this community, health care services are now available by interactive video communications (telehealth) and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of several health care problems.

**It is important that you understand and agree to the following regarding telehealth visits:**

1. The healthcare provider will be at a different location than me.
2. I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make arrangements for follow-up care
3. I understand that I have the option to refuse telehealth service at anytime without affecting the right to future care or treatment.
4. I understand that not all insurance companies allow telehealth visits. In consideration for telehealth services rendered to me, I agree to pay the charges not covered by my insurer including any deductible or co-payment, or any charges not covered by my insurance company.

I authorize Southeastern Pediatrics & Family Practice to provide treatment to myself or the above-named patient. I authorize the provider to determine the type of appointment needed and authorize the use of telemedicine via HIPAA secure telecommunications which may include video and/ or telephone. It is my responsibility to secure a quiet location with the appropriate method of remote communication to ensure the provider can clearly hear and/or see myself or my family member that is being treated and such communications are conducted in a manner which is consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules (HIPAA Rules). This may include:

* **Communication applications (apps) on a smartphone or another computing device.**
* **VoIP technologies.**
* **Technologies that electronically record or transcribe a telehealth session.**
* **Messaging services that electronically store audio messages.**

Potential risks and vulnerabilities to the confidentiality, integrity, and availability include:

* **There is a risk the transmission could be intercepted by an unauthorized third party.**
* **The device or app automatically terminates the session or locks after a period of inactivity.**

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

**ASSIGNMENT OF BENEFITS:** I authorize my insurance company to pay and hereby assign directly to Southeastern Pediatrics & Family Practice 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. I understand the practice has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to the practice, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

**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 Southeastern Pediatrics & Family Practice. I understand that it is my responsibility to provide Southeastern Pediatrics & Family Practice with current insurance information. I will be responsible for the balance due, plus any costs that are incurred by Southeastern Pediatrics & Family Practice in collecting my account.

**Financial Policy Patients with Insurance**

Payment is due at the time of visit. 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. 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 by your insurance company prior to being seen by the provider. 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 hours advance notice of cancellation may be charged

$25. We reserve the right to discharge you from the practice for continued missed appointments.

There is a $1.00 charge for the first page then a 0.50 charge per page (up to $200 plus cost of mailing) to obtain a copy of your medical records. Fees are waived if medical record requests are transferred from provider to another physician’s office. All medical records requests must be in writing and can take up to 2 weeks to process.

There will be a $2.00 charge for printing official shot records and processing may take up to 48 hours. FMLA/ Medical necessity letters will have a fee assessed and will be due prior to paperwork being completed.

**REFERENCE LABORATORY SERVICES:** I understand that Southeastern Pediatrics & Family Practice utilizes the

services of an outside lab to perform some of the lab tests requested by its providers. I further understand that the Reference Laboratory will bill separately for its services. I consent to Southeastern Pediatrics & Family Practice

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.

**USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION**

My insurer may share my past, current and future health and account records with Southeastern Pediatrics & Family Practice about services I’ve received from Southeastern Pediatrics & Family Practice and other care providers

unrelated to Southeastern Pediatrics & Family Practice. These records may be used by Southeastern Pediatrics & Family Practice as needed to manage or coordinate my care and to improve the quality of that care.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:** I authorize release of copies of pertinent medical

records to providers outside of Southeastern Pediatrics & Family Practice, 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 reference laboratories for billing purposes.

I hereby permit practice/clinic, and the providers or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information regarding a prior service(s) at other providers may be made available to subsequent providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient’s behalf to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer’s designee when the services delivered are related to a claim under worker’s compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law.

I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

**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.**

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

**Medical Authorization for Minors/ Emergency Contacts**

Printed Name of Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disclosures to Friends and/or Family Members. I may give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others. I will communicate the Name, Relationship, and contact information to the clinical team to ensure it is documented.

We (I) hereby authorize the following person(s) to be listed as emergency contact(s), authorize medical treatment, call to request medical information, and / or sign for immunization(s) for the above-named person:

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone Number** | **Relationship to Patient** |
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**No-Show/Late Cancellation Policy**

**At Southeastern Pediatrics and Family Practice, we strive to provide comprehensive, compassionate, and timely care to every patient. To reduce the number of late cancellations for appointments and missed (or “no-show”) appointments, Southeastern Pediatrics and Family Practice has a No-Show/Late Cancellation Policy. We understand that there are times when you must miss an appointment due to an emergency or other commitments. However, when a patient repeatedly cancels or arrives late for appointments, clinic flow is disrupted, which negatively impacts other patients, our providers, and our staff**.

* You are expected to arrive for your scheduled appointment at the **appointment arrival time or to notify the clinic at least 24 hours in advance of a scheduled appointment** if you cannot keep the appointment.
* Arriving **more than 15 minutes** after your appointment time may result in the appointment being rescheduled to another day.
* Patients who do not show up, who arrive late or who cancel less than 24 hours of a scheduled appointment **three times within 12 months** can be dismissed from the provider's or clinic’s care.

We are committed to ensuring that **all patients** have access to the care they need. Thank you for working with us to continue to meet this standard.

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Patient (or legal guardian) Signature Date Staff Signature

**Patient Consent and 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.

1. **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.

1. **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.**

1. **Patient Privacy Rights effective 2013**

* **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.**

1. **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.

I have read and received a copy of Southeastern Pediatrics & Family Practice Privacy Practices in compliance with

HIPAA legislation.

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Patient or Guardian Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider/ Staff Signature Date

**A PATIENT’S GUIDE TO MYHEALTH**

**Southeastern Pediatrics and Family Practice keeps pace with advancements in health care, we have a growing need to safely and efficiently use computers to electronically share your health information with the team of health professionals who provide care to you. Currently, when we need to share your health information with other health providers the process is difficult and usually means numerous phone calls, mailings and faxes. And, when we need to gather information from one of your other providers it can take hours or even weeks and sometimes the information is not available at all. Technology can help us do better.**

**MYHEALTH ACCESS NETWORK**

MyHealth Access Network (MyHealth) is a nonprofit coalition of Oklahoma health providers, including doctors, hospitals, labs, pharmacies, emergency services, and other health industry professionals, who are using technology to link medical providers, exchange timely information and improve the delivery of local health care. MyHealth allows us to deliver the right information to the right doctor, at the right time, to help care for you.

**FREQUENTLY ASKED QUESTIONS**

Although MyHealth is designed to be used by health care professionals, it provides many important benefits and choices for you. We’ve attempted to answer the most common questions here:

**WHO CAN ACCESS MY INFORMATION?**

Only the health industry professionals involved in your care (and their approved staff members) that belong to the MyHealth network can access your information, and only as their jobs require it.

**WHAT ARE SOME EXAMPLES OF HOW MyHealth HELPS ME?**

Time is important when addressing your health needs. Some examples of when and how your personal health information is used to help you include:

• When you see a medical specialist, your doctor and the specialist need to share your information to help coordinate effective care. The quicker this happens, the quicker you receive the care you need.

• In a medical emergency such as a car accident, ambulance and emergency room doctors can have access to important health information that might save your life or that of a loved one, like a medication list, drug and food allergies, presence of a pacemaker, etc.

• If you manage care for yourself, a child, parent, etc., then you know the challenges of keeping up with medication lists, procedures, allergies, and vaccinations. MyHealth can help make these available in the doctor’s office.

**HOW DOES MY INFORMATION STAY SECURE?**

We take your privacy very seriously, and information shared through MyHealth is protected with the highest forms of security, including encryption and secured connections. We know that patients must trust their information is safe. MyHealth complies with all State and Federal laws (like HIPAA) to protect your information.

**DO I NEED TO SIGN UP FOR THIS SERVICE?**

No. Because (Name of ORGANIZATION) is a participating MyHealth partner you are included in the network. You may opt out if you wish (see how below).

**CAN I CHOOSE NOT TO PARTICIPATE IN MYHEALTH?**

Yes, you can choose to not participate in, or ’opt out’ of MyHealth at any time. Choosing to opt out generally means that your doctors will not be able to use the MyHealth network to electronically access your health information. You can opt out of MyHealth by:

1. Obtaining an Opt Out of MyHealth Form from our front desk clerk, or by downloading the form from [www.myhealthaccess.net/opt-out](http://www.myhealthaccess.net/opt-out)

2. Complete the form (please wait to sign it in front of our desk clerk)

3. Bring the form to our front desk clerk and sign it with our clerk as a witness. We will send it to MyHealth for you. OR you may sign your form with a Notary Public as a witness and mail it to the address provided on the form. You can always return to MyHealth by completing the Return to MyHealth Form, which is also available from our front desk clerk, or online at [www.myhealthaccess.net/opt-in](http://www.myhealthaccess.net/opt-in)

**WHO IS MYHEALTH ACCESS NETWORK?**

MyHealth is a Oklahoma non-profit organization created by patients, doctors, hospitals, emergency responders, insurance plans, and other organizations providing health care to Oklahomans. To learn more about MyHealth, visit [www.myhealthaccess.net](http://www.myhealthaccess.net).

**WHO DO I CONTACT FOR MORE INFORMATION OR SUPPORT?**

If you would like more information about MyHealth, please visit: www.myhealthaccess.net or call 918-236-3451.