2781 Washington Drive, Suite 101
Norman, OK 73069
Phone: 405-857-8880
Fax: 405-279-0285

Patient Information

Patient's Legal Name: Last	First	M.I.	Sex:	DOB:	Age:
Social Security Number:		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced			
Patient's Address:		Employment Status: ☐ Employed ☐ Student ☐ Disabled ☐ Retired ☐ Other: ________			
City:	State:	Zip Code:	Who referred you to our office?		
Home Phone:	Work Phone:		Cell Phone:		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined	Race: ☐ White ☐ Asian ☐ Black ☐ Pacific ☐ Native American ☐ Multiple			Email Address:	

Insurance Information

Name of Primary Insurance:	Policyholder Employer:
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:
Name of Secondary Insurance:	Policyholder Employer:
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:

Financial Responsibility Information

Name of person responsible for entirety of payment:		Relationship to Patient:
Address:		Phone Number:
SSN:		DOB:
Employer:	Employer Phone:	Employer Address:

Emergency Contact Information

Nearest relative or friend (not spouse), that does not live with you:	
Phone:	Relationship to patient:

Insurance Authorization and Assignment

I request that payment of benefits be made on my/the patient listed above' behalf to Pinnacle Family Health Care, LLC for any services furnished to the patient listed above by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply (if applicable). I authorize any holder of medical or other information about the patient listed above to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and any information needed for this or any related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of the medical insurance benefits be paid to the party who accepts assignment. Any overpayment will be applied to any of my outstanding balance(s) owed to Pinnacle Family Health Care, LLC. I understand that it is mandatory to notify the healthcare provider of any changes in information provided on this form. I have answered the questions and have read and understand the terms of assignment and release of information. I fully authorize all treatment to be rendered to the patient listed above. I promise to pay for all services rendered.

Signature of Patient or Legal Representative (if applicable)	Date

Accident Questionnaire

Is your chief complaint the result of an accidental injury? ☐ **YES** ☐ **NO**
If yes, what is the date of that injury? ____

Where did that accident occur?

____
____
____

Describe how the accident occurred (Please give full details):

____
____
____
____
____
____
____

Have you filed a claim regarding this injury with any of the following?

☐ Workers Compensation
☐ Motor Vehicle Insurance Company
☐ Homeowners Insurance Company

If not, do you plan on filing a claim in the future? ☐ **YES** ☐ **NO**

Have you sought the advice of an attorney? ☐ **YES** ☐ **NO**

If yes, please provide the attorney's information:
Name: ____
Address: ____
Phone Number: ______________________ **Fax Number:** ______________________

Patient or Legal Guardian's Signature: ____

Print Name: ______________________________ **Date:** ______________________

NOTICE TO PATIENTS

Privacy Notice:

This document is the Notice of Privacy Practices for Pinnacle Family Health Care, LLC. Please print and sign your name below to acknowledge that you have received a copy of our Privacy Notice, at the date and time indicated below. If you have any questions about our Privacy Practices, please contact:

Privacy Officer
Pinnacle Family Health Care, LLC
2781 Washington Drive, Suite 101
Norman, OK 73069
Ph: 405-857-8880

Patient or Legal Guardian Signature: ____

Print Name: ____ Date: ________________________

Witness Name: ____

Date and Time Notice was Obtained: ____

Authorization to Release Information

NOTICE: THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) ALLOWS YOU TO REQUEST THAT WE COMMUNICATE WITH YOU ABOUT YOUR PERSONAL HEALTH INFORMATION IN A WAY THAT IS CONFIDENTIAL. PLEASE USE THIS FORM TO DESCRIBE THE LIMITATIONS ON USE AND DISCLOSURE THAT YOU ARE REQUESTING. AS STATED IN THE LAW, WE ARE NOT REQUIRED TO HONOR YOUR REQUEST. IF WE ARE TO HONOR YOUR REQUEST, WE WILL COMPLY WITH YOUR REQUEST UNLESS THE INFORMATION IS NEEDED TO PROVED EMERGENCY TREATMENT, PAYMENT, OPERATIONS, AND IF LEGALLY REQUIRED BY APPLICABLE FEDERAL OR STATE LAW.

Patient Name: ____DOB:___________________________

I authorize the following individuals to call the office on behalf of the patient to verify the status of appointments, treatment plans, medications and account information. These individuals may also pick-up prescriptions and/or samples that I have requested:

Name: ____ Relation: __________________________________

Name: ____ Relation: __________________________________

Name: ____ Relation: __________________________________

Name: ____ Relation: __________________________________

__________ (Initials) I prohibit any/all information to be given out including appointments, treatment plans, medications and account information.

I understand that this authorization will remain in effect until I revoke this authorization in writing.

____ ______________________________

Signature of Patient or Legal Guardian **Date**

____

Printed Name of Patient or Legal Guardian

Financial Policy

The intent of this agreement is to establish an understanding between the office/provider(s) of Pinnacle Family Health Care, LLC and the patients and/or guarantors regarding finances, and account balances. Please read the following:

- **For Patients with Insurance:** Health insurance is in a state of constant change. Each carrier has many different types of plans, the plans are continually revised, reimbursement requirements are changed, and deductibles are continuing to increase. It is not possible for our office to know all the details of every plan. Although we make every effort to ensure we have the correct pre-authorizations and approvals for each patient, it is imperative that you, as the subscriber and responsible party, be familiar with the patient's specific insurance plan coverage and requirement details. ***Medical treatment costs associated with services not covered by insurance are the full responsibility of the patient/ or legal guardian which authorized all services/treatment to be rendered and will be billed accordingly. Any costs for non-covered service treatment must be paid in full prior to services/treatment being rendered to the patient.*** You must provide our office with a copy of your insurance card prior to the initial appointment or you will be responsible for all charges at the time of service. If your insurance changes, you must provide our office with an updated copy of your insurance card(s) for our business office to properly submit claims to your insurance company. ***All co-pays, deductibles and coinsurance amounts are due at the time of service.***
- **Medicare Patients**: We will bill Medicare for you. We will also bill any secondary insurance carrier for you.
- **Non-covered Services**: Any care not paid for by your existing insurance coverage will require payment in full at the time of service.
- **Personal Injury Cases**: As a courtesy to our patients, this office does, in some cases, bill for costs of services/treatment rendered by our provider(s) that are associated with auto accidents and other third-party liability cases. You must provide our office with the auto insurance/third-party liability insurance information PRIOR to services being rendered. The required information is as follows: Liable party name, Insurance company name, mailing address for claim submission, telephone number, claim/policy number and date of injury. If you are represented by an attorney, adjuster or nurse case manager then we will need your Case Representative's name, address, phone number and fax number. We may file a lien for any services rendered that result in any unpaid balance(s). You will be responsible for payment in full as services are rendered. All copayments, coinsurance and deductible amounts must be paid at time services are rendered. Our office only submits third-party insurance claims as a courtesy to our patients— We do not and will not wait for your third-party claim settlement to be issued before attempting to collect for services rendered by our office and its provider(s). Any third-party liability claim(s) will be filed after payment is received from the primary insurance payer/ or primary payment source/legal party (if patient is Private Pay due to not having private medical health insurance coverage at time of treatment).
- **Worker's Compensation**: PLEASE NOTE: The Workers Compensation claims adjuster or Nurse Case Manager that is assigned to your specific injury claim MUST contact our office on behalf of the patient to schedule the initial (first) appointment for medical treatment following your work-related injury. If your injury is work related, we must have the case number, insurance carrier name, adjustor name, telephone number and date of injury prior to services being rendered. This is to ensure that authorization has been given to treat and bill the worker's compensation company for all charges incurred in our office. If your case is pending or NOT authorized, you are responsible for all charges until a determination has been made regarding your case.
- **Missed Appointments**: In fairness to other patients and the provider, we require a 24-hour advance notice for cancellation or rescheduling of all appointments. If 24-hour advance notice is not provided to our office, you will be charged a 'no-show' fee of $50.00. Any no-show fees that have been charged must be paid in full prior to rescheduling any future appointments with our office.
- **Special Forms/Disability Forms/Accident Forms**: There will be a charge of $50.00 for any form or document to be completed by our office on behalf of the patient. Payment is required when forms are dropped off, faxed to our office or mailed to our office for completion. Forms will not be completed until payment is made.

- **Letters/Narratives**: Any patient requests for a “special letter” or “narrative report” on their behalf will be charged a flat rate of $600.00. Documents in excess of 6 pages will be charged an additional $150.00 per page. Payment for these requests is to be paid in full, at least five business days prior to being dictated. This type of correspondence will not be dictated until payment is received in full.

Upon signing this agreement, you understand all the above information and are responsible for maintaining cooperation with this agreement. If you have any questions or concerns, please express those prior to signing this agreement.

_______________________________________ _____________________

Signature of Patient/or Legal Guardian **Date**

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Printed Name of Patient/or Legal Guardian