PATIENT INFORMATION

Doctor: ____________
office use only
Account #____________

Today's Date: ____________

Child's Full Name: ____________ (First / Middle Initial / Last) Sex: ( ) Male ( ) Female

Date of Birth: ____________ Age: ____________ Race: ____________ Ethnicity: ____________

Current Address: ____________ Home Phone: ( ) ____________

City: ____________ State: ____________ ZIP: ____________

Child resides with: ☐ Mother ☐ Father ☐ Other *(please specify)*: ____________

Who may we thank for referring you to our practice? ____________

Family email address *(no spam, we promise!)* ____________

Would you like to receive our e-newsletter? ☐ Yes ☐ No

Father's Name: ____________ (First / Middle Initial / Last) DOB: ____________

Social Security #: ____________ Marital Status: **S M W D Sep** Pager/Cell #: ____________

Employer: ____________ Work Phone: ____________

Mother's Name: ____________ (First / Middle Initial / Last) DOB: ____________

Social Security #: ____________ Marital Status: **S M W D Sep** Pager/Cell #: ____________

Employer: ____________ Work Phone: ____________

Child's Siblings: ____________ DOB: ____________

____________ DOB: ____________

Name of Emergency Contact or Relative *not living with you* <u>other than Parents of Child</u>:

Name: ____________ Relation: ____________

Address: ____________ City: ____________ State: ________ ZIP: ____________

Employer: ____________ Home Phone: ____________ Wk Phone: ____________

<u>Insurance Information</u>: ***(Please provide a copy of your/your child's insurance card to the receptionist)***

Company or Program: ____________ Effective date: ____________

Claims Address: ____________ Insured SSN: ____________

Insurance ID#: ____________ Policy or Group #: ____________

Insured Party's Name: ____________ DOB: ____________ Relation to Pt: ____________

Employer Plan: ( ) YES ( ) NO Employer Name: ____________

What is your copay amount? $____________ Is Well Baby (Child) Care covered on your plan? ____________

Do you have a deductible to meet? *(circle one)* Yes No If **Yes**, what is your deductible amount? $____________

<u>Benefits to Physician</u>: I hereby authorize payment from my insurance company to be paid directly to my child's physician for medical benefits. I also understand that I am responsible for my co-pay or deductible at the time of each visit and that **I am responsible for any portion of my balance not covered by insurance**. I understand that it is my responsibility to determine whether my child's physician participates with my insurance program/network, and that I am financially responsible for any out-of-network costs incurred as a result of my child's visit, if any.

SIGNATURE: ____________

<u>Release of Information</u>: I hereby authorize release of my child's medical information for insurance purposes. I certify that all of the above information is correct to the best of my knowledge. My signature indicates that I have read the above and hereby grant the request of authorization. This medical information may or may not include records indicating the present of a communicable or venereal disease such as, but not limited to, hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Syndrome (HIV/AIDS).

Ptinfo.frm Rev 10/06 **SIGNATURE**: ____________

The Pediatric Group, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Patient Name:______________________________________ DOB:___________________________

I have received a copy of The Pediatric Group, PLLC's Notice of Privacy Practices.

______________________________________ ___________________________
Signature of Parent or Legal Guardian Date

INSTRUCTIONS REGARDING LEAVING REMINDER CALLS ON HOME MESSAGE RECORDER

I □ give permission □ do NOT give permission

to the physicians or staff members of The Pediatric Group, PLLC to leave a message(s) on my home recorder for the purpose of reminding me that my child/ren has/have an scheduled appointment.

INSTRUCTIONS REGARDING LEAVING HEALTH CARE INFORMATION ON HOME MESSAGE RECORDER

I □ give permission □ do NOT give permission

to the physicians or staff members of The Pediatric Group, PLLC to leave a message(s) on my home recorder for the purpose of informing me of medical information about my child/ren, including results of diagnostic tests, specialists' impressions, and/or other medical information necessary for the continuing care of my child/ren.

INSTRUCTIONS REGARDING PROVISION OF IMMUNIZATION RECORDS WITHOUT WRITTEN AUTHORIZATION

I □ give permission □ do NOT give permission

to the physicians or staff members of The Pediatric Group, PLLC to provide a copy of my child's immunization record (only) to any person or facility I designate via a telephone call to the practice. I understand that this authorization replaces a written authorization for each specific release.

THE FOLLOWING NAMED INDIVIDUALS MAY RECEIVE INFORMATION ABOUT MY CHILD'S HEALTH CARE/CONDITION (Please include both parents if applicable)

Name	Relationship	Email Address	Phone#

______________________________________ ___________________________
Signature of Parent or Legal Guardian Date

Rev 10/13

The Pediatric Group, PLLC
3330 NW 56th, Suite 400 * Oklahoma City, OK 73112 * 405/945-4220 * Fax 405/945-4893

AUTHORIZATION TO CONTACT

I AUTHORIZE THE PEDIATRIC GROUP, PLLC TO DELIVER OR CAUSE TO BE DELIVERED THE FOLLOWING TYPES OF MESSAGES BY VOICE CALL OR TEXT MESSAGING USING AN AUTOMATIC TELEPHONE DIALING SYSTEM OR AN ARTIFICIAL OR PRERECORDED VOICE:

Appointment reminders
Visit recalls
Situational/seasonal service suggestions (Such as flu shot clinics)
Balance due reminders

I AUTHORIZE SUCH MESSAGES TO BE DELIVERED TO THE FOLLOWING PHONE NUMBER:

______________________________ **CELL PHONE**

______________________________ **LAND LINE**

Please circle your preference on either text or call for appointment reminders- TEXT OR CALL

Signed by: ______________________________ ______________________________

Signature or Patient, Parent or Legal Guardian — Relationship to patient

______________________________ ______________________________

Printed Name of Patient — Date

Consent to Treat Patient – Without Parent/ Legal Guardian Present

AUTHORIZATION:

I am the legal guardian of the child listed below and have the legal right to preauthorize The Pediatric Group and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections (including allergy injections), x-rays, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations), rehab services, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations.

I ______________________________ request and authorize The Pediatric Group and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I acknowledge that I am responsible for all charges in connection with care and treatment rendered during this time.

Child's Name: ____ DOB: ___________
Allergies: ____
Current Medications: ____
Chronic Conditions: ____

Immunizations are given and all will be updated according to recommendations by the Center for Disease Control (CDC.GOV). I agree to give my authorization for the person I have listed below to act on my behalf in receiving Vaccination Information Sheets, (VIS) and giving this approval for vaccines.

_______ **YES (This person may provide approval for vaccinations)**

_______ **NO (This person may not provide approval for vaccinations and receive the VIS on my behalf)**

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none".)

____

Parental contact information for questions regarding treatment of the child:

Parent's name: ____
Phone info: (c) __________________ (h)____________________ (w)______________________
Address: ____________________________City________________ State________ Zip___________

I hereby authorize (print) ____ to bring my child to his/her appointments if I am unable to attend. I understand that medical advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or in case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

______________________________ ____________________ ___________________
Parent or Legal Guardian (please print) Today's Date Valid thru Date

____
Parent or Legal Guardian (Signature)

The Pediatric Group, PLLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING YOUR CHILD'S MEDICAL INFORMATION:
We understand that medical information about your child is personal. We are committed to protecting your child's medical information. We create a record of the care and services your child receives in our practice. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice applies to all of the records of your child's care.

We are required by law to: (a) Make sure that medical information about your child stays private; (b) give you this notice of our legal duties and privacy practices with respect to medical information about your child; and (c) follow the terms of the notice currently in effect.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of your child's records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

WE MAY USE AND DISCLOSE YOUR CHILD'S HEALTH INFORMATION IN THE FOLLOWING WAYS:
Treatment: We may use medical information about your child to provide your child with medical treatment or services. We may disclose medical information about your child to doctors, nurses, medical assistants, medical students, or other personnel who are involved in taking care of your child. We also may disclose medical information about your child to people outside our practice who may be involved in your child's medical care, such as your family members or others we use to provide services that are part of your child's care.

Payment: We may use and disclose medical information in order to bill and collect payment for the treatment and services your child may receive from us. For example, we may contact your health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your child's treatment to determine if your insurer will cover, or pay for, your child's treatment.

Health care operations: Our practice may use and disclose your child's medical information to operate our business. For example, our practice may use your child's medical information to evaluate the quality of care your child received from us, or to conduct cost-management and business planning activities for our practice.

Disclosures required by law: Our practice will use and disclose your child's medical information when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OF YOUR CHILD'S MEDICAL INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES
Public health risks: Our practice may disclose your child's medical information to public health authorities that are authorized by law to collect information for the purpose of: (a) maintaining vital records, such as births and deaths; (b) reporting child abuse or neglect; (c) preventing or controlling disease, injury, or disability; (d) notifying a person regarding potential exposure to a communicable disease; (e) notifying a person regarding a potential risk for spreading or contracting a disease or condition; (f) reporting reactions to drugs or problems with products or devices; (g) notifying individuals if a product or device their child may be using has been recalled.

Worker's compensation: We may release medical information about your child for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness. Release of such information is controlled by state and/or federal law.

Health oversight activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs (e.g., Medicaid, Vaccines for Children), and compliance with civil rights laws.

Lawsuits and disputes: If your child is involved in a lawsuit or similar proceeding, our practice may use and disclose your child's medical information in response to a subpoena or discovery request, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information requested.

Law enforcement: We may release medical information if asked to do so by a law enforcement official: (a) in response to a court order, subpoena, warrant, summons, or similar process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the parent or guardian's consent; (d) about a death we believe may be the result of criminal conduct; (e) about criminal conduct involving our practice; and (f) in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Serious threats to health or safety: Our practice may use and disclose your child's medical information when necessary to reduce or prevent a serious threat to your child's health and safety, or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military: We may disclose your child's medical information if he/she is a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities.

National security: Our practice may disclose your child's medical information to federal officials for intelligence and national security activities authorized by law. We also may disclose your child's medical information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

YOUR RIGHTS REGARDING YOUR CHILD'S MEDICAL INFORMATION

Right to inspect and receive copies: You have the right to inspect and receive copies of medical information that may be used to make decisions about your child's care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and receive a copy of medical information that may be used to make decisions about your child, you must submit your request in writing to our medical records department. If you request a copy of your child's medical information, you will be charged 25¢ (25 cents) per page plus postage expense.

Right to amend: If you believe that medical information we have about your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our practice. To request an amendment, your request must be made in writing and submitted to our office manager. In addition, you must provide a reason to support the request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request; or certain other circumstances.

Right to a record of disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of your child's medical information. To request this record or accounting of disclosures, you must submit your request in writing to our office manager. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request before you incur any costs.

Right to request restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about your child for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about your child to someone who is involved in your child's care or the payment for your child's care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide your child with emergency treatment. **Note: Oklahoma law permits disclosure of medical information to both of a child's legal parents, regardless of their marital state or any custody determination. The right to request restrictions does not take precedence over that law.** To request restrictions, you must make your request in writing to our office manager. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply.

Right to request confidential communications: You have the right to request that we communicate with you about your child's medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to our office manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to file a complaint: If you believe your child's privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact our office manager. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to use regarding the use and disclosure of your child's medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's medical information for the reasons described in the authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to your child.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about your child as well as any information we receive in the future. We will post a copy of the current notice in our office. The effective date of any and all notices will appear on the first page under the title.

QUESTIONS

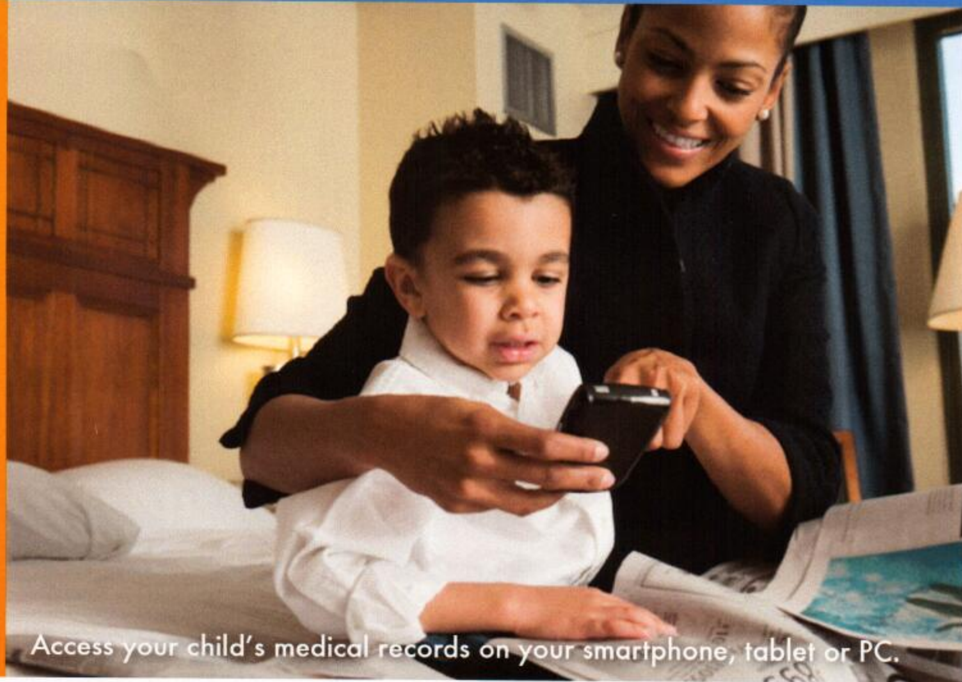
If you want more information about our privacy practices or have questions or concerns, please contact us. Our office manager serves as the Privacy Officer for The Pediatric Group, PLLC. Our address is: 3330 NW 56th Street, Suite 400, Oklahoma City, OK 73112.
Phone: (405) 945-4220 Fax: (405) 945-4893

Our Patient Portal is Here

Sign Up Now

Speak with a member of our staff to start using

https://tpg.pcc.com/portal



Access your child's medical records on your smartphone, tablet or PC.

Adding Convenience to Your Life

Life is busy. Juggling your day-to-day and staying on top of your family's health care can be a challenge, but we've set up our new portal to help. Our practice's online tool at:
https://tpg.pcc.com/portal
lets you communicate with us easily, any time and from anywhere.

You can access your child's medical records on your smartphone through The Pediatric Group, PLLC's secure patient portal at https://tpg.pcc.com/portal.

Using your secure password and user ID, you can log into our practice at https://tpg.pcc.com/portal
24/7 from your home or office. All you need is a mobile phone, tablet device or a computer with internet access.

Information You Can Access Through My Kid's Chart

When you access our patient portal, you can review a complete health information summary for each child in your care, including:

- Most recent physical date
- Upcoming appointments
- Historical visits
- Allergy list and medications list
- A complete immunization record

You can download or print your child's immunization record directly from The Pediatric Group, PLLC's portal at https://tpg.pcc.com/portal, and you can review a detailed visit summary for any appointment.

The Pediatric Group, PLLC
3330 NW 56th, Suite 400
Oklahoma City, OK 73112-4402
405-945-4220

Powered by
PCC
Pediatric EHR Solutions

The Pediatric Group, PLLC

Parent/Guardian Request to access Patient Portal

Please Print Clearly

Parent Name: ______________________________

Parent Email: ______________________________

Parent Phone: ______________________________

Patients requested for portal access

First Name	Last Name	Birthdate

Please allow 48 hours to receive your email from our office containing your temporary password to access the portal.

The Pediatric Group, PLLC
FINANCIAL POLICY

We believe that clear communication with our patient families has the result of improving doctor-patient relationships and thus patient care. We have prepared the following information regarding our financial policies so that you may know what to expect from us and what we will expect from you. We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak with our office manager if you have questions.

What you can expect from The Pediatric Group, PLLC:

1. We will be courteous, professional, and candid with you when we discuss your account balance.
2. We will keep your financial information confidential, except as permitted by HIPAA regulations.
3. We will file your child's insurance claim promptly and accurately, usually on the next business day.
4. We will only bill for services rendered; if we identify an error, we will promptly file a corrected claim and refund any insurance payment to your insurance carrier.
5. We will perform active follow-up to resolve unpaid claims.
6. We will accept payment by cash, check, credit or debit card. We take VISA, MasterCard and Discover Card.
7. We will refund any patient credit within 60-90 days if there is no other service pending insurance payment.
8. In the event that your account balance remains unpaid, we will utilize the legal means at our disposal to effect collection of monies due us.
9. We will charge you a fee for checks drawn on an account with insufficient funds. Checks not redeemed within two weeks of our notification to you may be, at our option, sent to the Oklahoma County District Attorney's office for collection.

What we cannot do:

1. We cannot determine which services are considered covered benefits under your insurance plan.
2. We cannot resolve a dispute between you and your insurance carrier.

What we expect from you:

1. We expect the person who brings the child to the appointment to pay the copay, co-insurance (percentage amount that is patient responsibility) or deductible **at the time of service**. Our receptionists have been instructed to collect that amount at check out. Please do not ask them to bill you; they are not permitted to override office policy. We cannot be involved in payment disputes between divorced, separated, custodial and/or non-custodial parents.
2. We expect you to provide us with correct insurance information and to update that information promptly if it changes.
3. We expect you to know or determine which services are covered by your health insurance plan.
4. When your insurance company sends you a letter asking for additional information, we expect you to respond to the insurance company promptly so that our claim will not be delayed further.
5. If your insurance carrier does not pay our claim in the way you expected, we expect you to contact your insurance carrier and attempt to resolve the matter before contacting our office.
6. We expect you to pay any patient-due balance in full when requested at check-out or upon receipt of the first statement.
7. If you are unable to pay the patient-due balance in full at check-out or upon receipt of our statement, we expect you to contact us promptly to make a mutually agreeable payment arrangement.
8. Once a payment arrangement is established, we expect you to make payments as promised.
9. In the event that an exceptional circumstance prevents you from making a payment as agreed, we expect you to contact us to make us aware of the reason for the delay and when we can expect payment to resume.

We value the confidence you have demonstrated in our practice by choosing us to participate in your child's health care. Our financial policies permit us to maintain the resources required to ensure that your child's care is of the highest quality. Your signature below indicates you have read and understood our policy and agree to abide by its terms.

Account Number:____________________ Child/Children's name(s):____

____ ______________________________

Parent/Guarantor Signature Date