BIXBY PEDIATRICS

Patient Identification Sheet

Name _____ Date of Birth ___/___/_____

Referred By _____ Race_____ Sex (please circle) M/F

Father's Name_____ SSN____-____-_____ Date of Birth ___/___/_____

Address_____ City, State, Zip _____

Cell Phone _____ Employer_____ Work Phone _____

Mother's Name_____ SSN____-____-_____ Date of Birth ___/___/_____

Address_____ City, State, Zip _____

Cell Phone _____ Employer_____ Work Phone _____

Preferred phone number for us to contact you _____

Other children in the family:

1. _____ Date of Birth ____/____/_____
2. _____ Date of Birth ____/____/_____
3. _____ Date of Birth ____/____/_____
4. _____ Date of Birth ____/____/_____
5. _____ Date of Birth ____/____/_____

Emergency Contact _____ Relation _____ Phone_____

Responsible Person_____ Relationship _____

Insurance Company Name _____ **Effective Date**_____

Policy Holder _____ **Date of Birth** ____/____/____ **Relationship**_____

Member ID _____ **Group Number** _____ **Co-Pay $** _____

Secondary Insurance Name _____ **Effective Date**_____

Policy Holder _____ **Date of Birth** ____/____/_____ **Relationship**_____

Member ID _____ **Group Number** _____ **Co-Pay $** _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (please read and sign)I hereby authorize Dr. Nidhi Koul to treat my child/ children for any illness in my absence and furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for medical services rendered to my dependents.

I UNDERSTAND COPAYMENT AND DEDUCTIBLE ARE DUE AND APAYABLE AT THE TIME OF SERVICE. It is my responsibility to provide proper insurance information to this office for staff to file insurance properly. I understand that I am responsible for any amount not covered by insurance. I further permit a copy of this authorization to be places in place of original.

_____ _____ _____

Signature of parent/ legal guardian **Relationship** **Date**

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ **Date of Birth** ___/___/_____

_____

Address City State Zip Code

I hereby authorize Bixby Pediatrics, PLLC (8315-D East 111th Street South Bixby, OK 74008) to:

Release to (who/where):

Name: _____Bixby Pediatrics PLLC_____

Address: _8315-D E. 111th St. S. Bixby OK 74008

Phone/ Fax: __918-394-6963 / 918-394-6962__

Obtain From Previous Pediatrician:

Name:_____

Address: _____

Phone/ Fax: _____

Photocopies of my child's medical records and/or health information.

Requested Information: (circle applicable)

1. Entire Designated Records
2. Patient Notes
3. Information created or received for other providers
4. Specify _____
5. Other_____
6.
6. Billing Records
7. Shot Records Only
8. X-Ray Reports
9. Lab Reports

For records release by Bixby Pediatrics, PLLC; I agree to pay $25 for each copy of medical records and I also agree to pay the actual cost of postage if the record is to be mailed.

I understand that this authorization will expire on ___/___/_____ (MM/DD/YY) Initials _____

I understand that I may revoke this authorization at any time by notifying Bixby Pediatrics, PLLC. In writing, but if I do so, such revocation shall hall no effect on any actions taken before receipt of my revocation. Initial _____ I further release Bixby Pediatrics, PLLC from the responsibility from any deleterious effect the release of my clinical medical records effect the release of my clinical medical records may have upon myself or others both now and in the future. I personally accept all responsibility for my own distributions and interpretations of medical information contained therein and hold blameless Bixby Pediatrics PLLC for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

By state law, you must be advised that: The information authorized for release may include records which may indicate the presence of communicable or non-communicable disease; or venereal diseases, which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS)

I realize by the release and / or receipt of these records that I am accepting responsibility for the protection of my own right and medical record confidentiality.

Signature of parent/parent/legal guardian Relationship (if other) Date

AUTHORIZATION FOR TREATMENT FOR A MINOR

Patient Name:_____ Date of Birth_____

I hereby authorize the following people to bring my child to an appointment in my absence to Bixby Pediatrics, PLLC, the clinic of Dr. Nidhi Koul, MD, for evaluation and treatment. I also grant permission to release any medical and/or billing information to the named designated person(s) listed below.

1._____ (First & Last Name, Relationship)

2. _____ (First & Last Name, Relationship)

3. _____ (First & Last Name, Relationship)

4. _____ (First & Last Name, Relationship)

5. _____ (First & Last Name, Relationship)

Parent/Guardian printed name: _____

Parent/Guardian Signature: _____**Date:** _____

Witness Signature:_____ **Date:** _____

Telephone Consent

1. Consent by telephone may be obtained when prompt treatment is needed or desirable if the patient is a minor.
2. Telephone consents require two witnesses.
3. Telephone consent is for date of service only. If further visits are required, a new consent form will need to be completed and on file.

Parent/Guardian printed name: _____

Parent/Guardian Signature: _____**Date:** _____

Witness Signature:_____ **Date:** _____

Authorized Signature Form/ Patient agreement.

Patient's Name----------Birthdate----------

DISCLOSURE OF INFORMATION: I understand that my medical records and billing information are made and retained by Bixby Pediatrics PLLC (BPPLLC) and are accessible to BPPLLC and medical staff. BPLLC and physician in attendance may use and disclose medical information for healthcare personnel involved in my continuum of care. Safeguards are in place to discourage improper access. BPPLLC personnel and medical staff are authorized to disclose all or part of my medical records to any insurance carrier, worker compensation carrier, or self-insured employer group liable for any part of BPPLLC charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that BPPLLC advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to syphilis, gonorrhea, HIV and AIDS. By signing this agreement, you are consenting to such disclosure.

ASSIGMENT OF INSURANCE BENEFITS

I agree that insurance benefits for BPPLLC charges payable to the insured are to be made payable to the BPPLLC and that the physician benefits otherwise payable to the insured are to be made payable to the BPPLLC responsible for my care.

PRECERTIFICATION POLICY

I understand that BPPLLC will assist with insurance precertification requirements which are the responsibility of the policy holder and /or physician, but will not assume responsibility for precertification or any impact which it may have on an insurance payment.

FINANCIAL RESPONSIBILTY

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for services rendered by BPPLLC. I agree to notify BPPLLC of any changes to my insurance or demographic information. I also agree that the demographic information that I have provided to BPPLLC is complete, correct and accurate.

CERTIFICATION: I hereby certify that I have read each of the above statements, and have had each item explained to me, to my satisfaction. I am aware that I can request a copy of my patient agreement at any time at no cost to me and /or have received a copy. I further certify that I am the patient or am duly authorized by the patient to accept the terms of this patient agreement. A photocopy of this document has the same effect as the original.

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by BPPLLC is in our NOTICE OF PRIVACY PRACTICES, Copies are available at the clinic.

Signature of parent/legal guardian Relationship Date signed

Print name of Parent/legal guardian/responsible Party's name

Basis of refusal, if refused.

CONSENT FOR MEDICAL INJECTION

Patient Name: _____ Patient DOB_____

I understand that it is medically recommended that my child receive immunizations as per the Center of Disease Control (CDC) immunization schedule, and American Academy of Pediatrics guidelines.

I understand that each vaccine will be discussed with me prior to administration. I will be given the Vaccine Information Statement for each vaccine and will be given the opportunity to ask questions.

The Vaccine Information Sheet(s) (VIS) from the Center for Disease Control (CDC) explain the vaccine(s) and the disease(s) they prevent. I will have the opportunity to discuss these with my child's doctor or nurse, who will answer all of my questions regarding the recommended vaccine(s), and the following information:

- The **purpose** of and the need for the recommended vaccine(s)
- The **risk and benefits** of the recommended vaccine(s)
- If my child does not receive the vaccine(s) **the consequences** may include:
    - Contracting the illness the vaccine should prevent (the outcomes of these illnesses may include one or more of the following: pneumonia, illness requiring hospitalization, death, brain damage, meningitis, seizures, and deafness. Other severe and permanent effects from these vaccine-preventable diseases are possible as well)
    - Transmitting the disease to others
    - Requiring my child to stay out of child care or school during disease outbreaks
- My child's doctor or nurse, the American Academy of Pediatrics, and the Center for Disease Control all strongly recommend that these vaccines be given according to recommendations.

I understand that by signing this form, I give consent for my child to receive recommended immunizations as per the CDC Immunization Schedule, including the influenza vaccine. ***I will be consulted on each vaccine given prior to administration.*** While I will be given specific information for each immunization, I will not need to sign individual consents for each vaccine.

I understand that I may address this issue with my child's doctor or nurse at any time and that I may re-visit decisions on immunization for my child anytime in the future.
I acknowledge that I have read this document in its entirety and fully understand it.

Parent/ Guardian Signature _____ Date _____

Witness_____ Date_____

Immunization Consent in the Absence of a Parent or Guardian

I understand that this consent covers all routine, recommended immunizations, unless otherwise specified by me. This includes visits during which my child is not accompanied by a legal guardian. The Vaccine information Sheet will be given to be taken home.

Parent/Guardian Signature _____ Date_____

Witness_____ Date _____

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 Signature Date

_____ _____

Provider Signature Date