We are pleased to welcome you to our practice. Please fill out all paperwork completely.
If you have any questions we will be glad to help.

PEDIATRIC NEW PATIENT INFORMATION (Please Print)

Patient's Legal Name: ______________________ ___ ______________________ **Date of Birth:** __________
First MI Last

Age: ______ **Social Security #:** ______________________ **Marital Status:** Married/ Single/ Widowed **Sex:** Male / Female

Address: ________________________________ **City:** ______________________ **State:** ______ **Zip Code:** ______

Home Phone: ______________________ **Cell Phone:** ______________________

Email address: ____

Race: _____ American Indian or Alaska Native _____ White
_____ Asian _____ Hispanic
_____ Black or African American _____ Other
_____ Hawaiian or Other Pacific Islander

Ethnicity: _____ Hispanic or Latino
_____ Not Hispanic or Latino

Language: ______________________

Employer: ____ **Phone#:** ______________________

EMERGENCY CONTACT

Name: ____ Phone: ______________________

Relationship to patient: ______________________________

INSURANCE INFORMATION (Please give the receptionist your insurance card to copy)

Primary: ______________________ ID#: ______________________ Group#: ______________

Subscriber Name: ______________________ Social Security#: ______________________ DOB: ____________

Secondary: ______________________ ID#: ______________________ Group#: ______________

Subscriber Name: ______________________ Social Security#: ______________________ DOB: ____________

WORK COMP/MVA INFORMATION

Is your injury work related? ☐ Yes ☐ No
Has a claim already been filed? ☐ Yes ☐ No
Is your injury due to a motor vehicle accident? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR BILL (If patient is a minor)

Name: ______________________________ DOB:______________ ss#:______________________

Address: ____ Phone: ______________________
(If different than patient)

AUTHORIZATION:

I hereby authorize my insurance benefits to be paid directly to the facility and the physician and I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge I have access to a copy of the Total Healthcare Partners/TPG/HPI Privacy Notice.

Print Name: ________________________________ **Signature:** ________________________________

Date: ______________________

PATIENT FINANCIAL RESPONSIBILITIES AND OBLIGATIONS

Thank you for choosing Total Healthcare Partners as your health care provider. Your clear understanding of our patient's financial responsibility is important to our professional relationship. **It is your responsibility to notify our office of any patient information changes (address, name, insurance information, etc).**

Co-pays/Balances: **All co-pays and balances are due at time of check-in. If your deductible has not been met you will be required to pay for your visit upfront until your deductible has been satisfied. Failure to pay all amounts due will subject you to collections efforts. Overdue accounts may be assigned to a third party debt collector.** We accept cash, check, money orders, Visa, MasterCard, and Discover.

Insurance Claims: In order to properly bill your insurance company, we require that you disclose all insurance information including: primary, secondary, as well as any change of insurance. Failure to provide complete insurance information may result in nonpayment by your insurance, thus you will be responsible for the entire bill.

Returned checks: The charge for a returned check is $35. This amount plus the amount of the check will be due. You will receive a notice from Checks Inc. regarding your account.

Personal Disclosures: The patient consents to the use and the release of their personal financial records to third party agencies for payment of medical claims.

I have read and understand the above Patient Financial Responsibilities policy and by signing this page I agree to the terms and conditions stated above.

______________________	______________________	__________
Print Name	**Signature**	**Date**

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

By state law you must be advised that: **The information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease, which may include, but are not limited to diseases such as Hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).**

I hereby authorize the physicians and staff of Total Healthcare Partners to release any and all medical records and also consent to having test results mailed for:

______________________ ______________________

Patient's full name (PRINT) Date of Birth

____

Social Security No.

______________________ ______________ ______ ________

Address City State Zip Code

All information is to be released to: ______________________

(Please list relationship to patient) ______________________

____

I understand this consent can be revoked at any time, except that disclosure is made in good faith has already occurred in reliance on this consent. Total Healthcare Partners, all employees and officers, and attending physicians are released from legal responsibility or liability for the release of the above requested information.

______________________ ______________________

Patient or Legal Representative (Print Name) **Signature**

______________________ ______________

If other than patient, provide relationship to patient **Date**

The Physicians' Group, LLC **HP Form 01**
HPI Physicians, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how The Physicians' Group, LLC or HPI Physicians, LLC, as applicable (the "Practice"), will use protected health information for the purposes of treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient's Name (print): ____

Patient's Date of Birth: ____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:

____

____

________________________________ **Date:** ______________
Signature of Patient or Patient's Personal Representative

Current Contact Information for Patient or Personal Representative signing this form:

Name (print): ____

Address: ____

Telephone Number: ____

Email: ____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgement but did not because:
______ It was emergency treatment.
______ I could not communicate with the patient.
______ The patient refused to sign.
______ The patient was unable to sign because ______________________.
______ Other: ______________________.

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dustin Baker MD, Joseph Broome MD, Stephen Brown MD, David Fisher MD, Russell Ingram MD, Wade McCoy MD, and Paul Rothwell MD, have an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

______________________________	______________________________
Signature of Patient	Signature of Parent or Guardian (if applicable)
______________________________	______________________________
Print Name of Patient	Print Name of Parent or Guardian

Date: ________________________

PEDIATRIC NEW PATIENT QUESTIONNAIRE

Patient Name (print): ________________________________ Age: _____ Sex: _____ Date of Birth: _____________

Preferred Pharmacy: ____

Mother's Name_________________________ Age_____ Father's Name_________________________ Age_____

Siblings' Names____

Medications

Please list all medications you are currently taking including dosage and strength:

____

Past Medical History

Previous Physician's name____ Date of last exam _______________

Which of the following conditions are you currently being treated for or have been treated for in the past (please check)

☐ Asthma ☐ Frequent Ear Infections ☐ Frequent Strep Throat ☐ Constipation

☐ Pneumonia ☐ Vision/Hearing problems ☐ Urinary Tract Infections ☐ Heart Problems

☐ Seizures ☐ Allergies ☐ Anemia

☐ Other: ____

Allergies Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

(List any allergic reactions to medications, foods, insect bites or stings)

Allergies: ____

Reactions to immunization? ☐ Yes ☐ No

If yes which ones? ____

Surgical History

List any Surgery and date: ____

Hospitalizations

List any Hospitalization and date: ____

Family History

Are the child's parents both in good health? Yes ☐ No ☐

List any significant chronic illnesses in the family: ____

Is there a smoker in the household? Yes ☐ No ☐

Do both parents live at home? Yes ☐ No ☐ If "No", with whom does the patient live? _______________________

Pregnancy and Birth **Mother's** age at child's birth ______

Child's birth weight ______ Type of delivery? Vaginal ☐ C-section ☐

Did mother have an illness during pregnancy? Yes ☐ No ☐ List illness: ______________________________

Did mother take medications other than vitamins? Yes ☐ No ☐ List: ______________________________

Was the baby premature? Yes ☐ No ☐ If "Yes", the baby was born at _______ weeks.

Did the baby have trouble in the hospital? Yes ☐ No ☐

If "Yes", what kind of trouble? ____

____ ________________________

Signature of Parent or Guardian **Date**