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 SOONERCARE 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
_____ Asian
_____ Black or African American
_____ Hawaiian or Other Pacific Islander
_____ White
_____ Hispanic
_____ Other

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**

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, education 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 you 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, Urgent Care Clinic or Hospital visit.
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 Name	Patient Date of Birth
_____	_____
Patient/Guardian Signature	Date
_____	_____
Provider Signature	Date