Patient Name: _____ DOB: _____ Date: _____

Patient History

Reason for Visit: _____

PEDIATRICIAN/Primary Care Physician: _____, or Soonercare assigned PCP _____

FOR FIRST-TIME PATIENTS : Please review this list and circle any doctors you have seen in the last 3 years

Jihan Abdul-Haqq, MD; Alana Adair, MD; Jennifer Baker, MD; Erica Faulconer, MD; Stephanie Grim, MD; Donald Hamilton, MD; Carla Hardzog-Britt, MD; Matthew Hatler, MD; Andrea Key, MD; Curtis Knoles, MD; Steven Krause, MD; Charles Leveridge, MD; Larissa Madore, MD; Juliana McClain, MD; R. Kevin Moore, MD; Tuyet (Megan) Pham-Nguyen, MD; Denise Scott, MD; Laura Shamblin, MD; Sonia Shukla-Ahluwalia, MD; Kala Sigler, MD; Joseph Stafford, MD; Richard Stanford, MD; Michael Vincent, MD

Patient's Current Medications: _____

ALLERGIES: _____

Past Surgery: _____ Inpatient Hospitalizations: _____

Major Medical Illnesses: _____

PATIENT -- REVIEW OF SYSTEMS

Check any item that applies to patient's ***current health*** – add brief comment if needed

GENERAL
___Weight Loss
___Fever
___Fatigue

EYES
___Glasses
___Blurred Vision
___Eye Pain
___Eye Discomfort

ENT
___Ear Pain
___Nosebleeds
___Sore Throat
___Hoarseness
___Nasal Stuffiness

CARDIOVASCULAR
___Heart Murmur
___Irregular Heart Beat
___Chest Pain
___Fainting Spells
___Blood Pressure Problems

RESPIRATORY
___Cough
___Wheezing
___Shortness of Breath

ENDOCRINE
___Loss of Hair
___Heat/Cold Intolerance
___Thyroid Problems
___Diabetes Mellitus

HEMATOLOGY
___Bleeding Problems
___Anemia
___Easy Bruising
___Enlarged Glands

GENITOURINARY
___Pain with Urination
___Blood in Urine
___Increased Urinary Frequency
___Abnormal Discharge

MUSCULOSKELETAL
___Joint Pain/Swelling
___Weakness
___Muscle Pain

NEUROLOGIC
___Headaches
___Seizures
___Dizziness

GASTROINTESTINAL
___Constipation
___Diarrhea/Vomiting
___Heartburn
___Blood in Stool
___Abdominal Pain

ALLERGY
___Hives/Eczema
___Hayfever
___Medication Allergies
___Food Allergies

PSYCHIATRIC
___Depression
___Appetite/other
___Developmental Delay

SKIN
___Rashes
___Sores
___Itching/Burning

Family -- Medical History of Immediate Family

___Anemia
___Asthma
___Cancer/Tumor
___Diabetes
___Depression
___Epilepsy/Seizures
___Heart Disease
___High Blood Pressure
___Liver Disease
___Hepatitis
___Kidney Disease
___Lung Disease
___Arthritis
___Stroke
___Thyroid Disease
___Infectious Disease
___GI Disease
___High Cholesterol
___HIV/Immune Disease
___Other

Change of Address? ☐no ☐yes _____

_____

Change of Phone Number(s)? ☐no ☐yes _____

Change of Insurance? ☐no ☐yes _____

_____

Use for Kid's 1st STAFF documentation only

Circle: NP EP if applicable> SC Self

Intake documentation:

___ All ROS systems reviewed with patient.

___ Only marked systems have been reviewed with patient.

____ initials of staff member/recorder

ROS & Family Hx reviewed by physician

⇦Other than as marked, Family History is non-contributory to today's encounter. _____

Notes:

KIDS 1ST PEDIATRIC AFTER HOURS CLINIC

12516 N. MAY AVE. STE B OKLAHOMA CITY, OK 73120
2820 N. KELLY, STE. 100 EDMOND, OK 73003
9821 S. MAY AVE. STE 102 OKLAHOMA CITY, OK 73159

NEW PATIENT INFORMATION (PLEASE PRINT) DATE _____

NAME _____ SEX: MALE FEMALE

BIRTHDATE _____ ETHNICITY _____

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

PREFERRED CONTACT/BEST NUMBER TO CALL _____

PARENT/GUARDIAN INFORMATION

FATHER'S NAME _____ BIRTHDATE _____

SS# _____ EMAIL ADDRESS _____

PHONE _____ ADDRESS _____

PARENT/GUARDIAN INFORMATION

MOTHER/S NAME _____ BIRTHDATE _____

SS# _____ EMAIL ADDRESS _____

PHONE _____ ADDRESS _____

FIRST AND LAST NAME OF PATIENT'S PEDIATRICIAN AND/OR PRIMARY CARE

PHYSICIAN _____ PHONE NUMBER _____

HOW DID YOU HEAR ABOUT US? TV __ INTERNET __ MAIL __ FRIEND/FAMILY __ REF BY DR __ OTHER ___

INFORMATION

PRIMARY POLICY INSURANCE COMPANY _____

ADDRESS _____ CITY _____ STATE _____

NAME OF INSURED _____ RELATIONSHIP _____

POLICY # _____ GROUP _____ COPAY _____

EMPLOYER _____

SECONDARY POLICY INSURANCE COMPANY _____

ADDRESS _____ CITY _____ STATE _____

NAME OF INSURED _____ RELATIONSHIP _____

POLICY # _____ GROUP _____ COPAY _____

EMPLOYER _____

INSURANCE IS FILED BY THIS OFFICE AS A COURTESY TO THE PATIENT, HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS THE PARENT'S RESPONSIBILITY TO BE AWARE OF BENEFITS THAT THEIR INSURANCE PROVIDES FOR SICK VISITS. ALL INSURANCE CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Kids 1st Pediatric After Hours Clinic to furnish information to the insurance carriers concerning my illness and/or treatment and hereby assign to the physician all payments for medical services rendered my dependents. I understand that I am responsible for any amount not covered by insurance.

DATE _____ SIGNATURE _____

Patient Name: _____ Date: _____

CONSENT TO TREAT MINOR CHILD

By signing below, I grant Kids 1st healthcare workers and staff permission to provide routine, emergency, or urgent care treatment for my child. I further give the staff permission to contact my child's primary care physician.

_____ _____

Signature of Parent/Guardian Date

CREDIT CARD ON FILE AUTHORIZATION

I agree to place my credit card on file to be charged by Kids 1st Pediatric After Hours Clinic for any patient responsibility charges. This includes any charges that may be due after they file a claim with my insurance company.

After they receive my processed claim from insurance, they will send me a notification of my balance. After 10 days, if other arrangements have not been made, my card on file will then be billed any balance left by my insurance carrier. This amount will be applied to my credit card as specified in the billing agreement.

I, _____, authorize Kids 1st Pediatric After Hours Clinic to run my credit card for the purpose(s) stated above.

Name on Card: _____

Authorizing Person (print name): _____

Signature of Authorizing Person: _____

BILLING AGREEMENT

I have read and agree to the terms laid out in the Kids 1st Pediatric After Hours Billing Agreement.

_____ _____

Signature of Parent/Guardian Date

NOTICE OF PRIVACY PRACTICE

My signature below indicated that I have received a copy of the "Notice of Privacy Practices and Release of Information" from Kids 1st and that I understand I may discuss any questions I have regarding this notice with the designated Privacy Officer for Kids 1st. I also authorize Kids 1st to copy and/or fax my child's/children's medical records at my request without an additional signed authorization.

_____ _____

Signature of Parent/Guardian Date

Kids 1st Pediatric After Hours Clinic Notice of Privacy Practices

Consent to the Use and Disclosure of Personal Health Information for Treatment, Payment, or Healthcare Operations

DISCLOSURE OF INFORMATION: As a part of your health and medical care, Kids 1st Pediatric After Hours Clinic originates and maintains medical records describing your child's health history, symptoms, examinations, test results, diagnoses, treatment, and any plan for future care or treatment. Kids 1st Pediatric After Hours Clinic, including physician and staff, may use and disclose your child's medical information for the following purposes:

- **TREATMENT:** We may use your child's health information to provide, coordinate or manage medical treatment or related services. **A COPY OF TODAY'S VISIT WILL BE FAXED TO YOUR PRIMARY CARE PROVIDER** if you give us their name.

- **PAYMENT:** We may use and disclose health information to bill or collect payment for services rendered from you and/or your insurance carrier. A full description of our billing agreement is provided and signed by all patients/ guardians.

- **LEAVING MESSAGES:** There are times when we cannot reach you and need to leave a message. We may use your or your child's information to contact you and leave a message on the provided phone numbers for nurse follow-up calls regarding your child's health.

- **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.

- **HEALTH CARE OPERATIONS:** We may use your child's health information to coordinate medical care with other health care providers. We may also use your child's health information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for Kids 1st.

INDIVIDUALS INVOLVED IN YOUR CHILD'S CARE:

Please list all individuals, including spouse, step-parent and/ or guardian who you authorize to have access to your child's information. We want to ensure protection of your child's information.

Name (Please print)	Relationship
Name (Please print)	Relationship
Name (Please print)	Relationship
Name (Please print)	Relationship

RESTRICTIONS:

I request to restrict the access of these records from the following individuals.

Name (Please print)	Relationship
Name (Please print)	Relationship

Kids 1st Pediatric After Hours Clinic Billing Agreement

Below are the billing practices for Kids 1st Pediatric After Hours Clinic effective January 1, 2012.

Please read the following document carefully and sign on the signature page.

OUR POLICY

Our clinic is available to the entire Oklahoma City Metro community, which makes billing a difficult task. Therefore, we ask that you provide your credit card information upon arrival to our clinic. At time of service, your credit card will be swiped. Your credit card information will be used to pay for your co-pay, and/ or additional payments due once your insurance company has processed your claim. Your credit card my also be used to process refunds due to you in the event of an overpayment. Any charges incurred that are not covered by insurance per your explanation of benefits (EOB) will be charged to your credit card. If your insurance company pays us in full, then your credit card will not be used. Your understanding with our policy is appreciated. Please see below (Credit Card on File Authorization) for more specific information. There are some cases where we will not request to have you credit card on file, including the following exceptions:

1) Patients who are self pay or filing their own insurance claim who pay the visit in full at the time of service will not be required to place a credit card on file.
2) Patients with ACTIVE and verified SoonerCare benefits will not be required to place a credit card on file.
3) Patients who have insurance but are willing to pay 100% of the visit using cash, check, or debit card at the time of service will not be required to place a credit card on file.

* We accept Visa, MasterCard, Discover, and American Express

CHECK PAYMENTS

All checks will be verified at the time they are presented to ensure there are sufficient funds in your account. If there are not enough funds, another form of payment will be required before we can provide services. We do not accept post dated or temporary checks.

RETURNED CHECK CHARGE

a $20.00 fee will be added to your account for returned checks. After receiving one returned check for insufficient funds, you will no longer be able to pay for services by check. Any balances due will need to be paid by cash, credit card, or money order. Any balance resulting from a returned check that is not resolved in a timely manner by you will be sent to the Oklahoma City District of Attorney's office for further action.

SELF-FILING PATIENTS

If your insurance company does not have a contract with Kids 1st, or wish to file your own claim, we will provide you with the information you need to file your own claim with your insurance company. It will be your responsibility to work with your insurance company to receive a reimbursement for the visit costs you incurred, which will be payable at the time of service.

SELF PAY PATIENTS

If you are a self pay patient, meaning your child has NO insurance coverage, you will receive a 20% discount at the time of service. You are responsible for making full payment for care at the times services are rendered. No discounts will be provided by Kids 1st after services have been rendered.

UNVERIFIED INSURANCE COVERAGE

Our office staff will attempt to verify your insurance coverage at the time of service. If we cannot verify that you have insurance, you will be required to pay the full amount of the visit at the time of service. Once you insurance coverage is verified, any payments received from the insurance company will be refunded to you. The refund will be returned to the credit card on file after we receive the Explanation of Benefits from your insurance company.

SEPARATED/DIVORCED FAMILIES

For any family where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible for the payment, and payment is due when services are rendered. Even though only a co-pay may be due at the time of service, there may be other charges that the insurance company determines are your

responsibility. In these cases, the parent who authorized treatment will be responsible for paying these charges. If the divorce decree requires both parents to split the charged incurred, it is the authorizing parent's responsibility to collect from the other parent. Kids 1st will not act as a mediator in collecting payments.

Know your insurance benefits. Your insurance plan is a contract between you and your insurance company, even if your employer provides it. We provide the medical service and submit the claim on your behalf. **It is the policy holder's responsibility to know their insurance benefits. Kids 1st cannot know every detail to your specific plan. Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility.** You will be responsible for any portion of services that your insurance does not cover. You should familiarize yourself and those bringing in your children for service with the insurance policy. This includes any specific laboratory requirements should a sample need to be submitted to an off-site lab for analysis.

Kids 1st Pediatric After Hours Clinic Credit Card on File Authorization
Kids 1st Pediatric After Hours Clinic requires a patient credit card on file except for the specific instances outlined in the Billing Agreement. Transaction Central is the credit card transaction company that we utilize. Transaction Central stores your information at separate and secure site and enables us to run credit card transactions within our computer system.

Credit cards on file will be used for one or more of the following purposes:

- **CO-PAYS**

If you owe a co-pay, you will be required to pay the full co-pay amount at the time of the visit, prior to services being rendered.

- **BALANCES**

If your insurance carrier does not cover certain parts of the visit, then the credit card on file will be charged for the amount deemed to be the patient's responsibility. **However, we will first send you a notification that there is a balance on your account, allowing you to send in or call with an alternate form of payment. If no response is made to the notification within 10 days, the credit card on file will be charged for the owed amount.**

- For all patient responsibility amounts assigned to you by your insurance company, our office reviews these amounts to ensure your claim has been properly processed. If there is a discrepancy with your insurance claim, where the insurance company will not cover a service, you will need to contact your insurance carrier. Members typically receive their Explanation of Benefits before the provider does, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.
- If it is determined that your credit card was charged in error, you will be issued a refund back to the card we have on file.
- If the credit card we have on file expired or becomes unusable, we will expect you to promptly provide a new payment source.
- If you receive a credit to your account after insurance has paid your claim, the credit card on file will be reimbursed.

If you have a previous balance, you will be required to pay your past due balance plus the charges for your current visit prior to services being rendered.

- **DEDUCTIBLE PLANS**

If you have a deductible plan with an insurance company contracted with Kids 1st, you will be required to pay 100% of your visit at the time of service. Kids 1st will then file a claim for the visit. Any payments received from the insurance company will be refunded to you via your credit card on file after we receive the Explanation of Benefits for the payment from the insurance company.

- **CO-INSURANCES**

We require for you to pay the entire percentage not covered by your insurance company at the time for service; for example, if your insurance company pays for 90% of the visit, then we will require you to pay for the 10% of the visit at the time of service.