TREASURED
PEDIATRIC CARE
Hilary Nicholson, APRN-CNP

PATIENT REGISTRATION

(USE BLACK INK ONLY)

Patient Demographic Information:

(*STATE REQUIREMENT)

***Child's Full Legal Name:**_____
(Last, First, Middle)

Home Address:_____ _____
(Street) (City, State, Zip)

***Date of Birth:**_____ ***Ethnicity: Hispanic / Not Hispanic**

***Race: Caucasian / Native American / African American / Asian**

Place of Birth:_____ Mother's Maiden Name:_____
(City, State)

Parent/ Guardian Information:

(*Required Information)

*Guardian Name:_____
(Last, First, Middle)

*Home Address:_____
(Street, City, State, Zip Code)

*Date of Birth:_____ Social Security Number:_____

*Home Phone:_____ Cell Phone:_____

Relationship:_____ Email:_____

Employer:_____ Work Phone:_____

Other Responsible Party:_____

Home Address:_____
(Street, City, State, Zip Code)

Phone:_____ Relationship:_____

Family Information:

Sibling Name:_____DOB:_____Relationship:_____

Sibling Name:_____DOB:_____Relationship:_____

Sibling Name:_____DOB:_____Relationship:_____

Sibling Name:_____DOB:_____Relationship:_____

Sibling Name:_____DOB:_____Relationship:_____

Sibling Name:_____DOB:_____Relationship:_____

Sibling Name:_____DOB:_____Relationship:_____

Sibling Name:_____DOB:_____Relationship:_____

Primary Insurance Information:

*Insurance:_____*Policy#_____*Group#_____

Phone:_____*Policy Holder:_____

*Policy Holder DOB:_____

Secondary Insurance Information:

Insurance:_____Policy#_____Group#_____

Phone:_____Policy Holder:_____

Emergency Contact:

Name:_____

Phone:_____ Relationship:_____

Name:_____

Phone:_____ Relationship:_____

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AUTHORIZATION FOR TREATMENT OF MINOR CHILD

Patient's Full Name: _____ *Date of Birth*: _____

I/ We, the parent(s)/ legal guardian(s), of the minor child listed above do authorize the providers of Treasured Pediatric Care Hilary Nicholson APRN-CNP, PLLC (TPC) to provide health services to this minor.

This health service may include, but is not limited to:

-examination,
-preventative and/ or curative treatment,
-radiology,
-laboratory,
-anesthetic,
-medical/ surgical diagnosis,
-any consultation deemed necessary at the provider's discretion.

Services shall not include research or experimentation.

It is also understood that TPC will bill my insurance company for services received. ***I understand that I will be responsible for charges*** that insurance does not cover including those resulting from a no-call, no-show appointment. I authorize the release of all necessary medical information to insurance carriers, third party payers, and billing companies as may be required or requested for the processing of claims for payment of services. I understand that I may obtain copies of my child's medical record at any time. However, if there is an outstanding balance on my account then there may be a charge of $.50 per page for the records, up to a maximum of $200 plus postage (if applicable), according to the Oklahoma Statutes Title 76 Section 19- Access to Medical Records. The Privacy Rule does not require the health care provider to share information with other providers.

This consent is valid until I provide TPC with written revocation or until the minor child may legally consent for him/ herself.

*Signature of parent/ legal guardian:*_____

*Date:*_____ *Relationship:* _____

*Signature of parent/ legal guardian:*_____

*Date:*_____ *Relationship:* _____

TREASURED
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AUTHORIZATION FOR TREATMENT TO MINOR CHILD IN THE ABSENCE OF PARENT/ GUARDIAN

This form is designed for those situations where a minor child is unaccompanied by either parent(s) or legal guardian(s) and gives authority to a designated adult to arrange for medical care.

Patient's Full Name: _____ *Date of Birth*: _____

Person(s) authorized to seek medical care on behalf of the patient:

Name: _____ *Relationship:* _____

Name: _____ *Relationship:* _____

I do hereby authorize the above person(s) to consent to any examination for preventive and/ or curative treatment, radiology, laboratory, anesthetic, medical/ surgical diagnosis, or any consultation deemed necessary by the providers at Treasured Pediatric Care Hilary Nicholson APRN-CNP.

Parent/ Legal Guardian Printed Name: _____

Parent/ Legal Guardian Signature: _____

Date Effective: _____ *Date of termination:* _____
(leave blank if this is an ongoing consent)

GUARDIAN CONSENT FOR SHARING PROTECTED HEALTH INFORMATION (PHI)

I, _____, give Treasured Pediatric Care Hilary Nicholson APRN-CNP, PLLC (TPC) permission to speak with the following people regarding my child's health information. This includes authority permission to discuss payment for health services received from TPC. I understand that sharing health information with specialists and other health providers is necessary and not excluded by this form. This form gives TPC permission to share health information with non-professionals such as extended family members should I desire.

This consent is valid until I provide TPC with written revocation.

Patient's Full Name: _____ *Date of Birth*: _____

Treasured Pediatric Care staff may speak with:

____***NO ONE EXCEPT PARENT(S) OR LEGAL GUARDIAN(S)***

Name: _____ *Relationship:* _____

Name: _____ *Relationship:* _____

Name: _____ *Relationship:* _____

Name: _____ *Relationship:* _____

****

I have received a copy of Treasured Pediatric Care Hilary Nicholson APRN-CNP, PLLC Notice of Privacy Practices, and consent to the sharing of PHI as outlined therein.

Parent/ Legal Guardian Signature: _____

Date Effective: _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____ *Date of Birth*: _____

Mother Full Name: _____ Mother DOB: _____

I hereby authorize Treasured Pediatric Care Hilary Nicholson APRN-CNP, PLLC staff to _____***release or*** _____***obtain*** records pertaining to my child's medical care and treatment.

RELEASE TO:

Treasured Pediatric Care

1101 W Main, Suite 112

Collinsville, OK 74021

(P) 918-553-8613/ (F) 918-371-2332

OBTAIN FROM:

_____
Name of designated Facility/ Provider

_____
Address

_____
City, State, Zip Code

_____
Phone

Information to be released:

_____ All medical records _____ Chronic diagnosis and medication list _____ Last well exam _____ Vaccine record

_____ Last visit _____ Other_____

Purpose for which request is being made:

_____ Continuity of care _____ Self _____ Attorney _____ Other_____

My Rights:
I understand that I do not have to sign this authorization in order to obtain health care benefits. I may revoke this authorization in writing by following the process described in the Notice of Privacy Practices posted in this office. I understand that the Provider has no control over any information/ records released to any other person, firm or agency under this Authorization and it is, therefore, possible that a release of this information/ records may occur by such other party. I understand that if I am requesting records for release to me or a patient representative, laws may prevent certain records from being released to the patient, parent or legal guardian but in certain situations, patients may request a copy of the denial.

I release Treasured Pediatric Care Hilary Nicholson APRN-CNP, PLLC and staff from any liability in connections with the use or disclosure of the information/ records released to any party pursuant to this Authorization.

_____ _____ _____
Signature of Patient or Patient's Authorized Representative | Date | Relationship to Patient

TREASURED
PEDIATRIC CARE
Hilary Nicholson, APRN-CNP

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 preventative 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 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, by treating us with dignity and respect in effort to meet all of your healthcare needs.
2. Communicate with us about all of your health care concerns and goals.
3. Report any changes related to your health, treatments, medications, etc.
    a. This includes use of all medications-- prescriptions, over-the-counter, herbal and street drugs.
    b. 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 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, if you fail to communicate with dignity and respect, or if you 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: _____

Parent/ Legal Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

TREASURED PEDIATRIC CARE
Hilary Nicholson, APRN-CNP

Vaccination Policy

We advocate following the American Academy of Pediatrics' recommendations for the immunization of children. Vaccines protect children and their families and friends from dangerous and life threatening diseases. Each vaccine has been thoroughly studied, approved and recommended by the Food and Drug Administration (FDA) and Center for Disease Control (CDC). The term vaccine and immunization are typically used interchangeably but vaccination is when a vaccine is administered to you and immunization is what is achieved after the vaccine is administered to you. The state of Oklahoma also has required childhood vaccines for daycare/ preschool/ school entry and we do not recommend delaying or refusing any of these vaccines.

We recommend the following websites to assist you as you learn about the benefits of vaccinations for your child:

- American Academy of Pediatrics:
  - https://www.healthychildren.org/English/safety-prevention/immunizations/Pages/default.aspx?_ga=2.239818883.169347192.1628513905-1061460560.1516224658&_gl=1*1wl9217*_ga*Mjg5NDk1MTU4LjE3MjkxNDIyMzI.*_ga_FD9D3XZVQQ*MTcyOTU0MjIzMS4xLjEuMTcyOTU0MjU0OS4wLjAuMA..
- Vaccinate your Family:
  - www.vaccinateyourfamily.org
- Vaccine Education Center at the Children's Hospital of Philadelphia:
  - www.chop.edu/centersprograms/vaccine-educationcenter
- Immunize.org
  - www.immunize.org
- Center for Disease Control and Prevention:
  - Vaccines for Your Children | Childhood Vaccines | CDC
- US Food and Drug Administration:
  - http://www.fda.gov/biologicsbloodvaccines/vaccines/default.htm

OUR OFFICE POLICY:

- Childhood vaccines are scheduled to be given at 2mo, 4mo, 6mo, 12mo, 15mo, 18mo, 4yr, 11yr and 16yr well child exams.
- We provide Vaccine Information Sheets (VIS) at every well child exam and discuss what the vaccine is, the protection it provides and any normal side effects to expect.
- Childhood vaccines required by the state of Oklahoma for daycare/ preschool/ school entry must be started by age 6 months.
- We will accommodate a slow vaccine schedule if desired, although we don't recommend this schedule because it leaves your child vulnerable to disease and illness.
- We will also work with families in the event that a child is behind on vaccinations, building a catch-up schedule with no more than 5 injections at one visit.
- If you choose not to comply with our policy, we will regretfully ask you to seek medical care with another medical office whose philosophy meets your needs better.

***This policy EXCLUDES COVID vaccine, ANNUAL FLU vaccine and GARDASIL vaccine which are all recommended but not required.**

Signature of parent/ legal guardian:_____ Date:_____