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:**_____

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

***Ethnicity: Hispanic / Not Hispanic**

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

Guardian Demographic 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:_____

AUTHORIZATION FOR TREATMENT OF MINOR

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

I/ We, the undersigned parent(s)/ legal guardian(s), of the minor person 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 also understand that I will be responsible for charges 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.

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

*Signature of parent/ legal guardian:*_____

*Date:*_____ *Relationship:* _____

*Signature of parent/ legal guardian:*_____

*Date:*_____ *Relationship:* _____

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

This form is designed for those situations where minors are unaccompanied by either parent(s) or legal guardian(s). This form gives authority to a designated adult to arrange for medical care for a minor in the absence of the parent or legal guardian.

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

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

Name: _____ *Relationship:* _____

Name: _____ *Relationship:* _____

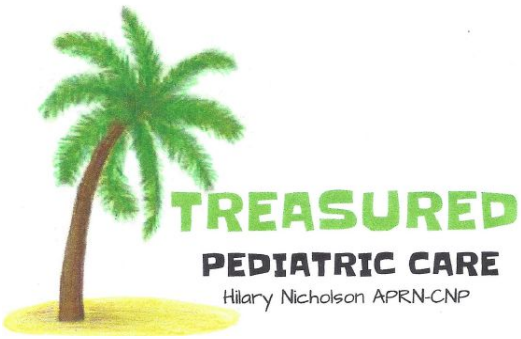
The undersigned do hereby authorize the above person(s) to consent to any radiology, laboratory, anesthetic, medical or surgical diagnosis, treatment and/ or hospital care for the above named minor which is deemed advisable by the providers at Treasured Pediatric Care Hilary Nicholson APRN-CNP and to be rendered under the general or special supervision of any physician and/ or surgeon, licensed under the Provision of Medicine Practice Act, whether such diagnosis or treatment is rendered at the office of said physician, or at a hospital, or elsewhere.

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 PHI

I, _____, give Treasured Pediatric Care Hilary Nicholson APRN-CNP (TPC) permission to speak with the following people regarding my child's personal health information. This includes permission pertaining to diagnosis, treatment options and plans. It also includes permission to discuss payment for health services received from TPC. I understand that sharing health information with specialist 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 use of PHI as outlines therein.

Parent/ Legal Guardian Printed Name: _____

Parent/ Legal Guardian Signature: _____

Date Effective: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

I hereby authorize Treasured Pediatric Care Hilary Nicholson APRN-CNP, PLLC staff to _____***release or*** _____***obtain*** records pertaining to my medical care and treatment which could include information about communicable disease, venereal disease, mental health, or drug, substance or alcohol abuse.

RELEASE TO:

Treasured Pediatric Care
Name of designated Facility

1101 W Main, Suite 112
Address

(P)918-553-8613

Collinsville, Ok 74021 **(F)918-371-2332**
City, State, Zip Code

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

MEDICAL HOME AGREEMENT

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: _____