NORMAN PEDIATRIC AFTER HOURS CLINIC

PATIENT REGISTRATION

Patient Name____ Date of Birth__________ M F
LAST FIRST MI

Patient Name____ Date of Birth__________ M F
LAST FIRST MI

Patient Name____ Date of Birth__________ M F
LAST FIRST MI

FATHER'S INFORMATION

Name____ Date of Birth ____________________
LAST FIRST MI

Address____ City_________________State_____Zip______

Home Phone Number______________________________ Social Security Number ________________

Cell Phone Number______________________________ Business Phone Number________________

Email Address:____

Employer______________________________________ Occupation___________________________

MOTHER'S INFORMATION

Name____ Date of Birth ____________________
LAST FIRST MI

Address____ City_________________State_____Zip______

Home Phone Number______________________________ Social Security Number ________________

Cell Phone Number ______________________________ Business Phone Number________________

Email address:____

Employer______________________________________ Occupation___________________________

INSURANCE

Primary Insurance ____________________________Policy Holder Name__________________________

ID # __________________________Group #______________________Copay Amount_______________

Secondary Insurance ___________________________Policy Holder Name__________________________

ID # __________________________Group #______________________Copay Amount_______________

Parents are responsible for knowing and understanding the benefits and limitations of their insurance coverage.

HOW DID YOU HEAR ABOUT US?

- □ Doctor Referred You
- □ Friend
- □ Returning Family
- □ Saw Our Sign
- □ Google or Facebook Page
- □ www.NormanPediatricAfterHours.com
- □ Brochure
- □ Other: _______________

Primary Care Physician (name and phone #): ____

EMERGENCY CONTACT OTHER THAN PARENT

Name____ Relationship_______________________

Home Phone Number ________________________ Work Phone Number: _______________________

Cell Phone:____

RESPONSIBLE PARTY: In situations where parents are not in the same household, to whom should all billing statements and any correspondence be sent? [ ] Father [ ] Mother [ ] Other

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PHARMACY

Pharmacy Name:____

Pharmacy
Location/Crossroads:____

AUTHORIZATION

I. GENERAL CONSENT TO TREATMENT

I agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by the patient's physician(s). I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or medical treatment.

II. RELEASE OF INFORMATION

I authorize physicians providing services on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care, the Social Security Administration, Medicare, Medicaid (or their various intermediaries), and the insurance company, health maintenance organization, employer, person acting on behalf of a preferred provider arrangement or third party affiliated with the patient's care (or any of their agents or representatives), when such information is requested for payment, worker's compensation, utilization review, or coverage determination purposes. I understand that this authorization will remain in effect unless revoked by me in writing and delivered to this physician's office.

III. ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE

I authorize any third party payor to pay directly to the physicians providing services to the patient, all benefits due and payable as a result of services rendered.

IV. ACKNOWLEDGMENT OF RESPONSIBILITY TO PAY FOR SERVICES

I understand that the physician will, as a courtesy, file claims with insurance carriers and third party payors. However, I acknowledge and agree that, except as provided by law, and in consideration of the services provided, I will pay any charges which, for any reason, are not paid by any third party payor unless there is a specific written agreement between the physician and the patient and the payor.

V. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (405)321-5114.

VI. ADMINISTRATIVE FEES

Late fees will be assessed if payment is not received by the statement due date.

Signature below is acknowledgement that you have received this notice and agree to the provisions therein.

________	____________________________	____________________
Date	Parent/Guardian's Signature	Relationship to Patient