Pediatric Cardiology of Oklahoma, PLLC
a place with heart

6151 South Yale Ave., Suite 2402, Tulsa, OK 74136
Tel: 918-481-4600 Fax: 918-481-4650
Email: info@kidsheartdoc.com

PATIENT INFORMATION

Patient
Name _____ D.O.B. _____ Male ___ Female ___

Patient
Address _____ City _____ State ___ Zip _____

Patient Social Preferred
Phone # _____ Security # _____ Language _____

Referred
By _____ Phone # _____

Patient's Primary
Care Physician _____ Phone # _____

The Patient
Lives With? Both Parents ___ Mother ___ Father ___ Other _____

Who is Responsible
For the Patient? _____ Preferred Pharmacy _____

Is the Patient Is the Patient
In Foster Care? _____ In DHS Custody? _____ Race _____ Ethnicity _____

Who Can Bring the
Patient to Appointments? _____

Why are We
Seeing the Patient? _____

_____

Has the Patient had If Yes,
Any Heart Exams? _____ Explain _____

_____

_____

GUARANTOR / PARENT RESPONSIBLE / GUARDIAN / FOSTER PARENT / OTHER

Mom's
Name _____ Address _____

City _____ State ____ Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ Social Security # _____ D.O.B. _____ Employer _____

Dad's
Name _____ Address _____

City _____ State ____ Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ Social Security # _____ D.O.B. _____ Employer _____

PERSON RESPONSIBLE FOR BRINGING THE PATIENT TO THE APPOINTMENT

Person's
Name _____ Address _____

City _____ State ____ Zip _____ Home Phone _____ Work Phone _____

Cell Phone _____ Social Security # _____ D.O.B. _____ Employer _____

Is this Person a Foster Parent? _____

Is this Person a Legal Guardian? _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Phone # _____ Relationship To Patient _____

FINANCIAL INFORMATION

Primary Insurance _____ I.D. Number _____ Group Number _____

Insured Party Name _____ D.O.B. _____ Relationship To Patient _____

Secondary Insurance _____ I.D. Number _____ Group Number _____

Insured Party Name _____ D.O.B. _____ Relationship To Patient _____

OKLAHOMA MEDICAID DISABILITY

ID Number _____

Case Worker Name _____

County _____

Medicaid Provider _____

ASSIGNMENT OF BENEFITS

_____ (name of insured) hereby authorize

_____ (name of insurance company) to pay and assign directly to Pediatric Cardiology of Oklahoma, P.L.L.C. all benefits, if any payable for services described on the claim form submitted.

I understand that I am responsible for paying any amounts not paid by the above insurance company due to co-payment amounts or services not covered under the plan benefits. I further acknowledge that any insurance payment(s), when received and paid to Pediatric Cardiology of Oklahoma P.L.L.C. will be credited to my account in accordance with the above assignment.

THE FOLLOWING IS NOT AN AUTHORIZATION TO RELEASE MEDICAL RECORDS. IT IS TO OBTAIN YOUR CONSENT TO SHARE INFORMATION WITH OTHER ENTITIES FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS.

I understand that as a part of the health care provided by this clinic, medical and health records must be maintained describing the patient's health history, symptoms, examinations, test results, diagnosis, treatment and plans for future care of treatment. This information will serve as a basis for the planning of care and treatment, communication between other doctors, hospitals or other health care professionals contributing to care; a source of information for applying the diagnosis and treatment to my account information for billing purposes; a means for a third party payer to verify services were billed correctly; a tool for routine healthcare operations.

I also understand and agree that this consent to share information shall apply to all information accumulated up to this date and to any information collected in the future. This agreement to share future information shall remain in effect until such time as it is revoked in writing by a parent, legal guardian, or other authorized person or entity as applies to the laws of the state of OKLAHOMA.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand Pediatric Cardiology of Oklahoma reserves the right to change their privacy practices, but will provide any revised notice as necessary. I understand that I have the right to request restrictions as to how health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that PEDIATRIC CARDIOLOGY OF OKLAHOMA is not required to agree to the restrictions requested. I understand that I Must revoke this restriction in writing. I understand that the clinic may have, relying on prior consent, already shared information prior to receiving the written revocation.

By Oklahoma law we are required to notify you – that the information authorized for release may include records which may indicate the presence of communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, herpes, gonorrhea, and Human Immune Deficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Information may be released to the following individuals for the indicted purposes:

Transcriptionist (for typed information which goes in the patient chart)
Hospital (for continuing care, obtaining tests, consultation with other healthcare professionals, record keeping, billing information)
Primary Physicians or Specialist Physician involved in the patient's care
Third Party Payer (insurance, DHS, etc.) for verification of services or diagnosis

I request the following restrictions to the use and/or disclosure of the patient's health information (We must follow the guidelines of Oklahoma Law)

_____

_____

Signature _____ Relationship To Patient _____

This organization ____ accepts ____ denies ____ accepts conditionally the restrictions imposed on the release of information as stated above.

Signature _____ Title _____ Date _____

NO SHOW POLICY

Pediatric Cardiology of Oklahoma is an extremely busy clinic due to the shortage of pediatric cardiologists throughout the state of Oklahoma. We ask that you give at least a 24 hour notice if you will not be able to make your appointment.

Due to the number of patients we see every day and the amount of people on our waiting list we will not tolerate NO SHOW appointments. When you NO SHOW an appointment your next appointment will be scheduled at the first available time slot and will NOT be worked in. This document is to inform you that if you NO SHOW appointments you are taking a risk of not being able to schedule future appointments with this office. By signing below you are acknowledging you have read this policy.

Signature _____ Date _____