pediatric ENT
OF OKLAHOMA
A DIVISION OF
McBRIDE ORTHOPEDIC HOSPITAL

9900 Broadway Ext, Ste #200
Oklahoma City, OK 73114
Phone: 405.608.8833
Fax: 405.608.8818

Please complete and PRINT (one-sided) to bring with you. Paperwork cannot be submitted online. To protect your patient privacy (HIPAA), please do not email paperwork.

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Sex: _____ Home Phone: _____ Cell: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Email: _____

Race: _____ Ethnicity: ❍ Hispanic ❍ Non-Hispanic Preferred Language: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Parent(s) or Legal Guardian (children only)

Parent: _____ Date of Birth: _____ Social Security #: _____

Parent: _____ Date of Birth: _____ Social Security #: _____

Insurance

Company Name: _____ Address: _____

Policy #: _____ Group #: _____ Effective Date: _____ Co-Pay: _____

Subscriber's Name: _____ Date of Birth: _____ Social Security #:_____

Relationship: _____ Insurance Phone: _____

Secondary Insurance

Company Name: _____ Address: _____

Policy #: _____ Group #: _____ Effective Date: _____ Co-Pay: _____

Subscriber's Name: _____ Date of Birth: _____ Social Security #:_____

Relationship: _____ Insurance Phone: _____

I give permission to you and any agent of Pediatric ENT of Oklahoma to contact me on any phone number/email I have provided to you, including my cell phone, for the purpose of collecting my debt, appointment reminders and changes. I fully understand my rights as a patient/caregiver.

Parent/Guardian Signature: _____ Date: _____

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Patient Name: _____ Date of Birth: _____

CONSENT TO MEDICAL CARE

I hereby authorize the physician(s) in charge of the care of the patient of Pediatric ENT of Oklahoma to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I request admission to McBride Orthopedic Hospital and authorize the facility, staff and physicians to provide care. I request and consent to medical care and diagnostic procedures that my attending physician(s), or his/her designees, determine are necessary. I acknowledge that the medical care I receive while in McBride Orthopedic Hospital is under the direction of my attending physician(s) and that McBride Orthopedic Hospital is not responsible for acts of omission of my attending physician(s). I authorize McBride Orthopedic Hospital to retain or dispose of any specimen or tissue taken from the above-named patient.

DISCLOSURE OF INFORMATION

I hereby authorize the physician(s) of Pediatric ENT of Oklahoma to disclose any or all information in my medical records to any person, corporation, or agency which is or may be liable for all or part of Pediatric ENT of Oklahoma charges or who may be responsible for determining the necessity, appropriateness, amount, or other manner to the physician's treatment of charge including carriers, welfare funds, the Social Security Administration or its intermediaries or carriers. The undersigned agrees that all records concerning this patient's hospitalization shall remain the property of the facility. The undersigned understands that medical records and billing information generated or maintained by the facility are accessible to facility personnel and medical staff. Facility personnel and medical staff may use and disclose medical information for treatment, payment and healthcare operations and to any other physician, healthcare personnel or provider that is or may be involved in the continuum of care for this admission. The facility is authorized to disclose all or part of the patient's medical record to any insurance company, third party payor, workers' compensation carrier, self-insured employer group or other entity (or their authorized representatives) which are necessary for payment of patient's account. Law requires that the facility advise the undersigned that THE INFORMATION RELEASED MAY INDICATED THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). The facility is authorized to disclose all or any portion of the patient's medical record as set forth in its Notice of Privacy Practices, unless the patient objects in writing. By signing this form, you are authorizing such disclosures.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Pediatric ENT of Oklahoma from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

LATE TO APPOINTMENT POLICY

We strive to see every patient as close to their appointment time as possible. We request new patients arrive 15 minutes before your appointment. If you are late by 15 minutes or more, you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in around them, leading to a considerable wait time. If this is not convenient for you, you may choose to reschedule.

I understand a photocopy of this document is as valid as the original.

Parent/Guardian Signature: _____ Date: _____

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LATE, MISSED OR NO SHOW POLICY

LATE TO APPOINTMENT POLICY:

If you are a **NEW** patient, we ask that you arrive 25 minutes prior to your appointment time. All other appointments, we request that you arrive 15 minutes prior to your appointment time. This ensures there is plenty of time to update insurance, photo ids, and paperwork, if needed.

If you are late by 15 minutes or more, you will likely be asked to reschedule, unless the provider's schedule can still accommodate you. Priority will be given to the patients who arrive on time, and you may have to be worked in between them. This could mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience for everyone. We strive to see every patient as close to their appointment time as possible, and we ask that you please be courteous of your provider's time and attention. The providers, office staff, as well as your fellow patients, will thank you.

MISSED APPOINTMENT OR "NO-SHOW" POLICY:

While we make every effort to provide a reminder call, text, or email at least 24 hours prior to your appointment, it is your responsibility to remember your appointment. If you feel we do not have the correct demographic information, please contact the clinic at 405-608-8833.

If you cancel less than 24 hours prior to your appointment, it will be considered a "No Show." If a patient "No Shows" at a NEW patient appointment, you will not be rescheduled. Your referring provider will be notified. For established patients, two "No Shows" within the last 24 months will result in a dismissal warning. If you have three or more "No Shows" within the last 24 months, you will be dismissed by the practice at the provider's discretion.

Your signature acknowledges receipt:

_____ _____

Patient Signature Date

_____

(Printed Name)

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Alternate Caregiver Consent Form

Except for life threatening emergencies, we are not able to treat your minor child unless they are accompanied to our office by a parent, legal guardian, or a designated adult. To appoint an adult to bring your child into our office for medical care in your absence, you must have the following form(s) completed, signed, and on file for each of your children. The designated adult must be a first order relative (parent, stepparent, sibling, step sibling, grandparent, aunts, or uncles). If a nanny, private sitter, or a friend brings your child in we must be able to reach you to discuss treatment. Minor children reporting for an appointment without a parent, legal guardian, an adult named in a signed designee form or a signed note from a parent may need to be rescheduled. I authorize the following individual(s) to bring in my children to their appointment:

Name:_____ Relationship to my child: _____

Name:_____ Relationship to my child: _____

Name:_____ Relationship to my child: _____

Name:_____ Relationship to my child: _____

I attest that the above-named individual(s) are all 18 years of age or older as of this date. I authorize the above-named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, vaccinations, procedures, and hospitalizations. Pediatric ENT of Oklahoma may relay any medical information about my child necessary for the above-named individual(s) to supply in-formed consent to the treatment. I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings in the child, and that under most circumstances, a follow up call to me personally should not be necessary. I agree to hold Pediatric ENT of Oklahoma and its staff harmless for any disagreement between the above-named individual(s) and myself about treatment decisions. I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke authorization for any or all individuals at any time.

Child covered by this consent:

Last Name, First Name: _____

Date: _____/_____/_____

Signature of Parent/Legal Guardian _____

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Patient Name: _____ Date of Birth: _____

FINANCIAL POLICY

Insurance
As a courtesy to our patients, Pediatric ENT of Oklahoma will gladly file the forms necessary so that you receive full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of the services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or otherwise we do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort in obtaining your insurance payment, we cannot force your insurance company to pay for the services we provide to you.

Patient/Parent/Guardian Responsibility

- I understand that whoever accompanies my child to their appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services.
- I acknowledge my responsibility for payment of all services provided by Pediatric ENT of Oklahoma in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for the payment.
- At the initial visit, you may sign our consent for minor treatment form that allows us to render care at follow-up visits without the presence of a parent or guardian.

Assignment and Release
I authorize payment to be made directly to Pediatric ENT of Oklahoma by my insurance company, and I accept financial responsibility if services are not covered by my insurance. I agree that, to the fullest extent permitted by law, Pediatric ENT of Oklahoma may remit all or a portion of any credit balances or other amounts due to me from Pediatric ENT of Oklahoma to any affiliates whom I have balance owing for fees, items, or services. I authorize release of any medical information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Parent/Guardian Signature: _____ Date: _____

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ENT CASE HISTORY

Date: _____ Patient Name: _____ DOB: _____

Pediatrician/Family Physician: _____

Pharmacy Name & Address: _____

Have you ever seen one of our providers in the past? ❍ Yes ❍ No
Are your child's immunizations up-to-date? ❍ Yes ❍ No
Is the child exposed to second hand smoke? ❍ Yes ❍ No

Surgical History:

❍ Patient has had no surgeries
❍ Ear surgery
❍ Cleft lip/palate repair
❍ Sinus surgery
❍ Ear tube insertion
❍ Heart surgery
❍ Airway surgery
❍ Tonsils removed
❍ Adenoids removed
❍ VP shunt
❍ Other: _____

Allergies: ❍ No known allergies _____

Medications: ❍ No medications at this time _____

Please check any symptom below that is currently a problem for the patient:

General:
❍ Fevers
❍ Chills
❍ Swelling
❍ Anorexia
❍ Fatigue
❍ Sleepiness
❍ Sleep problems
❍ Malaise
❍ Weight gain
❍ Weight loss
❍ Speech delay

Eyes:
❍ Eye pain
❍ Vision loss
❍ Excessive tears
❍ Blurring
❍ Diplopia
❍ Irritation
❍ Discharge
❍ Photophobia

Genitourinary:
❍ Urinary tract infections
❍ Incontinence

Ear/Nose/Throat:
❍ Ear pain/discharge
❍ Tinnitus
❍ Decreased hearing
❍ Nasal obstruction or discharge
❍ Nosebleeds
❍ Sore throat
❍ Hoarseness
❍ Difficulty swallowing

Cardiovascular:
❍ Chest Pain
❍ Palpitations
❍ Syncope
❍ Dyspnea on exertion
❍ Orthopnea
❍ Peripheral edema

Respiratory:
❍ Cough
❍ Difficulty breathing
❍ Excessive sputum
❍ Hemoptysis
❍ Wheezing

Gastrointestinal:
❍ Nausea
❍ Vomiting
❍ Diarrhea
❍ Constipation
❍ Change in bowel habits
❍ Abdominal pain
❍ Melena
❍ Hematochezia
❍ Jaundice

Musculoskeletal:
❍ Back pain
❍ Joint pain
❍ Joint swelling
❍ Muscle cramps
❍ Muscle weakness
❍ Stiffness

Skin:
❍ Rash
❍ Itching
❍ Ulcers/growths
❍ Excessive scarring
❍ Bleeding problems
❍ Dryness
❍ Suspicious lesions

Neurologic:
❍ Paralysis
❍ Weakness
❍ Seizures
❍ Syncope
❍ Tremors
❍ Vertigo

Psychiatric:
❍ Depression
❍ Anxiety
❍ Memory loss
❍ Mental disturbances
❍ Suicidal ideation
❍ Hallucinations
❍ Paranoia

Endocrine:
❍ Cold intolerance
❍ Heat intolerance
❍ Polydipsia
❍ Polyphagia
❍ Polyuria
❍ Weight changes

Heme/lymphatic:
❍ Abnormal bruising
❍ Bleeding
❍ Enlarged lymph nodes

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ENT CASE HISTORY CONTINUED

Date: _____ Patient Name: _____ DOB: _____

MEDICAL HISTORY: Please mark all conditions that the patient or patient's family has had.

PATIENT	FATHER	MOTHER	SIBLING	CONDITION
				Alcoholism
				Allergic rhinitis
				Allergy to penicillin
				Anemia
				Anxiety
				Arthritis
				Asthma
				Atrial fibrillation
				Attention Deficit Hyperactivity Disorder (ADHD)
				Auditory processing disorder
				Autistic disorder
				Bipolar disorder
				Bleeding disorder
				Cardiac arrhythmia
				Celiac disease
				Cerebral aneurysm
				Cerebral palsy
				Chest pain
				Chromosomal abnormality
				Chronic kidney disease
				Circulatory system disorder
				Congestive heart failure
				Depression
				Diabetes
				Down syndrome
				Epileptic seizures
				Family history of deafness or hearing loss
				Family history of sudden infant death syndrome
				Gastroesophageal reflux disease (GERD)
				Graves' disease
				Headache
				Hearing loss
				Heart disease
				High blood pressure
				Hypothyroid
				Impacted cerumen
				Laryngitis
				Leukemia
				Migraine
				Muscular dystrophy
				Obesity
				Obstructive sleep apnea
				Pharyngitis
				Sinusitis
				Smoking
				Stroke
				Thyroid cancer
				Vertigo

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION AND NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

Patient Name:_____
Last First MI Maiden or Other Name

Date of Birth: ____ /____/____ SS#: _____/____/_____ Medical Record #:_____
MO DAY YR

Address:_____ City: _____State_____Zip_____

Day Phone: _____ Evening Phone: _____

With your permission, McBride Orthopedic Hospital Clinic may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, McBride Orthopedic Hospital Clinic may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or a procedure or provide the person with a copy of a prescription. By completing the top portion of this form, you are authorizing release of this information to these individuals. However, you are not authorizing McBride Orthopedic Hospital Clinic to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate authorization form. Please be aware that McBride Orthopedic Hospital Clinic may use its professional judgment in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care or the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name:_____ Phone #:_____ Relationship:_____ Date of Birth:_____

Name:_____ Phone #:_____ Relationship:_____ Date of Birth:_____

Name:_____ Phone #:_____ Relationship:_____ Date of Birth:_____

Name:_____ Phone #:_____ Relationship:_____ Date of Birth:_____

- **By signing, I acknowledge that the McBride Orthopedic Hospital Clinic's Notice of Privacy Practices form: HIPAA Privacy, Patient Rights & Responsibilities, is available upon request as required by HIPAA.**
- **I understand that if I want to make any changes to the information listed above, I must contact McBride Orthopedic Hospital Clinic to revoke this form in its entirety or complete a new form.**
- **I have read the Disclosure of Physician Ownership.**

_____
Patient Name (Please Print)

_____ _____
Signature of Patient Date

_____ _____
Parent/Legal Guardian/Authorized Person Date

McBRIDE ORTHOPEDIC HOSPITAL
INTEGRIS HEALTH

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance**, or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services form an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

_____	or	_____
Patient Signature		Guardian/Authorized Representative's Signature
_____		_____
Print Patient Name		Print Guardian/Authorized Representative's Name
_____		_____
Date		Date

McBRIDE
ORTHOPEDIC HOSPITAL
INTEGRIS HEALTH

DISCLOSURE OF PHYSICIAN OWNERSHIP & COVERAGE NOTIFICATION

McBride Orthopedic Hospital (the "Hospital") is required to provide this Notice to you by federal law.

- The Hospital is physician-owned. The physician who referred you to the Hospital for treatment and other physicians who provide care to you at the Hospital may be owners of the Hospital. A list of the current physician owners of the Hospital is available upon your request.

- During most hours of operation, the Hospital has arranged for one or more physicians to be on-site at the Hospital and readily available to respond to medical emergencies. However, at certain times, the Hospital may not have a physician available on the premises to provide services. The Hospital does have the capacity to provide assessments and initial treatment for patients and has a physician on call 24 hours a day/7-days a week. In addition, the Hospital may refer and transfer patients to another hospital with the capability to treat the needs of the patient involved.

_____ _____

Signature Date