Tulsa Pediatric Urgent Care Clinic
Patient Information Sheet

Please read carefully and fill out form completely *Date:*_____

Patient Name: _____
(Last) (First) (MI)

Date of Birth: _____ __Male or __Female

Home/Mailing Address: _____
(City) (State) (Zip Code)

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Primary Family Email: _____

Emergency Information – Please list below authorized person to notify in case of an emergency other than someone living in your home

Name: _____ Primary Number:_____

Responsible Party Information

__Mother __Stepmother ___Guardian ___Other _____

Name: _____
(Last) (First) (MI)

Resides with Patient___Yes or ___No Social Security Number:_____

If different from, Patient Mailing Address: _____
(City) (State) (Zip Code)

__Father __Stepfather ___Guardian ___Other _____

Name: _____
(Last) (First) (MI)

Resides with Patient___Yes or ___No Social Security Number:_____

If different from, Patient Mailing Address: _____
(City) (State) (Zip Code)

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Primary Care Physician Information

Primary Care Physician: _____

Phone:_____ Fax: _____

Insurance Information

Subscribers Name: _____
(Last) (First) (MI)

Date of Birth: _____ Relationship:_____Child or _____Self

Insurance Company Name: _____

Claims Address: _____

Member ID Number:_____ Group ID Number:_____ CoPay:_____

Are there any additional insurance policies for this patient? ___Yes or ___No

Tulsa Pediatric Urgent Care Clinic Notice of Privacy Practices

Consent to the Use and Disclosure of Personal Health Information for Treatment, Payment, or Healthcare Operation

I understand that as part of my Health and Medical Care, Tulsa Pediatric Urgent Care, originates and maintains medical and health records describing my child's health history, symptoms, examination and test results, diagnoses, treatments, and plans for future care and treatment. I further understand that this information serves as:

1. A basis for planning my child's care and treatment.
2. A means of communicating between the health professionals who contribute to my child's care.
3. A source of information for applying my diagnosis and treatment information to my bill.
4. A means for third party payers to verify that services were billed as actually provided.
5. A tool for routine healthcare operations such as quality and reviewing the competence of healthcare professionals.

I hereby authorize Tulsa Pediatric Urgent Care and any of its employees or other authorized personnel or agents, to release any medical records or other personal medical information for purposes of determining benefits for services; for purposes of obtaining reimbursement from my insurance company of record, any public agency or any other potential third party. I further authorize Tulsa Pediatric Urgent Care, including laboratory or diagnostic testing facility performing services on my behalf, to release any of my medical records or other personal or medical information to any employee, authorized personnel or other agent of any physician, laboratory or diagnostic facility or other healthcare provider involved in my care or treatment, or purposes of billing and obtaining reimbursement from any payer, for the purpose of developing an appropriate treatment plan or diagnosis, or for the purposes of quality assurance, utilization review or other analyses designed to monitor and maintain a quality of care.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and any information accumulated in the future. I also understand that I do have the opportunity to request a hard copy of my child's medical records.

IN AUTHORIZING THIS RELEASE OF INFORMATION, I HAVE READ THE NOTICE PATIENTS SET FORTH BELOW AND I UNDERSTAND THAT SUCH INFORMATION MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME(AIDS).

Information may be released to the following persons/organizations (Please list all patients involved in your child's care such as parent, step-parent, grandparent, or guardians):

Name (Please Print)	Relationship	Name (Please Print)	Relationship
Name (Please Print)	Relationship	Name (Please Print)	Relationship

PATIENT ACKNOWLEDGEMENT: By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, and that I have been given adequate opportunity to ask any questions about the same. I also acknowledge that my signature on this form authorizes Tulsa Pediatric Urgent Care to leave phone messages and send emails regarding my care to the phone numbers and email addresses I provide on the patient information sheet.

SIGNATURE: By Patients signature below, Patient represents that Patient is 18 years of age or over and is legally capacitated to give consent to treatment and to authorize release of the above information. By signature of Parent or Legal Guardian below, such individual represents that Patient is under the age of 18(a minor) or has a court appointed guardian.

Patient or Parent's Signature	Date
Patient's Name (Please Print)	Patient's Date of Birth
Witness Signature	Date

Tulsa Pediatric Urgent Care Clinic
Billing Agreement

Below are our billing practices for Tulsa Pediatric Urgent Care Clinic effective January 31, 2009 and forward. **PLEASE READ THE FOLLOWING DOCUMENT CAREFULLY AND SIGN ON BACK:**

CREDIT CARDS ON FILE

All patients must place a credit card on file; see exceptions below. This credit card will be used for any services not covered by your insurance or any co pay or deductible amounts that were not collected at the time of service. Please see Credit Card on File Authorization information.

Patients with SoonerCare benefits, that have been verified as active, will not be required to place a credit card on file. If Soonercare is secondary to a private insurance policy, a credit card on file will be required.

Patients with insurance, who are willing to pay 100% of the visit at the time of services rendered will not be required to place a credit card on file. Any credits remaining on the account, once the insurance claim has been adjusted will be sent to you via check at the address provided.

CO PAYS

All patients with a co pay are required to pay their co pay at the time of visit, prior to services rendered.

BALANCES

All patients with a balance are required to pay the balance plus their co pay prior to services rendered. All balances sent for third party collections will incur a 35% collection fee.

DEDUCTIBLE PLANS

All patients on an insurance plan contracted with the clinic who have a deductible plan are required to pay 100% of their visit at the time of service. Tulsa Pediatric Urgent Care Clinic will file the claim for your visit. Any adjustments received from the insurance company will be refunded to the patient via the credit card on file after we receive the Explanation of Benefits from the insurance company.

SELF PAY PATIENTS

All patients that are self pay are required to pay the full amount of the visit at the time of service.

UNVERIFIED INSURANCE COVERAGE

Our office staff will attempt to verify each patient's insurance coverage at the time of service. If we cannot verify your insurance, you will be required to pay the full amount of the visit at the time of service. Once your insurance payment has been received any additional credits on your account will be credited back to the credit card on file.

SELF-FILING PATIENTS

If your insurance company does not participate with Tulsa Pediatric Urgent Care Clinic, we will provide you with the information you need to self-file with your insurance company and it will be the patient's responsibility to work with the insurance company to receive personal reimbursement for the visit costs. No additional discounts will be provided after services have been rendered.

SEPARATED/DIVORCED FAMILIES

For any family where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible for payment and payment is due when services are rendered. In the case that only a co pay is due at the time of service, any charges deemed by insurance as patient responsibility are due to Tulsa Pediatric Urgent Care Clinic by the parent who authorized treatment.

If the divorce decree requires both parents to split the charges incurred, it is the authorizing parent's responsibility to collect from the other parent. Tulsa Pediatric Urgent Care Clinic will not act as a mediator in collecting our payments.

VACCINES

Additional paperwork and agreements may be required for certain vaccines as deemed necessary by the practice.

Please sign on backside of form →

LABS AND X-RAY'S

Please be advised that your lab work and/or x-ray's may be sent to a third party company for reading. Tulsa Pediatric Urgent care will provide that company with your billing information but based on your coverage, you may be responsible for their charges. TPUC has no control over billing issues with these companies. Please contact the company directly with any questions regarding charges.

***We accept Visa, MasterCard, Discover, and American Express. You can at any time make a payment over the phone.**

I understand and agree to the above billing practices as set forth by Tulsa Pediatric Urgent Care Clinic.

_____

Patient Name(s)

_____ _____

Signature of Parent/Guardian Date

Tulsa Pediatric Urgent Care Clinic
Policy for Credit Cards On File

Tulsa Pediatric Urgent Care Clinic requires a patient credit card on file. Instamed will be the credit card transaction company that will be utilized. Instamed stores your information on a separate and secure site and enables us to run credit card transactions within our computer system. Office personnel will not have access to your card, and only the last 4 digits of your card will be viewable in our system. Instamed is certified as a Level One Service Provider with the Payment Card Industry (PCI) Data Security Standard, as well as the VISA Cardholder Information Security Program (CISP). They are audited and scanned for PCI compliance and is regularly scanned for vulnerabilities by ScanAlertT and is a member of their HACKER SAFE® program.

- **Credit cards on file will be used for:**
- **-Co pays**
  When you are in the office, you will need to present your credit card for payment, even if the card is on file.

  -Deductibles
  We require at the time of service for you to pay 100% of the amount owed for each visit. Your credit card on file will be utilized to settle up any additional balances that were not credited to your account at the time of service.

  -Coinsurance
  We require at the time of service for you to pay the entire percentage not covered by your insurance company for example the full 10% if your insurance carrier covers 90% and 20% if your insurance carrier covers 80%.

  -Balances
  If your insurance carrier assigns any additional patient responsibility amounts, we will run the credit card on file for this amount.

- For all patient responsibility amounts assigned by insurance, our office reviews these amounts to ensure your claim has been properly adjudicated. If what is adjudicated by insurance company does not match the benefits we verified with insurance at the time of service, we will contact you and your insurance carrier. Members typically receive their explanation of benefits prior to the provider, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.

- If your credit card is mistakenly run, we will immediately issue you a refund back on the credit card you have on file.

- During the time you leave a credit card on file, if it expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.

- Credits on your account after your insurance claim has been adjusted will be returned to the credit card on file.

Know your insurance benefits. Your insurance plan is a contract between you and your insurance company, even if your employer provides it. We provide the medical service and submit the claim on your behalf. We do our best to verify your benefits prior to the appointment to make sure we collect the appropriate amount owed and to make sure your visit will be covered by your insurance plan. We do our best to notify and educate the patient of any learned information from insurance that may affect the visit. **However, it remains the policy holder's responsibility to know their insurance policies. Tulsa Pediatric Urgent Care Clinic cannot know every detail to your specific plan. Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility.** You will be responsible for any portion of services that your insurance does not cover. The policy holder should familiarize themselves and those bringing in their children for service with the insurance policy and any specific laboratory requirements should a sample need to be submitted to the lab for analysis.

Patient Name: _____

Date of service: _____

Phone Number: _____

Email for receipts: _____

Credit Card on File
Authorization

I agree to place my credit card on file to be run by Tulsa Pediatric Urgent Care Clinic once the insurance claim has been adjudicated for any additional patient responsibility amounts that has not been credited to my account.

On the day that we receive your adjudicated claim from insurance, we will call and cite the patient responsibility amount that has been assigned by insurance to you. You have provided one number above for us to reach you on. If we do not reach you on the number provided, we will leave a message. If we do not hear back from you by 9pm, we will run your transaction that afternoon before close of business (which is 11pm weekdays, 10pm weekends). A receipt will be emailed to the email provided above.

I, _____, authorize Tulsa Pediatric Urgent Care Clinic to run my credit card for the purpose(s) stated above.

Name on card: _____

Authorizing Person (print name): _____

Signature of Authorizing person: _____

Please read. We will be utilizing the services of Instamed, a third party vendor for credit card transactions. Instamed stores your information on a separate and secure site. Office personnel will not have access to your card, and only the last 4 digits of your card will be viewable in our system. Instamed is certified as a Level One Service Provider with the Payment Card Industry (PCI) Data Security Standard, as well as the VISA Cardholder Information Security Program (CISP). They are audited and scanned for PCI compliance and is regularly scanned for vulnerabilities by ScanAlertT and is a member of their HACKER SAFE® program.