Tulsa Pediatric
After Hours Urgent Care

PATIENT REGISTRATION

Patient's Last Name _____ First Name _____ Middle Name _____

Date of Birth: ____/____/____ Gender: M ( ) F ( )

Patient's Last Name _____ First Name _____ Middle Name _____

Date of Birth: ____/____/____ Gender: M ( ) F ( )

Patient's Last Name _____ First Name _____ Middle Name _____

Date of Birth: ____/____/____ Gender: M ( ) F ( )

Address _____ Apt# _____ County _____

City _____ State _____ Zip _____

PLEASE CHECK ONE: ***Confidential Email*** ☐ Gives you access to your child's records (school notes, Summary of Visit)

Email Address _____

How did you hear about us? _____

Preferred Pharmacy: _____

Pediatrician's Name: _____ **Pediatrician's Phone Number** _____

Race: (circle one) American Indian/Alaska Native Asian Black/African American White Native Hawaiian/Other Pacific Islander

Ethnicity: (circle one) Hispanic or Latino Not Hispanic or Latino

Mother's Name _____ **DOB** _____

Social Security Number _____ **Cell:** _____

Father's Name _____ **DOB** _____

Social Security Number _____ **Cell:** _____

ALTERNATE CONTACT

Name _____

Relationship _____ **Cell:** _____

Primary Insurance:

Policy Holder's Name _____ **Policy Holder's DOB** _____

Insurance Company Name _____ **Claims Address** _____

ID# _____ **Group Number** _____

Secondary Insurance:

Insurance Company Name _____ **Claims Address** _____

ID# _____ **Group Number** _____

TULSA PEDIATRIC URGENT CONSENT AND SIGNATURE

PATIENT NAME: _____

PATIENT NAME: _____

PATIENT NAME: _____

CONSENT TO TREAT

I have the legal right and responsibility to obtain and consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Tulsa Pediatric Urgent Care Providers believe are necessary for this child. I understand that by signing this form, and by bringing this child to this medical office for care, I am giving permission to the doctors and other health care providers treatment to this patient as long as he/she is a patient of this practice.

DELEGATION OF CONSENT

(This section is OPTIONAL. Include adults other than parents/legal guardians)

I hereby authorize (when I am unavailable to give consent) to the following individual(s):

_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient

to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the State of Oklahoma. This consent includes medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw this delegation of consent.

WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By Signing below, you acknowledge receiving the Tulsa Pediatric Urgent Care Notice of Privacy Practices ("Notice"). The Notice explains how Tulsa Pediatrics may use and disclose your child's protected health information for treatment, payment, and health care operations purposes. "Protected health information" means your child's personal health information found in his/her medical and/or billing records. Your signature below only acknowledges that you have RECEIVED the Notice. If you have questions about the Notice, please contact the Privacy Officer for the office.

GUARANTOR'S STATEMENT OF RESPONSIBILITY

I have received a copy of the Tulsa Pediatric Urgent Care's Financial Policy and understand that I am personally responsible for the payment of this patient's account.

SIGNATURE ACKNOWLEDGES I RECEIVED AND UNDERSTAND THE STATEMENTS ABOVE.

_____	_____
GUARANTOR'S SIGNATURE	DATE
_____	_____
GUARANTOR'S PRINTED NAME	RELATIONSHIP TO PATIENT

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.

- 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 evening 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.

Signature of Authorizing person: _____
*Authorizing signature must match name on credit card.

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.