



**PATIENT INFORMATION**

**PLEASE PRINT**

Name of Patient:		Date:	
Home Address:	City:	State:	Zip:
Daytime Phone:	Other Phone:	Email:	
Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Parents Names:	
Mom's Work #:	Cell #:	Dad's Work #:	Cell #:
Person Financially Responsible for Patient:		Relationship:	
Emergency Contact:	Relationship:	Phone:	
Whom May We Thank for Referring You:			

**PRIMARY INSURANCE**

Name of Insured:		Relationship to Patient:	
Address (if different from patient):			
Insured's Date of Birth:	Insured's Employer:	Work #:	
Insurance Plan Name:			
Policy Number:	Group Number:		
Copay:	Deductible:	Type of Plan: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Commercial	

**SECONDARY INSURANCE**

Name of Insured:		Relationship to Patient:	
Address (if different from patient):			
Insured's Date of Birth:	Insured's Employer:	Work #:	
Insurance Plan Name:			
Policy Number:	Group Number:		
Copay:	Deductible:	Type of Plan: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Commercial	

**AUTHORIZATION FOR TREATMENT**

I authorize any medical provider at Twelve Oaks Pediatrics to provide medical treatment for myself or my child or \_\_\_\_\_ (name).

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I request that payment of authorized insurance benefits be made to me or on my behalf to Twelve Oaks Pediatrics for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the \_\_\_\_\_ (name of insurance company) and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Twelve Oaks Pediatrics

## PATIENT DEMOGRAPHICS QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Account # (office use only): \_\_\_\_\_

We are asking for your race and ethnicity because some people have higher risks of developing certain diseases. It is also important that we know your preferred spoken language so that you and your health care team can communicate clearly.

We will keep this information confidential (private) and will update it in your medical record. This information will assist us in continuing to provide you with the best health care.

Please fill in the information below. We greatly appreciate your participation.

**1. Race – please mark which best describes you.**

- |   |   |
|---|---|
| <input type="checkbox"/> White/Caucasian                  | <input type="checkbox"/> Native Hawaiian        |
| <input type="checkbox"/> Black/African American           | <input type="checkbox"/> Other Pacific Islander |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> More than one race     |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> I prefer not to answer |

**2. Are you of Hispanic Origin?**

- Yes  
 No  
 I prefer not to answer

**3. Please indicate your preferred spoken language:** \_\_\_\_\_

- I prefer not to answer

**4. Interpreter Services: Would language interpreter services be helpful to you during your medical visit?**

- Yes  
 No

**5. Email address (please print):** \_\_\_\_\_



# Twelve Oaks Pediatrics

## **AUTHORIZATION AND AGREEMENTS OF MEDICAL TREATMENT INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY**

**CONSENT FOR EXAMINATION:** I understand that medical treatment may be necessary for the patient by Twelve Oaks Pediatrics, or associates or assistants.

I understand the examination be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with my physician. I hereby release my examiner from all responsibility in connection with this examination.

**CONSENT FOR TREATMENT:** | understand that medical treatment is necessary for the patient by Twelve Oaks Pediatrics or associates or assistants. I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments.

1. Payment is due at the time of service. We accept cash, checks, and credit cards.
2. All co-payments, deductibles and non-covered services must be paid in at the time of service.
3. A schedule of fees for our services is available at the reception desk. Our office will submit claims to your insurance company as a service to you. It is important that know what your insurance plan covers. Services not covered by your insurance are your responsibility.
4. If your insurance company requires laboratory specimens be sent to a lab, it is your responsibility to know the participating lab. Please make us aware of plan requirements.
5. If your insurance is a managed care plan please review your coverage. If you require services that require a referral adequate planning is essential. Referrals must be authorized by your doctor and usually require an office visit. Authorization from managed care plans for your referrals may take one or more days. Please be aware that we are often unable to accommodate call in requests for referrals with short notice. Do not expect our office staff to obtain your referral forms - this is your responsibility. Failure to obtain necessary authorizations often lead to out of pocket expense. We are happy assist you in any way with your managed care plan. However, our experience with these plans has demonstrated that planning and adequate lead time are essential. Your knowledge of your plan regulations and benefits as well as adequate planning will help avoid delays and denied claims.
6. In the case of estranged or divorced parents, the parent accompanying the child to the visit is responsible to pay for services rendered regardless of coverage arrangements. We will gladly furnish you with necessary statements for reimbursement.
7. Your doctor is here to manage your medical care. The physicians-are not experts on insurance and cannot be aware of all financial arrangements. Please discuss insurance problems and financial arrangements with the business staff.
8. If you are experiencing financial difficulties, please discuss this with the business office staff. We will gladly work with you to make payment arrangements. Accounts over 90 days past due may be referred to a collection agency.

| have read the above Acknowledgements and Agreements and fully understand the same.

Patient's Name (print) \_\_\_\_\_

Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

# HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: January 1, 2014

## Your Information. Your Rights. Our Responsibilities.

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may deny your request, but we'll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will approve to all reasonable requests.

### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may deny it if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will approve your request unless a law requires us to share that information.

### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the PRIVACY OFFICIAL at 248-347-8040.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Effective Date of this Notice: January 1, 2014

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# Our Uses and Disclosures

## **How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

### **Treat you**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

### **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

### **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

## **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

### **Do research**

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

### **Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, and/or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can **in writing**. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Contact the Twelve Oaks Pediatrics **PRIVACY OFFICIAL** at 248-347-8040 at any time with questions or concerns.

**Effective Date of this Notice: January 1, 2014**

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# Twelve Oaks Pediatrics

## **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

\_\_\_\_\_  
Guardian or Patient Signature

\_\_\_\_\_  
Date

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### **Documentation of Failure to Obtain Signed Acknowledgement**

On \_\_\_\_\_, \_\_\_\_\_ presented this Acknowledgement of Receipt of Privacy Practices Form to \_\_\_\_\_ (the patient). The patient refused to provide a signature when requested.



# Twelve Oaks Pediatrics

## **ELECTRONIC PERSCRIPTIONS FORM**

As a convenience to our patients, we are offering electronic prescriptions and prescription renewals. If you are interested, please complete the following questionnaire.

Please be certain that the information you provide is correct. Please ask if you have any questions about medication allergies.

Date completed:

Patient's Name:

Patient's Date of Birth:

Patient's Phone Number:

Patient's Zip Code:

Medication Allergies and Reactions:

Pharmacy Name:

Pharmacy City and Cross Streets:

If you have other children, you may include them below:

Name	Date of Birth	Medication Allergies/Reactions
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_____	_____	_____
_____	_____	_____
_____	_____	_____