SOLID OAK ADULT AND PEDIATRIC CLINIC

PATIENT REGISTRATION

Please fill in all the information completely.

Patient's Last Name _____ MI ____ First_____

Date of Birth _____ Social Security # _____

Maiden Name _____ Preferred Name _____

Address_____

City_____State_____Zip_____

Email Address_____

Home# _____ Cell _____ Work_____

Circle One Male/Female**Circle One** Single/Married/Divorced/Widow

Referring Physician (if applicable) _____

Emergency Contact _____ Phone # _____

Relationship to Patient _____

PARENT OR GUARDIAN RESPONSIBLE FOR PATIENT

Statements will be sent to this person

Responsible Party Name _____

DOB_____ Social Security #_____

Billing Address_____

City_____ State_____ Zip _____

FOR PEDIATRIC PATIENTS ONLY

Mothers Name _____ DOB _____

Address *(if different from above)*_____

Phone Number_____

Fathers Name_____ DOB _____

Address *(if different from above)*_____

Phone Number _____

INSURANCE INFORMATION (MUST BE COMPLETED YEARLY)

Patient Name:_____ DOB:_____

Please be sure to have your Insurance Card and Driver's License at your appointment as we will need copies for our records as well as proof of insurance is required at any visit. If completed insurance information cannot be provided at the time of service, the patient's appointment will need to be rescheduled. By not providing complete insurance information, as well as filling out this form completely, you are consenting to pay in full the cost of treatment.

PLEASE FILL OUT THIS SECTION COMPLETELY

Primary Insurance Company Name:_____

Policy Holder Name:_____

Relationship to Patient:_____

Policy Holder's date of Birth:_____

Policy Holder's Social security #:_____

Contract or ID #:_____

Group #:_____

Secondary Insurance Company Name:_____

Policy Holder Name:_____

Relationship to Patient:_____

Policy Holder's date of Birth:_____

Policy Holder's Social security #:_____

Contract or ID #:_____

Group #:_____

** Please know that some Insurances require a referral OR to have your PCP set as Dr. King. It is YOUR responsibility to make sure that you either have a referral on file or have Dr. King set as your PCP for your claims to be processed and paid by your insurance company. If that is not done, your claims will not be paid and the cost of the visit will be patient responsibility. Any and all balances MUST be paid before being checked in for your next appointment.

Signature: _____

Date:_____

(Signature is required by the patient if the patient is 14 yrs old or older)

Permission to Release Info

Patient Name: _____ DOB: _____

Any Physicians, staff, employee, or representative of Solid Oak Adult and Pediatric has my permission to discuss and/or disclose information regarding my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medication or any other type of protected health information in order to facilitate and coordinate my care, treatment and payment with the following people below. Also, the following people listed below have my permission to pick up any prescriptions and/or paperwork for me if I am unable to do so. Also, if my minor child is the patient, the people listed below have my permission to bring my child to any appointments without my present.

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

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Phone Number: _____

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Relationship to Patient: _____
Phone Number: _____

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Relationship to Patient: _____
Phone Number: _____

COMMUNICATOR AUTOMATED MESSAGING PREFERENCES
(CIRCLE PREFERRED)

Health Notifications	Email	Phone	Text Message
Appointments	Email	Phone	Text Message
Announcements	Email	Phone	Text Message
Billing	Email	Phone	Text Message

Consent to call YES / NO Consent to text YES / NO

_____ *Initial*

Audio and Video recordings are not allowed. We feel that such recordings interfere with medical treatment and the privacy of our staff and patients

SIGNATURE: _____ Date: _____

(Signature is required by the patient if the patient is 14 yrs old or older)

PAYMENT PLANS:

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our office promptly for payment arrangements and assistance in the management of your account. We do offer a limited payment plan for those patients who need some flexibility, with the following criteria:

1. You will be required to provide us with a credit or debit card number to automatically process your payment on specified dates.

2. The balance must be paid in full within six months of the date of a signed payment plan agreement (unless otherwise specified).

3. A copy of this agreement will serve as your reminder. Regular statements will not be mailed for this balance.

4. No future charges may be added to this payment plan, as it is not intended to be a revolving charge account. Until the initial payment agreement is paid in full, all future visit costs will be due in full at the time of service.

5. If at any point you are unable to keep this payment agreement without speaking to the office, your account will be sent to a collection agency. If your account is forwarded to collections, you will be given 30 days to select a new primary care physician. During that 30-day period, we will continue to provide emergency-only medical care.

Sign Here: _____

Date: _____

(Signature is required by the patient if the patient is 14 yrs old or older)

Please see the following and consent and/or digitally sign before you are checked in for your appointment.

This is giving consent to pull vaccine records from the state's database to better help the office know what vaccines are needed and have been received in the past.
Initial beside:

I consent -	I do not consent -

This is giving consent for the office to communicate with your pharmacy and pull records for previous prescriptions.
Initial beside:

I consent -	I do not consent -

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPPA/Privacy Policy for SOLID OAK**

Signed_____
Date_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____
Date_____

- **I authorize SOLID OAK to release medical information required to process my claim**

Signed_____
Date_____

- **I have read and understand the Financial Policy for SOLID OAK**

Signed_____
Date_____

- **I authorize SOLID OAK to obtain/have access to my medication history**

Signed_____
Date_____

(Signature is required by the patient if the patient is 14 yrs old or older)

SOLID OAK ADULT & PEDIATRIC CLINIC
MEDICAL HEALTH QUESTIONNAIRE

Your answers on this form will help keep your medical records current & gives the provider a better understanding of your concerns & conditions. Add any additional remarks on the back if you need extra space.

PATIENT NAME: _____ DOB: _____

CIRCLE ONE: INTERNAL MED (PCP) OR GI

REASON FOR VISIT: _____

Please list any medical conditions you have:_____

_____

_____

_____

_____

Please list ANY surgeries with the Month/year they were done: _____

_____

_____

ALLERGIES WITH REACTIONS

_____

_____

_____

Do you drink alcohol? YES or NO

Do you smoke tobacco? YES or NO

Do you use recreational drugs? YES or NO

MEDICATIONS

List your prescribed drugs AND over the counter drugs such as vitamins/herbs/inhalers, etc.

DRUG: _____ Dose/Frequency: _____

DRUG: _____ Dose/Frequency: _____

DRUG: _____ Dose/Frequency: _____

DRUG: _____ Dose/Frequency: _____

DRUG: _____ Dose/Frequency: _____

DRUG: _____ Dose/Frequency: _____

PHARMACY: _____ **PHONE NUMBER:** _____

**** Please complete **FAMILY MEDICAL HISTORY** on the back of this page.

Condition:	Mom	Dad	Sibling	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Alcohol Abuse							
Anemia							
Anxiety Disorder							
Arthritis							
Asthma							
Autoimmune Problems							
Birth Defects							
Blood Clots							
Bowel Disease							
Breast Cancer							
Cervical Cancer							
Colon Cancer							
Coronary Artery Disease							
Crohn's Disease							
Depression							
Diabetes							
Diverticulitis							
Fibromyalgia							
Gout							
Growth/Develop Disorder							
Heart Attack							
Heart Murmur							
Hepatitis							
High Blood Pressure							
High Cholesterol							
HIV							
Kidney Disease							
Liver Cancer							
Liver Disease							
Lung Cancer							
Lung/Respiratory Disease							
Mental Illness							
Osteoporosis							
Pacemaker							
Prostate Cancer							
Pulmonary Embolism							
Rectal Cancer							
Reflux/GERD							
Seizures							
Stroke/CVA of the brain							
Thyroid Problems							
OTHER							

FINANCIAL POLICY

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan, and you will be 100% responsible for these charges. **The following are your responsibilities:**

-Ensure our providers actively participate with your insurance carrier.

- Know your and your dependents benefit coverage and verify your eligibility, prior to receiving services.

- Know your co-pay, coinsurance, and/or deductible amounts.

- Make sure that all individuals on your policy have the correct primary care physician selected at your insurance company as this is the number one reason why claims are denied.

- Ensure that all pre-authorization requirements are met to avoid denials or out-of-network benefits.

You will be considered self-pay for the day's visit if:

- You do not have insurance.

- Our practice does not participate with your health plan. You are unable to present a valid member identification card from your insurance carrier at your visit;

- We are unable to verify your insurance coverage.

You can NOT be self pay if you have a Medicaid or Medicare plan (the red white and blue cards) due to Dr. King not being an in-network provider.

To summarize, you are financially responsible for

- Denied and non-covered services:

- Services deemed not medically necessary by your policy;

- Co-payments, deductibles, and coinsurance;

- Pended claims due to lack of patient or guarantor information.

- Non-Insurance and/or out-of-network benefits.

INSURANCE BILLING:

Remember that we must receive up to date billing information in order to meet the claims submission guidelines set by your insurance plan. If you fail to provide complete and accurate primary and/or secondary insurance information on the date of service, you will be held responsible for services rendered that day.

If we are not a participating provider with your insurance plan or if your insurance plan does not provide coverage for the provider you are seeing, you will be 100% responsible for all charges incurred and will be considered self-pay for all visits.

CO-PAYS: Co-payments, deductibles, and coinsurance balances are expected to be paid in full at the time of your visit. If balances are too high, a payment plan can be discussed.

We are required by our insurance contracts to collect all co- pay and patient responsible amounts. Co-pays are due at the time of service. If you do not know your co-pay, we may request a deposit of $25.00 prior to your being seen by a physician.

DEDUCTIBLES: If you have not met your deductible, we may request a deposit prior to your being seen by the physician.

SELF-PAY PATIENTS: Self-pay patients are required to make full payment for Office visit during check-in. If additional charges (in office tests) are accrued during the visit, you must pay for the charges before leaving the office.

NON-EMERGENCY APPOINTMENTS: Well child visits, physicals, or any non-emergent follow-ups or visits may be rescheduled if outstanding balances, co-pays, or self-pay charges are not paid at the time of service.

RETURNED CHECKS: The current fee for returned checks is $30.00. We have the right to adjust the amount at any time.

HIPAA/PRIVACY NOTICE:

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at Solid Oak Adult and Pediatric (hereafter "SOAP") may be billed to and payment may be collected from you, an insurance company, or a third party. For example: we may disclose your records to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at SOAP or the hospital. For example, we may disclose medical information about you to people outside SOAP who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run SOAP and ensure that all our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other SOAP personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION: We create a record of the care and services you receive at SOAP. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by SOAP, whether made by SOAP personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private: give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety: and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors: health oversight activities: law enforcement: lawsuits and disputes; military and veterans: national security and intelligence activities: organ and tissue donation: public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS- You have the following rights regarding medical information we maintain about you:You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You have the right to inspect and copy medical information that may be used to make decisions about your care. A request form may be obtained at the front desk. We may deny your request to inspect and copy in certain very limited circumstances. Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, SOAP. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, and you must provide a reason that supports your request. A request form may be obtained at the front desk. We may deny your request for an amendment. You have the right to opt out of receiving fundraising communications from the Practice.You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which you have paid out of pocket in full.You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing, and you must specify how or where you wish to be contacted. A request form may be obtained at the front desk.You have the right to request an accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. A request form may be obtained at the front desk.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. A current copy will be available at the front desk.