A Place To Grow Pediatrics

Patient Information:

Patient Name: _____ Middle: _____ Last: _____

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

Nickname: _____Date of Birth: _____/_____/_____ Sex: Male or Female

Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Declined to Specify

Race: American Indian or Alaska Native / Black or African American / White / Hispanic Indian /Asian / Declined to Specify

Parent Information:

Mother/Guardian Name: _____ Last: _____

Maiden Name:_____ Date of Birth: ____/____/_____

Cell Phone: _____ Work Phone: _____ Other Phone: _____

Email Address: _____

Father/Guardian Name: _____ Last: _____

Cell Phone: _____ Work Phone: _____ Other Phone: _____

Email Address: _____ Date of Birth: _____/_____/_____

Patients Family Members:

Sibling Name: _____ Date of Birth: _____/_____/_____ Relation: _____

Sibling Name: _____ Date of Birth: _____/_____/_____ Relation: _____

Sibling Name: _____ Date of Birth: _____/_____/_____ Relation: _____

Laboratory Information:

It is the parent/guardian's responsibility to know which lab is in network with the patient's insurance, and to notify the provider at the time of service. Otherwise all labs will be sent to Diagnostic Laboratory of Oklahoma (DLO).

Insurance Information:

Primary Insurance Name: _____

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

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: ____/____/_____

Secondary Insurance Name: _____

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

Policy Number: _____ Group Number: _____

Policy Holder: _____ Date of Birth: ____/____/_____

Preferred Pharmacy: _____ **Pharmacy Street Location:** _____

Patient/Guardian Signature: _____ Date: ____/____/_____

A Place to Grow Pediatrics

Name_____

DOB_____

Sex_____

Birth Hospital_____

How many weeks were you at delivery?
_____

Information at birth

Delivery type: Vaginal / C-section / Repeat C-section
Birth Weight: _____ lbs _____oz
Complications: _____
Was the patient admitted to the NICU ◯Yes ◯No
Explain:_____
Was initial feeding: ◯Formula ◯Breast milk.
How long breastfed?_____
Did the baby go home with mother from the hospital?
◯Yes ◯No Explain:_____

Household information

Does anyone in the home use tobacco? ◯ Yes ◯No Who? _____
IF >13yo have ever used tobacco? ◯ Yes ◯No
If age appropriate does child attend:
◯Daycare ◯Public School ◯Private School ◯Homeschool
Who lives in the household with child:
◯Parents ◯Grandparents ◯Siblings How many:_____ Others:_____
What is the child's living situation if not with both biological parents?
◯ Lives with adoptive parents ◯ Joint custody ◯ Single Custody ◯ Lives with foster family

List any food and/or drug allergies

List any allergies, including any allergic reactions to drugs.

_____

_____

_____

Surgeries

Date	Type of surgery:
_____	_____
_____	_____

Hospitalizations or serious/unusual illnesses

Identify any serious and/or unusual illnesses or injuries which your child has experienced.

Date	Please explain:
_____	_____
_____	_____
_____	_____

Medications

List any medications your child is currently taking and dosage given

_____

_____

_____

Patient and family health history – Please check and/or explain all that apply

Have the patient and/or family members had any of the following? Please √ where the child or members of the child's family (parents, siblings, grandparents, aunts, uncles) have had the following illnesses or problems.

Please √ one	Child/Patient	Mom/Dad	Grandparent (Maternal/Paternal)	Other
ADHD				
Alcohol/Drug Problems				
Anemia/Blood Problems				
Arthritis				
Asthma/Wheezing				
Bed-Wetting (after 10 yrs)				
Birth Defects				
Bladder/Kidney Problems				
Bone Disease				
Cancer				
Chemotherapy				
Congenital Cataracts				
Constipation				
Neurologic Problems				
Croup				
Cystic Fibrosis				
Dental Decay				
Developmental Delay				
Diabetes				
Eczema/Skin Problems				
Eye Problems				
Family Violence				
Frequent Abdominal Pain				
Frequent Ear Infections				
Frequent Headaches				
Hay Fever/Allergies				
Hearing Problems				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Learning Disorder				
Lung Disease/Tuberculosis				
Bone Marrow Transplant				
Depression				
Mental/Emotional Disorders				
Metabolic/Genetic Disorders				
Migraines				
Mumps, Measles, Chicken Pox				
Obesity				
Organ Transplant				
Pneumonia				
Recurrent UTI				
Seizures/Convulsions				
Serious Injuries				
Sleeping Problems				
STDs				
Thyroid Disease				
Ulcers/Stomach Problems				

Other chronic health issues not listed above:

_____

A Place to Grow Pediatrics

Dr. Trinity Loveless, M.D.
Dr. Diana Farrow, M.D.
Leslie J. Whisenhunt, APRN-CNP
Allison Scott, PA-C

Authorization of Treatment of Minor

Child's Name _____Birthdate _____

I _____ (Parent/Guardian), do hereby give permission for medical treatment from Dr. Trinity Loveless, M.D. and/or Dr. Diana Farrow, M.D., Leslie J. Whisenhunt, APRN-CNP and/or Allison Scott, PA-C of

_____(child's name).

The following person (s) have my permission to bring the child listed above:

	Name	Phone Number	Relationship
1.			
2.			
3.			

Parent/Guardian Name _____

Parent/Guardian Signature _____Date _____

A Place to Grow Pediatrics

Dr. Trinity Loveless, M.D.
Dr. Diana Farrow, M.D.
Leslie J. Whisenhunt, APRN-CNP
Allison Scott, PA-C

Vaccination Policy Agreement

Child's Name_____

I, _____, understand that I must vaccinate my child according to the following schedule provided by Dr. Trinity Loveless, M.D., Dr. Diana Farrow, M.D., Leslie J. Whisenhunt, APRN-CNP, Allison Scott, PA-C. I understand that this is a private practice and the providers can choose to deny care to my child if I do not follow the attached schedule.

I understand that my child will receive the first set of vaccines at the 2 month well child check. If I choose to follow an alternate vaccine schedule I will provide a copy to my provider at our 2 month well child check. I understand that my alternate schedule will require approval by Dr. Trinity Loveless, M.D., Dr. Diana Farrow, M.D., Leslie J. Whisenhunt, APRN-CNP, Allison Scott, PA-C. I understand that the provider has a right to disagree with the alternate schedule that I have provided and can require my child to be vaccinated according to the attached schedule.

I understand that if I choose to not vaccinate my child at all, or choose to completely eliminate any vaccine from the schedule, my provider can refuse to provide services to my child. I also understand that there are vaccine information statements on file in the office for patient education, and I have the right to request and obtain said documents if I so desire.

Parent/Guardian Name _____

Parent/Guardian Signature_____ Date _____

A Place to Grow Pediatrics

812 South Mustang Road ~ Yukon, Ok 73099

HIPAA NOTICE OF PRIVACY PRACTICES

Effective April 25, 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOUR CHILD(REN) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Who will follow this notice:

- Dr. Trinity Loveless, Dr. Diana Farrow, Leslie J. Whisenhunt (nurse practitioner), & Allison Scott (physician assistant)
- All employees of A Place to Grow Pediatrics and those who provide services for A Place to Grow Pediatrics

Our pledge regarding health information: We understand that health information about your child's healthcare is personal. We are committed to protecting health information about them. We create a record of the care and services your child has receive from us. We need this record to provide your child with quality care and to comply with certain legal requirements. This notice applies to all of the records of your child's care generated by this health care practice, whether made by the doctor or others working in this office. This notice will tell you about ways in which we may use and disclose health information about your child.

We are required by law to:

- Make sure that health information that identified your child is kept private.
- Give you this notice of our legal duties and privacy practices with respect to the health information of your child.
- Follow the terms of this notice that is currently in effect.

How we may use and disclose health information about your child: The following categories describe different ways that we may use and disclose health information. For each category of uses and disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in a category is listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

For treatment: We may use and disclose health information about your child so that treatment and services your child receives from us may be billed to and payment collected from you, an insurance company or a third party.

Appointment reminders: We may use and disclose health information to contact you as a reminder that your child has an appointment. Please let us know if you would like other means of notification.

Treatment alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you and your child.

Health Related Benefits and Services: We may use and disclose protected medical information to tell you about health related benefits or services that may be of interest to you or your child.

Individuals involved in your child's care and payment: We may release protected medical information about you to a friend or family member who is involved in your child's medical care. We may also give medical information to someone who helps pay for your child's care.

Research: Under certain circumstances, we may use and disclose protected medical information about you or your child for research purposes. We will always ask for specific permission if they will have access to your child's name, address or other information.

As required by law: We will disclose protected medical information about your child when required by federal, state, and local law.

Special situations and public health risks: We may disclose protected medical information for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report a suspected crime
- To report child abuse or neglect
- To report vulnerable adult abuse
- To report reactions to medications and problems with products
- To notify the appropriate government authority if we believe patients have been the victim of domestic violence. We may only make this disclosure if you agree or when required by law.

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, and licensure. These activities are necessary for government programs and compliance of civil rights.

Lawsuits and disputes: If you/your child are involved in a lawsuit or dispute, we may disclose protected medical information about you/your child in a response to a subpoena (request to other lawful process by someone else involved in the dispute), but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may release protected information if asked to do so by a law enforcement official:

- In response to a court order, warrant, summons or similar process.
- To identify, locate a suspect, fugitive material witness, or missing person.
- About the victim of a crime if unable to obtain the person's agreement
- About a death we believe may be a result of criminal conduct.
- In emergency situations to report a crime, the location of a crime and the identity of the person who committed the crime.

Medical examiners and funeral directors: We may release protected medical information to a medical examiner.

National Security and Intelligence Activities: We may release protected information about your child to authorized Federal officials for intelligence and other national security activities authorized by law.

Protected Services for the President and Others: We may discuss protected medical information about your child to authorized federal officials so they provide protection to the President and other authorized persons of foreign heads of state, or to conduct special investigations.

Inmates: If you are an inmate to a correctional institution or under custody of a law enforcement official, we may release protected medical information about you to the correctional institution or official.

Your Rights Regarding Medical Information about Your child: You have the right to inspect and copy your child's medical information that may be used to make decisions about your child's care. This does not include psychotherapy notes. To inspect and/or copy you must submit a request to a member of our office in writing. The charge by statute of Oklahoma is $0.25 per page plus the cost of postage. An x-ray image is $5.00 per image.

Right to Amend: If you feel your child's information is incorrect or incomplete, you may ask us to amend your information. This must be in writing and submitted to the office manager. In addition, you must provide a reason that supports your amendment request.

Right to an Accounting of Disclosures: You have a right to request an "accounting of disclosures." This is a list of the disclosures we have made of your medical information.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or a certain location. To request confidential communications, you will need to request in writing to our office manager.

Right to Request Restrictions: You have a right to request a restriction or limitation on the protected medical information we use or disclose about your child for treatment, payment, or health care operation. However, we must receive your restrictions in writing before we have made such decisions. We are not required to agree with your request. If we do not agree, we will comply with your request unless the information is needed for emergency treatment.

Right to Copy of the Notice: We reserve the right to change this notice. We reserve the right to make revisions or change information as we receive it in the future. We will post a current copy in our office and it will have the effective date at the top of the notice.

Complaints: If you believe your child's privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office manager at 405-265-3900. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Use of Medical Information: Other uses and disclosures of protected medical information not covered by this notice or the laws that apply, will be made only with your written permission. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care we have provided to your child.

I have received a Notice of Privacy Practices from the office of Dr. Trinity Loveless, Dr. Diana Farrow, Leslie J. Whisenhunt, APRN-CNP, and Allison Scott, PA-C.

Patient/Guardian Signature:_____ Date:_____

Medical Home Agreement

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient, and treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services.
3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with ***ongoing, quality*** and ***safe*** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.
7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed ***medically*** necessary by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed ***medically*** necessary by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your ***PCP,*** to meet ***all*** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report ***any*** changes related to your health, treatments, medications, etc.
   This includes use of ***all medications*** - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us ***before*** going to the Emergency Room, unless it is life threatening.
5. Notify us ***after*** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including ***follow-up*** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call ***before*** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

_____ _____

Patient or Guardian Signature Date

_____ _____

Provider Signature Date

Updated 1/13/2015

A PLACE TO GROW PEDIATRICS

ATTENTION: BILLING AND INSURANCE INFORMATION

I hereby authorize A Place To Grow Pediatrics and/or all providers, including Physicians, Nurse Practitioners, and Physician Assistants to furnish information to insurance carriers concerning my child's illness and treatments, and hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for providing any and all insurance information to the office at the time of service. I understand that I will be responsible for any amounts not covered by insurance and agree to pay all amounts in a timely manner.

I agree that in order, for your office to service my child's and/or dependents account, or to collect any amounts that may be owed, I may be contacted by your office on any of the telephone numbers associated with the account, including any of the telephone numbers I have listed on the Authorization of Treatment of Minor form. This may include wireless telephone numbers, which could result in charges to you by your wireless carrier. We may also contact you by sending text messages or sending e-mails to the e-mail that you have provided to our office. Methods of contact may include pre-recorded/artificial voice messages, and/or use of an automatic dialing device as applicable.

I also understand and agree that if any balance has been left unpaid and/or I have failed to set up payment arrangements of the balance for any period over 6 months the account will be subject to further collection services, including being sent out to a third-party collection agency. I agree and understand that in the event that my account is placed to a third party collection agency, they will be sent any and all information I have listed on the account, including names, telephone numbers, addresses, and any billing information they may made need in order to collect the balance for which I am responsible for.

_____	_____	_____
PARENT/GUARDIAN NAME (PRINT)	PARENT/GUARDIAN SIGNATURE	DATE