

Center for Internal Medicine and Pediatrics

205 S. Academy Rd. Suite D Guthrie, OK 73044

(405) 282-9449

Authorization for Outpatient Emergency Treatment

The undersigned has been informed of the outpatient/emergency treatment considered necessary for the patient whose name appears below and that the treatment and procedures will be performed by physicians, members of the house staff and employees of the hospital. Authorization is hereby granted for treatment and procedures.

Consent for Treatment

I hereby consent to treatment deemed appropriate by my physician and agree to complete appropriate forms required by the clinic.

Personal Valuables

I have also been advised that any personal valuables I elect to keep with me, if lost or stolen, will not be the responsibility of Logan Medical Center clinics.

Release of Medical Information and Insurance Assignment

I authorize Logan Medical Center clinics to release any medical information required by any payer of patient service, to include any worker's compensation carrier, Soonercare and/or Medicaid programs and any HMO's, and assign insurance benefits to LMC clinics or Logan Medical Center. I understand that I am financially responsible to the clinic and physician for charges not paid by my insurance company. I also understand it is my responsibility to provide LMC clinics with insurance information to be filed in a timely manner. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAYBE CONSIDERED A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS (HIV), ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

Medicare Release of Information and Benefit Assignment

I authorize release, by any holder of medical or other information about me to the Social Security Administration or its intermediaries. I authorize the same release for this or other related Medicare Claims. I assign benefits payable to the physician or organization furnishing services or authorize them to submit a claim to Medicare on my behalf.

Notice of Privacy Practices

I hereby acknowledge receipt of Logan Medical Center's NOTICE OF PRIVACY PRACTICES.

Our goal at LMC clinics is to provide quality health care service. If you are not satisfied with any aspect of the care you received at LMC clinics, please notify the department manager or the administration office. Your access to healthcare will not be affected by your inquiry. Your comments will assist us in improving our services to you.

Patient Name

Signature of patient, spouse or authorized consentor

Witness

Specify relationship

Date and time

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MEDICAL HEALTH INFORMATION

Date: _____

Name _____ Age _____ Birth Date: _____

Have you lived or traveled outside the U.S. or Canada? Y N Where & When _____

<u>Living</u>	<u>Age or Age of Death</u>	<u>Present health / Cause of Death</u>
Father <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mother <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brothers <input type="checkbox"/> Yes <input type="checkbox"/> No		
No. living ____ No. dead ____	_____	_____
Sisters <input type="checkbox"/> Yes <input type="checkbox"/> No		
No. living ____ No. dead ____	_____	_____
No. of Children Living _____	Ages and Health _____	_____
No. of Children Dead _____	Ages and Cause _____	_____

Please check off illnesses which have occurred in any of Your Blood Relatives:

- | | | | | |
|--|---------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervous Illness | |

Please check off illnesses or conditions YOU have had:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Vein Trouble | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> CHF | <input type="checkbox"/> COPD | |

Have you had serious injuries, broken bones, etc? Yes No _____

Allergies: Have you had allergy or sensitivity to medicine or other substances? Yes No _____

Medications: Please name medications used recently. (Prescription and over the counter) _____

Please list hospitalizations and surgeries:

Date	Hospital Name	Physician/Surgeon	Reason for Hospitalization	Type of Surgery
Date	Hospital Name	Physician/Surgeon	Reason for Hospitalization	Type of Surgery
Date	Hospital Name	Physician/Surgeon	Reason for Hospitalization	Type of Surgery
Date	Hospital Name	Physician/Surgeon	Reason for Hospitalization	Type of Surgery
Date	Hospital Name	Physician/Surgeon	Reason for Hospitalization	Type of Surgery

Previous x-ray therapy or similar treatment: _____

Do you drink coffee, tea or colas (caffeine)? Yes No Amount per day? _____

Do you use tobacco now? Yes No Amount per day? Yes No Type and daily amount _____

Do you use alcoholic beverages? Yes No Type? _____ Weekly amount? _____ How long? _____

Do you use chemical substances? Yes No Type? _____ How long? _____

Health Maintenance Status: (please provide shot record for all children under 21):

		Date			Date
Flu Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Breast Examination	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pneumonia Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis A Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Pelvic/Pap Smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Hepatitis V Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Blood in Stool Test	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tetanus/Diphtheria Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Rectal/Prostate Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cholesterol Level _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Sigmoidoscope	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Have you ever taken Cortisone-type drugs? Yes No Have you every taken Oral Contraceptives? Yes No

Have you ever received a blood transfusion? Yes No Date: _____

Your weight dressed _____ How long have you been at this weight? _____

Menstrual History: Last period date onset _____ Periods are Regular Irregular

Have you established an "Advanced Directive" (Living Will)? Yes No If **yes**, we will need a copy for your physician.

Would you like information about Advance Directives? Yes No Provided by _____ Date _____

Nutritional Functional Screening:

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Difficulty swallowing or chewing food | <input type="checkbox"/> Pressure ulcer | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Loss or gain of more than 51 pounds within last 2 months | <input type="checkbox"/> Receiving tube feedings | <input type="checkbox"/> Chronic illness | <input type="checkbox"/> CVA |
| <input type="checkbox"/> Falls | <input type="checkbox"/> Food allergy or intolerance | <input type="checkbox"/> Fracture | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Wound Care | <input type="checkbox"/> Diabetic | |
| <input type="checkbox"/> Decrease ability for self care | <input type="checkbox"/> Change in speech | <input type="checkbox"/> Increased ambulation | |

Center for Internal Medicine and Pediatrics

PATIENT FINANCIAL POLICY

It is the goal of Logan Medical Center Clinics to provide the best of care on your behalf. It is also our desire to assist you in the financial arrangements related to this care. Therefore, it is important for you to fully understand our insurance, credit, and collection policies. Please read the following information carefully and feel free to ask any questions you may have in any area. We ask that you sign this statement when you have read and understand each point covered.

1. Upon initial registration each patient is asked to complete our Patient Information Form, a Medical Information Sheet and a Patient Financial Policy. Updated information may be requested intermittently.
2. A copy of your primary and secondary insurance card will be requested each time your register for verification of insurance coverage and benefits.
3. If you have been referred to this office by your primary care physician and belong to an insurance plan that requires pre-certification or referral for this office visit, we request that you have this information available before your visit. Failure to supply this information may postpone your visit to the physician or make you responsible for the full balance of your account.
4. Your signature is requested for: Authorization and Consent for Treatment, Personal Valuables, Release of Medical Information and Insurance Assignment (including Medicare), Notice of Privacy Practices and Patient Financial Policy.
5. Payment for the patient portion is due at the time of service. If unusual circumstances should make it impossible for you to meet these terms, we invite you to discuss this with our business office the options available to you. We will work with you to arrive at a mutually agreeable payment plan. We accept Discover Card, MasterCard and Visa.

If you have health insurance, it should be understood that this is an agreement between you and your insurance carrier to pay for medical care. Our office is able to file your insurance claims for you. We hope this will alleviate part of the burden of necessary paper work. Your physician's bill is an agreement between you and this office. You are ultimately responsible for the payment of your bill regardless of the status of your insurance claim. The only exception in the above applies to those patients who are covered by insurance companies that our office has contracted to provide services within their fee schedule. These contracts are subject to change with or without notice.

6. All co-pays are due at the time of service.

7. You will receive regular statements (every 25 days) from our office informing you of the status of your balance. Feel free to call our office should you have any questions. If we have not received any payment after 120 days from the date of service, we reserve the right to refer your account balance to an outside collection agency where you will be responsible for all collection and legal fees. I also understand that there will be a \$20.00 fee for all checks presented for payment with non-sufficient funds (bad checks). You will also be billed separately by the hospital or other source, if it applies, for certain lab fees, radiology fees, and/or out-patient or in-patient procedures.

I have read and understand the above financial policy.

Signed: _____

Date: _____

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PATIENT INFORMATION:

_____	_____	_____	_____
Last Name	First Name	M.I..	Gender (male/female)
_____	_____	_____	_____
Mailing Address	City	State	Zip
_____	_____	_____	_____
Home Phone	Date of Birth	Age	Social Security No.

RESPONSIBLE PARTY: (if different from above):

_____	_____	_____	_____
Last Name	First Name	M.I..	Home Phone
_____	_____	_____	_____
Mailing Address	City	State	Zip
_____	_____	_____	_____
Employer	Work Phone	E-mail address (may be used for marketing)	

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY (person other than the above):

_____	_____	_____	_____
Name	Relationship to Patient	Home Phone	
_____	_____	_____	_____
Mailing Address	City	State	Zip
_____	_____	_____	_____
Employer	Employer's phone		

ADDITIONAL PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY (Neighbor preferably):

_____	_____	_____	_____
Name	Relationship to Patient	Home Phone	
_____	_____	_____	_____
Mailing Address	City	State	Zip
_____	_____	_____	_____
Employer	Employer phone		

INSURANCE INFORMATION (please give cards to receptionist for copying):

Please complete for billing purposes:			
_____	_____	_____	
Insurance Company	Office Visit Co-Pay	Telephone Number	
_____	_____	_____	_____
Claims Address	City	State	Zip
_____	_____	_____	
Name of Insured	Social Security No.		
_____	_____		
Policy Number/ID Number	Subscriber's Date of Birth		