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Allergic To:

Client Information Sheet and Agreement/Consent Form

Date: _____

Patient Information

Patient Last Name: _____ Patient First Name: _____ Middle: _____
Nickname: _____ Date of Birth: _____/_____/_____ Gender: ☐M ☐F
Social Security #: _____
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino
Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐White ☐Other (please specify):_____

Guarantor/Parent Information

Relationship to child:_____
Last Name: _____ First Name: _____ Middle: _____
Street Address: _____ City: _____ Zip:_____
Social Security #: _____ Date of Birth: _____ Gender: ☐M ☐F
Marital Status: Single / Married / Widowed / Divorced / Separated
Home Phone #: _____ Mobile Phone #: _____ Email:_____
Preferred method of communication: ☐Home Phone ☐Mobile Phone ☐Email
Do you give Hilltop Clinic consent to send text and voice reminders and messages for this patient? ☐**Yes** ☐**No**
Place of Employment: _____ Job Title: _____

Insurance Information

☐Uninsured/Self Pay ☐Insured (We will need to make a copy of your insurance card(s))

Primary Insurance: _____ Insured: _____ Social Security #: _____
Date of Birth: _____ Insured's Relationship to Patient: _____
Policy #: _____ Group #: _____
Secondary Insurance: _____ Insured: _____ Social Security #: _____
Date of Birth: _____ Insured's Relationship to Patient: _____
Policy #: _____ Group #: _____

I verify the above information is correct and complete to the best of my knowledge. I also authorize Reid D. Hebert, MD to file claims and for the release of medical records to the insurance company for claims purposes. The records authorized for release may include information which may indicate the presence of a venereal or other communicable disease. This includes, but is not limited to, Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Signature: _____ Date: _____

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Additional Contact Information

Emergency Contact Name: _____

Relationship to Patient: _____ Emergency Contact Phone #: _____

The following person(s) are authorized to bring the above named minor to the physician's office for medical treatment. Please indicate with an "X" if you would like the person(s) listed to receive medical records.

Name: _____ Phone : _____ Relationship to Patient: _____ Release MR: __

Name: _____ Phone : _____ Relationship to Patient: _____ Release MR: __

Name: _____ Phone : _____ Relationship to Patient: _____ Release MR: __

Any adult bringing a minor in for treatment will be required to validate their identity before services are provided.

Agreement and Consent for Services

My signature below signifies that I understand the following:

- Medical services offered through Christ Community Health Coalition (CCHC) may be administered by a variety of licensed medical professionals, which may include Residents and students.
- To ensure holistic care, it may be necessary for Christ Community Health Coalition care providers (physicians, volunteers, counselors, etc.) to share information about me with other providers involved in my care.
- Results of tests or procedures may be reported to me by telephone.
- Non-medical services may be provided by a variety of staff, volunteers, and students.
- Students and interns may shadow physicians.
- In accordance with the law, in the following situations, appropriate reporting will occur:
    - Any suspicion of child abuse under the age of 18 (mandated reporting).
    - Any suspicion of elder abuse over age 65 or vulnerable adult (mandated reporting).
    - Any suspicion of intent to harm self or others (mandated "Duty to Warn").
    - As mandated by law, such as court orders or subpoenas.
    - To defend a legal action against any volunteer, staff member, or CCHC.
- I understand that I am free to leave at any time and am here voluntarily.
- Encouragement and praying with and for patients are a part of CCHC care.
- Written communication from CCHC may be sent to the address provided above.

Understanding the above, I hereby give my consent to receive medical service and treatment from Christ Community Health Coalition.

Patient (or Parent/Legal Guardian) Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notices takes effect on 1/14/15 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices, and the new terms of our Notice effective for all health information that we maintain, including the health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information at the end of this Notice.

Uses and Disclosures of Health Information

Treatment: We may use or disclose medical information about you to provide you with medical treatment or services. We may use or disclose your medical information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to make payment for services we provide to you, if applicable.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. We may also disclose information to doctors, nurses, technicians, medical students and other practice personnel for review and learning purposes.

Research: We may use your health information for research and quality improvement purposes. All health information will be de-identified when used for such purposes. Your health information may also be maintained in an electronic medical record called Practice Fusion. Practice Fusion's stored clinical information is used as a de-identified clinical dataset that may be used at the discretion of Practice Fusion and its counterparts.

Appointment Reminders: We may use and disclose medical information in connections with our efforts to remind you that you have an appointment.

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

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

Abuse or Neglect: We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment or authorized by law.

Public Health and National Security: We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security.

For Law Enforcement: As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes.

Family, Friends, and Caregivers: We may disclose your health information to those you tell us will be helping you with your treatment and medications, but only if you agree we may do so.

Your Authorization: Disclosing your health information for any other purpose will require your written authorization. You may revoke that authorization at any time.

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Patient Rights

Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information.

Confidential Communications: You have the right to request that we communicate with you in a certain way. You must make this request in writing.

Access: You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records.

Amendment: You have the right to ask us to update or modify your records if you believe that your health information records are incorrect or incomplete. We may deny your request under certain circumstances.

Disclosure Accounting: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than treatment or health operations.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice direction from our office at any time.

Patient Acknowledgement

I hereby acknowledge that I have been provided with the **Christ Community Health Coalition Notice of Privacy Practices** and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

I understand the above information and give my permission to proceed:

Patient Name Date

Patient/Legal Guardian Signature Date

Office Use Only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevent us from obtaining acknowledgement
- Other _____

Authorization to Release Medical Records

Patient Name _____ Date of Birth __/__/__ Social Security # _____

I hereby authorize: _____
Physician / Facility Name

_____
Address

_____ _____
City/ State/ Zip Code Phone

And its authorized agents and employees to release the following information from the above named patient's medical records for the purpose of:

_____

Information to be released includes:

_____

Release to:

HILLTOP CLINIC
101 SW 25TH ST
OKLAHOMA CITY, OK 73109
OFFICE: (405) 724-7482
FAX: (405) 815-3297

In accordance with State Law, you are hereby advised that the records you authorize for release may include information regarding communicable or venereal diseases including, but not limited to, hepatitis, syphilis, gonorrhea, and human immunodeficiency virus, also now as acquired immune deficiency syndrome (AIDS).
Information released may include alcohol and drug abuse records protected under the code of Federal Regulations and Psychiatric Records. Re-disclosure of this information by the recipient is prohibited without specific authorization.
I understand that this authorization will automatically expire in 90 days from this date, but may be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.
I waive all rights and privileges allowed by law relating to disclosure of confidential information and release the facility, its agents, and employees from legal responsibility arising from the release of this information.

_____ _____ _____
Signature of Patient (or Representative) Relationship Date

_____ _____
Signature of Witness Date

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Identification Verification

Federal law requires patients/guarantors to validate their identity before services are provided. Section 114 of the Fair and Accurate Credit Transaction (FACT) Act of 2003 mandates implementation of a Red Flag Program that is consistent with the policies and procedures issued under section 326 of the USA PATRIOT Act, 31 U.S.C. 5318(1), requiring verification of the identity of persons opening new accounts. In order to be in compliance with the Federal regulations, please provide your photo identification and the policy holder's social security number when required by your insurer. This information will be maintained in a secure location and used only for identity validation. If you are unable to provide a photo ID, your account will be flagged for possible identity theft.

- ☐ Guarantor was unable to provide photo ID.
- ☐ Guarantor refused photo ID to be copied.
- ☐ Guarantor was unable to provide social security number of policy holder as required by insurer.

- ☐ Guarantor was able to provide photo ID.
- ☐ Guarantor was able to provide social security number of policy holder as required by insurer.

ID was viewed and verified by:_____ (employee signature)

Print Patient's Name: _____

Patient/Guarantor Signature: _____ Date: _____

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Wellness Visit Policy

Making sure your child is cared for on a routine visit is just as important as taking care of them when they are not feeling well. In accordance with American Academy of Pediatrics guidelines and Dr. Hebert's personal practicing policy, all patients are highly recommended to be seen at regular infant well child checks. Infants are seen at birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, and 24 months. After age two, patients are seen on a yearly basis. Each patient is reminded at well child visits when the next visit is due and is encouraged to schedule that visit.

Reminder phone calls are made to encourage the scheduling of these appointments. If patients fail to schedule and keep these appointments, resulting in repeated no-show appointments or refusing to comply with this policy, they will be terminated from Dr. Hebert's practice. Once a patient is terminated from Dr. Hebert's practice for failure to comply with the Wellness Visit Policy, they will not be reinstated.

Childhood immunizations are equally emphasized by Dr. Hebert and his staff. If a parent chooses not to administer a recommended vaccine, they will be required to sign the American Academy of Pediatrics Vaccine Refusal form. The form will become part of the patient's medical record. Refusing to sign this form will result in termination from our practice.

I have read and understand the wellness visit policy of Hilltop Clinic.

Patient (or Legal Guardian) Signature: _____ Date: _____

FINANCIAL POLICY AND AGREEMENT

Hilltop Clinic staff is committed to providing you with the best possible care. Your full understanding of our Financial Policy is important to our professional relationship. Please read this document to become familiar with our current Financial Policy.

Patients with Insurance: We are a participating provider with a number of insurances. Please bring your insurance card with you at the time of your appointment. You will be asked to pay all co-payments at the time of service. If your health insurance company does not cover 100% of the services rendered, you are responsible for any co-insurance, deductibles, or non-covered services that are not paid by your insurance. You will receive a statement from our office indicating the amount your insurance has paid and the amount remaining. Any remaining balance is due from you within thirty (30) days of your receipt of statement.

Patients without Insurance: If you are uninsured and self-pay at the time of your appointment, you will be charged the full cost of the visit based on our current fee schedule. We will do a self-pay adjustment to this cost that should in most situations lead to an out-of-pocket cost of no more than $20. In the event that any services may be rendered that will cause the out-of-pocket cost of the visit to exceed $20, you will first be notified before any of these services are done. Of note, we can only control the cost of the services within our facility. If you are referred for services outside of our facility, these will not be included in the $20 out-of-pocket cost, and you will be responsible for the full cost of these services. If you are unable to pay due to financial difficulties or any other reason, you may request to speak with the clinic manager or director about payment options.

Payment Following an Appointment: Regardless of your insurance status, if you are not able to pay any amount owed at the time of your appointment (i.e. the amount of your co-pay, co-insurance, deductible, non-covered services, uninsured service) and you must be billed by us, we will mail a statement to you within seven days of service or when we are alerted by your insurer that you must make a payment with us, as applicable. Payment is due from you to us within thirty (30) days of your receipt of the statement. In the event you fail to make the payment within this timeframe, we reserve the right to provide your name, contact information, and payment information to a national debt collection agency. The debt collection agency will then seek payment from you. In the event you continue to fail to pay the amount owed, we will notify you, by certified mail, that you have been dismissed from the Hilltop Clinic practice, and that you must find a new provider. For a period of thirty (30) days from the date you receive the notification from us, Hilltop Clinic will treat you for urgent matters only.

Separated/Divorced Families: Any family where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible for payment, and payment is due when services are rendered. Even though only co-pay may be due at the time of service, there may be other charges that the insurance company determines are your responsibility. In these cases, the parent who authorized treatment will be responsible for paying these charges. If the divorce decree requires both parents to split the charges incurred, it is the authorizing parent's responsibility to collect from the other parent. Hilltop Clinic will not act as a mediator in collecting payments.

FAILURE TO CANCEL A SCHEDULED APPOINTMENT CAN RESULT IN A $20 NO SHOW FEE.
I have read and understand the above financial policies of Hilltop Clinic.

_____ _____

Signature Date

Appointment Cancellation and "No Show" Policy

In order to be respectful to the medical needs of all our patients, we have established a "no show" policy. "No shows" inconvenience those individuals who need access to medical care in a timely manner, and they tie up our office and personnel resources.

A "no-show" is someone who misses an appointment without cancelling it in advance of the scheduled appointment time. Failure to present at the time of a scheduled appointment or a late cancellation will be recorded in the patient's account and in the chart as a "no show." A fee of $20.00 may be billed each time, which must be settled before another appointment is scheduled. This fee is not covered by health insurance plans. Emergency medical treatment will never be withheld.

*Patients covered by Soonercare are exempt from the above fee. OHCA guidelines are enforced. Patients will be notified by mail after their second "no show" occurrence. After the third "no show" occurrence, the patient will be removed from our panel.

Please be courteous and call us if you are unable to keep your scheduled appointment so you do not incur a "no show" charge.

I have read and understand the appointment cancellation and "no show" policy of Hilltop Clinic.

Patient (or Legal Guardian) Signature: _____ Date: _____

Telemedicine Informed Consent

Telemedicine services involve the use of the secure interactive videoconferencing equipment and devices that enable healthcare providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting HILLTOP CLINIC at 405-724-7482.
5. I understand that the laws that protect privacy and the confidentiality of healthcare information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of OKLAHOMA and will be in OKLAHOMA during my telemedicine visit(s).

_____ _____

Patient Printed Name Patient or Parent/Guardian Signature

_____ _____

Witness Signature Date