REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ Patient Date of Birth: _____

Patient Social Security Number (if known): _____ Sex: M F

Street Address: _____City: _____ State: _____Zip: _____

Preferred Pharmacy: _____

Referred By: _____

Additional Children with same address and insurance information may be listed for registration here:

Name: _____ Date of Birth: _____ SS#: _____ Sex: M F
Name: _____ Date of Birth: _____ SS#: _____ Sex: M F
Name: _____ Date of Birth: _____ SS#: _____ Sex: M F
Name: _____ Date of Birth: _____ SS#: _____ Sex: M F

PARENT INFORMATION

Father's Name: _____ Date of Birth: _____

Social Security Number: _____ Employer: _____

Address if Different than Above: _____

Home Phone: _____ Mobile Phone: _____

Mother's Name: _____ Date of Birth: _____

Social Security Number: _____ Employer: _____

Address if Different than Above: _____

Home Phone: _____ Mobile Phone: _____

E-mail Address for Patient Portal Access: _____

Emergency Contact (not in household): _____ Phone: _____

Relationship to patient: _____

INSURANCE INFORMATION

Policy Holder: _____ Insurance Name: _____

Policy ID Number: _____Group Number: _____

Secondary Policy Holder: _____ Insurance Name: _____

Policy ID Number: _____Group Number: _____

LABORATORY INFORMATION

It is the patient's (or primary insured's) responsibility to know which lab, diagnostic facility, or specialist is in their insurance network. If the patient does not provide the office staff with the correct information, all lab orders will be sent to Norman Regional Hospital or Diagnostic Laboratory of Oklahoma (DLO). Any additional charges will be patient responsibility. Please list the lab you prefer, if any, below.

Name of Lab: _____

Patient/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE (ATTACHED)

I have received a Notice of Privacy Practices from the office of Dr. Crystal Sparling and Dr. Ashley Yates.

Patient/Guardian Signature: _____

Date: _____

FINANCIAL POLICY

Payment for services from Scissortail Pediatrics is your responsibility as the patient account guarantor. As a courtesy to you, Scissortail Pediatrics verifies the insurance benefit information that you provide and files your claims accordingly. You are responsible for understanding your insurance network, coverage, and benefits. You are responsible for any unpaid balance on your account.

It is the policy of Scissortail Pediatrics that appropriate payment is due at the time of service. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visit, Scissortail Pediatrics will file your insurance claim for your convenience. Once we receive the Explanation of Benefits (EOB) and payment from your insurance company it will be posted to your account. Your insurance company will send you the same EOB. If there is an unpaid balance on your account, we will send you an account statement (1st notice). A positive account balance greater than $25.00 may be refunded to you upon request.

Scissortail Pediatrics offers an Easy Pay program for your convenience. All patients with commercial insurance are encouraged to keep a credit, debit, or health savings account (HSA) card on file via our secure payment gateway. If an unpaid balance remains on your account 30 days after the statement date (1st notice), Scissortail Pediatrics will charge the unpaid balance to your card on file. If the balance due is more than $100.00, you will receive a courtesy call prior the charge. If the charge payment is unsuccessful (i.e. due to insufficient funds or invalid card) another statement (2nd notice) will be sent to you. Accounts that are unpaid for 60 days from statement date (1st notice) will be charged a 30% collection fee and forwarded to our collection agency.

Scissortail Pediatrics accepts payments via cash / check / credit card. A $30.00 fee will be charged for each returned check.

I have read the above financial policy and agree to its terms. This policy supersedes any policy previously signed. I understand that I am responsible for understanding my insurance network and benefits. I am responsible for all unpaid balances on my account.

I hereby authorize Dr. Crystal Sparling and Dr. Ashley Yates to furnish information to insurance carriers concerning my child's illnesses 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 any amount not covered by insurance for any reason. I understand copays/coinsurance/or deductibles are due at the time of service.

_____ _____

Signature of Account Guarantor (Parent/Guardian) Date

_____

Printed Name of Account Guarantor (Parent/Guardian)

Policy Updated 8/31/2017

FREQUENTLY ASKED QUESTIONS

What is a Deductible and How Does It Affect Me?
An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the insurance company begins to pay for any services. This works just like the deductible for your car insurance or homeowner's insurance policy. Your deductible begins at the start of your plan year. Most plan years begin either January 1 or July 1, but plans can start on any date.

How will I know when my deductible has been met?
You can call your insurance company at any time to check on how much of your deductible has been met and some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay if the amount went to your deductible when they send you an Explanation of Benefits (EOB.)

Why Easy Pay?
With the changing environment in healthcare, more responsibility of payment is being placed on the patient/family. We need to be sure that patient balances are paid in a timely manner so that we can continue to care for our patients appropriately. Easy Pay card on file allows us to process your account in a timely, convenient manner. This is the same situation you have likely encountered at other businesses such as hotels and car rental companies!

My High-Deductible Health Plan has a Health Savings Account (HSA) Card. Can I keep my HSA card on file?
Yes, you can keep your HSA card on file.

But I always pay my bills, why should I use Easy Pay?
We have wonderful families, and we know that most of you pay your balances and pay in a timely fashion. Unfortunately, that is not always the case. Easy Pay helps simplify our payment process for all our patients. Easy Pay is secure and convenient for our busy families.

How will I know how much you are going to charge me?
You will receive a letter in the mail (or e-mail) from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB.) This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay.

Then what?
We receive the same Explanation of Benefits (EOB) that you do. Most Insurances will send your EOB prior to us receiving our copy. It arrives about 10-20 days after your appointment has been billed. We look at each EOB carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a statement for in the mail.

But wait, I'm nervous about leaving you my credit card information…
We do not store your sensitive credit card information in our office. We store it on a secure website called a gateway. The secure gateway we use is called Availity. Availity uses industry standard encryption and security. This gateway is only used to process your payment and email you a receipt once payment is processed. You will fill out the Easy Pay Authorization Form and give us your credit card in person. We will enter your card information directly in the Availity gateway and return the card to you. With the provided encryption, we will never see all the numbers of your credit card. Once your information is collected, our staff only has access to the last 4 digits of your card number for verification purposes.

What if I need to dispute my bill?
We will always work with you to understand if there has been a mistake. We will refund your credit card if we or if your insurance company has made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the EOB they send to us, in the same way that we normally determine how much to send you a bill for in the mail.

What if I have more questions?
Our staff is happy to speak with you about your account at any time.

EASY PAY AUTHORIZATION FORM

Scissortail Pediatrics accepts payments via cash / check / credit card for payments made in person at our office. We will store your HSA/debit/credit card information to be processed for any remaining balance after your insurance's Explanation of Benefits (EOB) and payment has been processed.

Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the secure Availity system.

The undersigned agrees and authorizes Scissortail Pediatrics to charge the credit card below for payments by the guarantor named below:

NAME AS IT APPEARS ON CARD _____

LAST 4 DIGITS OF MY CARD NUMBER __ __ __ __

EXPIRATION DATE __ __ / __ __

BILLING ADDRESS _____

BILLING CITY / STATE / ZIP_____

PHONE NUMBER _____

EMAIL (to send receipts) _____

I understand that once my insurance claim has been processed, I will receive an Explanation of Benefits (EOB). ***The insurance plan EOB will state any balance remaining to be paid by me. Scissortail Pediatrics will also send me a statement with any unpaid balance.*** *If I do not make other arrangements to pay my statement balance, I agree that Scissortail Pediatrics may charge my payment card on file for the total balance due 30 days after my statement date.*

If the balance due is more than $100.00, I will receive a courtesy call prior to my card being charged.

AUTHORIZED SIGNATURE_____ DATE_____

Patient accounts this card applies to:

NAME_____ DOB_____

NAME_____ DOB_____

NAME_____ DOB_____

NAME_____ DOB_____

OFFICE USE ONLY

Guarantor Account Number: _____ Date Entered Into Availity: ___/___/____ Entered By: _____

Scissortail Pediatrics

Crystal Sparling, MD, MPH
Ashley Yates, MD

Vaccination Policy Agreement

Child's Name_____

I, _____, understand that I must vaccinate my child according to the attached schedule provided by Dr. Ashley Yates and Dr. Crystal Sparling unless a medical condition requires otherwise. 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 vaccines according to the attached schedule which is in accordance with the recommendations of the American Academy of Pediatrics and the Centers for Disease Control and Prevention unless a medical condition requires early or delayed vaccination. If my child is new to the practice, I agree to continue vaccinating according to the CDC schedule or according to the recommended catch-up schedule appropriate for my child's age. Dr. Yates and Dr. Sparling may be willing to make adjustments to the attached schedule provided that each vaccine is given within the age range recommended by the CDC. Dr. Yates and Dr. Sparling reserve the right to approve or deny alterations to the attached vaccine schedule. I understand that I am responsible for any additional fees associated with alternate vaccine schedules.

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 _____

IMMUNIZATION SCHEDULE

BIRTH
HEPATITIS B

2 MONTHS
PEDIARIX (HEPATITIS B, DIPTHERIA, TETANUS, ACELLULAR PERTUSSIS, INACTIVATED POLIO VIRUS)
HIB (HAEMOPHILUS INFLUENZAE TYPE B)
PREVNAR (PNEUMOCOCCAL PCV 13)
ROTATEQ (ROTAVIRUS, ORAL)

4 MONTHS
DTAP
IPV
HIB
PREVNAR
ROTATEQ

6 MONTHS
PEDIARIX
PREVNAR
ROTATEQ

12 MONTHS
MMR (MEASLES, MUMPS, AND RUBELLA)
VARICELLA
HEPATITIS A

15 MONTHS
DTAP (DIPTHERIA, TETANUS, ACELLULAR PERTUSSIS)
HIB
PREVNAR

18 MONTHS
HEPATITIS A

4 YEARS
KINRIX (DTAP/IPV)
PROQUAD (MEASLES, MUMPS, RUBELLA, AND VARICELLA)

10-12 YEARS
MENACTRA (MENINGOCOCCAL)
TDAP
GARDASIL (HUMAN PAPILLOMA VIRUS, 2 DOSES)

16 YEARS
MENACTRA
TRUMEMBA (MENINGOCOCCAL B, 3 DOSES)

SEASONAL INFLUENZA VACCINES NEEDED YEARLY AFTER 6 MONTHS OF AGE. FIRST SEASON WILL REQUIRE 2 VACCINES, 1 MONTH APART.

Updated 3/10/17

SCISSORTAIL PEDIATRICS

865 E Veterans Memorial Hwy, Blanchard, OK 73010

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. Crystal Sparling and Dr. Ashley Yates
- All employees of Scissortail Pediatrics and those who provide services for Scissortail 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.

Crystal Sparling, MD
Ashley Yates, MD

Authorization of Treatment of Minor

Child's Name: _____Date of Birth: _____

I, _____ (Parent/Guardian), do hereby give permission for Dr. Crystal Sparling or Dr. Ashley Yates of Scissortail Pediatrics to administer medical treatment to my minor child,

_____ (child's name).

The following person (s) have my permission to accompany the child listed above for medical treatment:

	Name	Phone Number	Relationship
1.			
2.			
3.			

Parent/Guardian Name _____

Parent/Guardian Signature _____Date _____

Pediatric Health History – Initial Visit

Please answer all questions, circle choice when applicable

Patient's Name: _____ Date of Birth: _____

Your Name: _____ Relationship to Patient: _____

BIRTH HISTORY

Where was the child born? _____

Is the child yours by: birth adoption stepchild other _____

Pregnancy complications/infections: _____

Maternal use of: tobacco alcohol illegal substances prenatal vitamins medications _____

Delivered by: c-section vaginal Weeks gestation at delivery: _____ Birthweight: _____length:_____

Did the baby require any NICU care? Describe: _____

Was the baby discharged to home with mother? _____

GENERAL HISTORY

Does your child have any medical conditions? (describe) _____

_____

Has your child ever been hospitalized? (describe) _____

Are your child's immunizations completely up to date **including a flu** shot this season? _____

Any surgeries or procedures? (describe) _____

List any other physicians your child is currently seeing and why: _____

Child's dentist: _____ Optometrist or ophthalmologist: _____ Vision test in last year? _____

Medications (daily and as needed, including vitamins, inhalers):

Medication	Dose	Frequency	Reason

Allergies (medications, environmental, and foods):

Allergen	Observed Reaction

Has your child ever had any of the following?

Anemia	YES	NO	Explain
Asthma, wheezing, or reactive airway disease	YES	NO	Explain
Cancer or malignancy	YES	NO	Explain
Constipation	YES	NO	Explain
Depression/anxiety/mood problems/ADHD	YES	NO	Explain
Developmental delay or learning difficulty	YES	NO	Explain
Genetic syndrome/Metabolic Disorder	YES	NO	Explain
Infectious disease	YES	NO	Explain
Kidney or urologic disease	YES	NO	Explain
Recurrent ear infections	YES	NO	Explain
Seizures	YES	NO	Explain
Serious injuries/fractures/concussions	YES	NO	Explain
Sleep problems, snoring	YES	NO	Explain
Urinary tract infections	YES	NO	Explain
Vision or hearing problems	YES	NO	Explain

For girls: Has she had her first period? ___ If yes, age at first period ____ Any problems with periods? _____

DEVELOPMENT/NUTRITION

At what age did your child: sit alone? _____ walk alone? _____ say words? _____ toilet train? _____
Has your child had any unusual feeding/dietary problems? (describe) _____
Briefly describe your child's current diet: _____

REVIEW OF SYSTEMS (circle all that apply)

Constitutional: fever, chills, fatigue, unexplained weight loss
Eyes: poor vision, blurry vision, eye pain, eye discharge, eye redness, eye injury Does the patient wear glasses? _____
Ears/nose/throat: sore throat, mouth-breathing, snoring, ear pain, ear discharge, runny nose, congestion
Respiratory: cough, shortness of breath, fast breathing, wheezing, loud breathing
Cardiovascular: chest pain, palpitations, fast heart rate, fainting, tires easily with exertion, turns blue
Gastrointestinal: nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain
Genitourinary: frequent urination, pain with urination, bedwetting, frequent accidents
Musculoskeletal: muscle pain, weakness, joint pain, joint swelling
Neurologic: headaches, seizures, milestone delay, clumsiness
Psychiatric: anxiety, stress, depression, sleep problems, anger, difficulty paying attention, difficulty controlling impulses

FAMILY HISTORY

Do any family members have any of the following conditions:

Alcohol abuse	YES	NO	Mother	Father	Sibling	Grandparent
Anemia or blood disorder	YES	NO	Mother	Father	Sibling	Grandparent
Asthma, wheezing, or reactive airway disease	YES	NO	Mother	Father	Sibling	Grandparent
Cancer	YES	NO	Mother	Father	Sibling	Grandparent
Depression/anxiety/mood problems/ADHD	YES	NO	Mother	Father	Sibling	Grandparent
Developmental delay or learning difficulty	YES	NO	Mother	Father	Sibling	Grandparent
Diabetes	YES	NO	Mother	Father	Sibling	Grandparent
Drug abuse	YES	NO	Mother	Father	Sibling	Grandparent
Heart problems or high blood pressure	YES	NO	Mother	Father	Sibling	Grandparent
Kidney disease	YES	NO	Mother	Father	Sibling	Grandparent
Migraines	YES	NO	Mother	Father	Sibling	Grandparent
Obesity	YES	NO	Mother	Father	Sibling	Grandparent
Seizures	YES	NO	Mother	Father	Sibling	Grandparent
Stroke	YES	NO	Mother	Father	Sibling	Grandparent
Thyroid disease	YES	NO	Mother	Father	Sibling	Grandparent

Other (please describe): _____

SOCIAL HISTORY

Household (please list everyone living in the child's home):

Name	Relationship to child	Name	Relationship to child

What is the child's living situation if not living with both biological parents?
Lives with foster family Lives with adoptive parents Joint custody Single custody
If one or both parents are not living in the home, how often does the child see them? _____
Do any household members smoke? YES NO
Does your child attend childcare not in the home? (describe) _____
Name of child's school: _____ Grade: _____
Any concerns regarding peer or teacher relationships? _____
Child's sports/exercise: type(s)_____ how often? _____
How many hours per day does the child spend: watching TV? ___ on a computer? ___ video gaming? ___ reading? ___