NEW PATIENT INDENTIFICATION SHEET

Name: _____ Birth date: _____
Last First Middle

Date First Seen: _____ Referred By: _____ Race: _____ Sex: _____

Mother's Name: _____ SS#___ ___ _____ Birth Date:_____
Last First Middle

Cell: _____ Online Patient portal sign up Email: _____

Address: _____
Street City Zip

Employer _____ Work Number_____ Home Phone: _____

Father's Name: _____ SS#___ ___ _____ Birth Date:_____
Last First Middle

Cell: _____ Online Patient portal sign up Email: _____

Address: _____
Street City Zip

Employer _____ Work Number_____ Home Phone: _____

Preferred phone number for us to call or Text You: _____.

Person to Call in an Emergency: _____ Relation: _____ Phone: _____

Other Children in Family:

Name Last First Birth Date

1. _____
2. _____
3. _____

Name: Last First Birth Date

4. _____
5. _____
6. _____

Guarantor's Name _____ **Relationship to patient** _____

Insurance Company Name: _____ **Effective date**_____

Policy Holder Name: _____ **Birth date:** _____ **Relationship to Patient**_____

Group No: _____ **Member ID No:** _____ **Co-Pay**_____

INSURANCE AUTHORIZATION, ASSIGNMENT & TEXT FROM OFFICE:

I hereby authorize Dr. Bharani to treat my child/children for any illness in my absence and furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for medical services rendered to my dependents. I hereby AUTHORIZE Dr Bharani's Office contact us via text and/or by patient portal. I am aware child's name will appear on Text.

I understand COPAYMENT AND DEDUCTIBLE ARE DUE AND PAYBALE AT TIME OF SERVICE. It is my responsibility to provide proper insurance Information to this office for staff to file insurance properly. I understand that I am responsible for any amount not covered by insurance. I further permit a copy of this authorization to be used in place of original. I will be paying today by:

Cash_____ **Check**_____ **Charge card**_____ **Debit card:** _____

_____ **Date:**_____

Signature of Parent/Legal Guardian **Relationship**

Authorized Signature Form/ Patient Agreement

Patient's Name: _____ Birth Date: _____

Last First Middle

DISCLOSURE OF INFORMATION: I understand that my medical records and billing information are made and retained by Aspen Children's Clinic Of Broken Arrow Inc.(ACC INC.) and are accessible to ACC INC. personnel and medical staff. ACC Inc. personnel and physician in attendance may use and disclose medical information for health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. ACC INC personnel and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of ACC INC charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that ACC INC advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human immunodeficiency Virus and acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance benefits for ACC, Inc. (P.C.) charges payable to the insured are to be made payable to ACC Inc.(P.C.) and that physician benefits otherwise payable to the insured are to be made payable to the ACC Inc responsible for my care.

PRECERTIFICATION POLICY

I understand that ACC Inc. (P.C.) will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on an insurance payment.

FINANCIAL RFSPONSIBILITY

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for services rendered by ACC Inc. (P.C.) I agree to notify ACC Inc of any changes to my insurance coverage and demographic information. I also agree the demographic and insurance coverage information that I have provided to ACC Inc is complete, correct and accurate.

CERTIFICATION: I hereby certify that I have read each of the above statements, and have had each item explained to me, to my satisfaction. I am aware that I can request a copy of the Patient Agreement at any time at no cost to me and/or have received a copy. I further certify that I am the patient or am duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by ACC Inc.(P.C) is in our NOTICE OF PRIVACY PRACTICES, Copies are available at the clinic.

(I received a copy of ACC Inc (P.C.) NOTICE OF PRIVACY PRACTICES)

_____

Signature of Parent/ Legal Guardian **Relationship** **Date Signed**

_____

Print Name of Parent/Legal Guardian/ Responsible Party's Name

_____

Basis for refusal, if refused.

ASPEN CHILDRENS CLINIC
3300 SOUTH ASPEN
SUITE B
BROKEN ARROW, OK 74012

CONSENT FOR MEDICAL INJECTION

Patient_____ Birthdate_____

I hereby give permission for Dr. Bharani, M.D. and medical assistant that he might designate to administer an injection of antibiotics, immunizations, or allergy serum to _____as needed for child's future healthcare.
(Patient's Name)

I have been informed of the purpose for the injection and am aware of possible side effects and reactions, some of which include, but not limited to:

Local site reaction
Discomfort at or around injection site
Rash
Itching
Hives

Difficulty breathing
Impaired vision or hearing

Asthma attack
Fainting
Facial or tongue swelling
Damage to kidneys
Damage to nerve, blood vessel, or muscle
Severe Anaphylactic attack resulting in brain damage or death

I HAVE READ AND UNDERSTAND THE ABOVE CONSENT FORM, AND ALL QUESTIONS WERE ANSWERED IN A LANGUAGE THAT I UNDERSTOOD. ALL OF THE BLANKS WERE FILLED IN PRIOR TO MY SIGNATURE.

Signature of Parent/Guardian_____
Relationship_____

Witness_____/Staff