I _____, parent/ guardian of

_____

understand that 24 hour notice is required for all prescription refills. If 24 hours falls on a holiday, weekend, or day of office closure, the refill will be ready 24 hours after the office has reopened. Please call 376-5439, option 3 to leave the nurse a voicemail. It is time stamped with your call time and date. Please do not leave a message with the after hours service or page Dr. Cosby with this request as it will NOT be written sooner than 24 hours.

##########

PATIENT INFORMATION

*******THIS IS A 2 PAGE FORM*******

PATIENT NAME_____ BIRTHDATE_____ SEX____

ADDRESS_____ CITY_____ STATE____ ZIP_____

PRIMARY PHONE_____ [ ] **CHECK IF OK TO TEXT**

SIBLINGS NAME_____ AGE_____ NAME_____ AGE_____

NAME_____ AGE_____ NAME_____ AGE_____

PARENTAL INFORMATION

MOTHER'S NAME_____ BIRTHDATE_____ SS#_____

HOME PHONE_____ CELL PHONE_____

ADDRESS_____ CITY_____ STATE____ ZIP_____

WORK PHONE_____ EMPLOYER_____

Does parent live with child? Please circle one. YES NO

FATHER'S NAME_____ BIRTHDATE_____ SS#_____

HOME PHONE_____ CELL PHONE_____

ADDRESS_____ CITY_____ STATE____ ZIP_____

WORK PHONE_____ EMPLOYER_____

Does parent live with child? Please circle one. YES NO

PRIMARY INSURANCE INFORMATION

NAME OF POLICY HOLDER_____ RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S DOB_____ POLICY HOLDER'S ADDRESS_____

INSURANCE COMPANY_____ PHONE NUMBER_____

INSURANCE IDENTIFICATION NUMBER_____ GROUP NUMBER_____

******* COMPLETE SIDE 2 (OVER) *******

SECONDARY INSURANCE INFORMATION

NAME OF POLICY HOLDER_____RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S DOB_____ POLICY HOLDER'S ADDRESS_____

INSURANCE COMPANY_____ PHONE NUMBER_____

ADDRESS_____ CITY_____ STATE____ ZIP_____

INSURANCE IDENTIFICATION NUMBER_____GROUP NUMBER_____

EMAIL INFORMATION

Would you like to be contacted by E-Mail? Circle one. YES NO (Appointment reminders, etc.)

If so, please validate your E-Mail address. _____

EMERGENCY CONTACT

NAME_____RELATIONSHIP TO PATIENT_____

PHONE #1_____ PHONE #2_____

(SOMEONE OUTSIDE OF THE HOME)

CONSENT FOR TREATMENT

I hereby apply for treatment by the physicians of this practice and/or their assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled, including Medicare, private insurance and other health plans, to this practice. I understand it is my responsibility to pay any deductible and/or co-payment amount, and that I am financially responsible for all charges whether or not paid by insurance. The practice is authorized to use my medical information in its quality assurance and utilization review programs, and may disclose such information for medical research purposes.

SIGNATURE_____ DATE_____

Consent and Authorization for treatment of minor

What would happen if your child became ill or had an accident while you were away? A physician's office is not legally authorized to treat a minor without the parent's or legal guardian's consent. That's why it is important for you to take necessary precautions. Take a moment to complete this consent form and leave it with our office to ensure your child will receive prompt medical treatment if an emergency occurs.

Date: _____

Parent or Custodial Guardian: _____

Address: _____

Telephone Number: _____

Name & DOB of Child: _____

Known Allergies: _____

I, hereby grant unto temporary guardianship of my minor child here and above named. Said guardian is authorized to approve medical care or treatment to my minor child in my absence.

(Please Print)

Temporary Guardian: _____
Address: _____
Phone Number: _____

Temporary Guardian: _____
Address: _____
Phone Number: _____

Temporary Guardian: _____
Address: _____
Phone Number: _____

Temporary Guardian: _____
Address: _____
Phone Number: _____

Signature: _____ Date: _____

Please complete a separate form for each child.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT AND CONSENT

The Notice of Privacy Practices tells you how we may use and share your health records. **Please read it.**

* We will use and share your health records to treat you.
* We will use and share your health records to bill you for the services we provide.
* We will use and share your health records to run our business.
* We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of the Notice of Privacy Practices for Park Place Medical.

Patient's Name: _____

Signature: _____ Date: _____
(of Patient or Legal Representative)

Capacity of Legal Representative (if applicable)*: _____

Staff only: If patient did not, or could not, acknowledge receipt of the Notice, indicate why: _____
_____

Park Place Medical, P.L.L.C.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting your medical information. We are required by law to:

- Maintain the privacy of your medical information;
- Give you a notice of our legal duties and privacy practices with respect to your medical information; and
- Follow the terms of the notice of our privacy practices currently in effect.

What is this document?

This Notice of Privacy Practices describes how we may use and disclose your medical information. It also describes your rights to access and control your medical information.

What and who does this Notice cover?

This Notice will be followed by all of the employees and volunteers associated with Park Place Medical, P.L.L.C. This Notice of Privacy Practices applies to *all* of your medical information used to make decisions about your care that we *generate or maintain*. Different privacy practices may apply to your medical information that is created or kept by other people or entities.

What will you do with my medical information?

The following categories describe the ways that we may use and disclose your medical information with your consent. Not every use or disclosure in a category will be listed.

If you do not consent, we cannot provide you with treatment, except in an emergency situation or when we cannot communicate with you for some other reason. If you are concerned about a possible use or disclosure of any part of your medical information, you may request a restriction.

Treatment. We will *use* your medical information to provide you with medical treatment and services.

> *Example:* Your medical information may be used by doctors, nurses and other health care providers who are involved in taking care of you.

We may *disclose* your medical information for the treatment activities of any other health care providers.

> *Example:* We may send a copy of your medical record to another health care provider who needs to provide follow-up or additional care to you.

Payment. We may *use* medical information about you for our payment activities. Common payment activities include, but are not limited to:

- Determining eligibility under a plan; and
- Billing and collection activities.

> *Example:* Your medical information may be released to an insurance company to obtain payment or pre-approval for services.

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We may *disclose* medical information about you to another health care provider, health plan or clearinghouse for its payment activities.

> *Example:* We may give your payment information to a hospital or laboratory that provide a service to you at our request in order for the hospital or laboratory to bill for its services.

Operations. We may *use* your medical information for our operations. These uses are necessary to run our office and to make sure patients receive quality care. Common operation activities include, but are not limited to:

- Conducting quality assessment and improvement activities;
- Training healthcare professionals;
- Arranging for legal or auditing services;
- Business planning and development;
- Business management and administrative activities; and
- Communicating with patients about services we provide.

> *Example:* We may use your medical information to conduct billing reviews or patient satisfaction surveys. We might use a patient list to announce the arrival of a new provider or service.

We may *disclose* medical information about you to another health care provider or covered entity for its operation activities under certain circumstances.

> *Example:* We may disclose your medical information to your health plan for its utilization review analysis or to another provider for its quality assurance activities.

Business Associates. We may disclose your medical information to other entities that provide a service to us or on our behalf that requires the release of patient medical information. However, we only will make these disclosures if we have received satisfactory assurance that the other entity will properly safeguard your medical information.

> *Example:* We may contract with another entity to provide transcription or billing services.

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

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend, family member or legal guardian who is involved in your medical care or who help pays for your care. We may tell your family or friends your general condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical treatment or services or that you need a prescription refill.

and/or disclose **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.

Research. We may use and disclose medical information about you to researchers. In most circumstances, you must sign a separate form specifically authorizing us to use your medical information for research. However, there are certain exceptions. Your medical information may be disclosed without your

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authorization for research if the authorization requirement has been waived or altered by a special committee that is charged with ensuring that the disclosure will not pose a great risk to your privacy or that measures are being taken to protect your medical information. Your medical information also may be disclosed to researchers to prepare for research as long as certain conditions are met. Medical information regarding people who have died can be released without authorization under certain circumstances. Limited medical information may be released to a researcher who has signed an agreement promising to protect the information released.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Can you ever use and disclose my medical information without my consent? Yes. The following categories describe the ways that we may be required to use and disclose your medical information without your consent. Not every use or disclosure in a category will be listed.

Required by Law. We may disclose your medical information when required to do so by federal, state or local law.

> *Examples:* (1) We may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. (2) We are required by law to report criminally inflicted injuries and cases of abuse and neglect. These reports may include your medical information.

Public Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat.

Public Health. We may disclose medical information about you for public health activities intended to:

- Prevent or control disease, injury, or disability;
- Report births and deaths;
- Report abuse, neglect, or violence as required by law;
- Report reactions to medications or problems with products;
- Notify people of recalls of products they may be using; or
- Notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

> *Example:* Oklahoma law requires us to report, among other things, tumors, birth defects, cases of communicable disease, infant eye infections, infants born exposed to alcohol and other harmful substances, and abortions.

Food and Drug Administration (FDA). We may disclose health information relative to adverse events, with respect to food, supplements, product and product defects, or post-marketing surveillance information, to enable product recalls, repairs or replacements to the FDA and to manufacturers.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena or discovery request, but only if efforts have been made to inform you about the request or to obtain an order protecting the information requested, unless the physician-patient privilege has been waived.

Law Enforcement. We may release medical information if asked to do so by law enforcement official:

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

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Military/Veterans. We may disclose your medical information as required by military command authorities, if you are a member of the armed forces.

Inmates. If you are an inmate of a correctional facility or under the custody of law enforcement official or agency, we may release your medical information to the correctional facility or law enforcement official or agency. This release may be necessary to: (1) enable the correctional facility to provide you with health care; or (2) protect the health and safety of you and/or other people.

Oklahoma law requires that we inform you that your medical information used or disclosed as described in this *Notice of Privacy Practices* may include records which indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). Any use or disclosure also may include mental health or other sensitive information.

What if you want to use and/or disclose my medical information for a purpose not described in this Notice?

We must obtain a separate, specific authorization from you to use and/or disclose your medical information for any purpose not covered by this Notice or the laws that apply to us. In other words, the consent you

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already provided will not be enough to use and/or disclose your information for any purpose that is not described in this Notice.

If you provide us with authorization to use or disclose your medical information, you may revoke the authorization, in writing, at any time. If you revoke your authorization, we will not use or disclose your medical information for the reasons covered by your authorization. *However,* your revocation will not apply to disclosures already made by us in reliance on your authorization.

What are my rights regarding my medical information?

You have the rights described below in regard to the medical information that we maintain about you. You are required to submit a written request to exercise any of these rights. We can provide forms for exercising any of these rights.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of medical information used to make decisions about your care maintained in our designated record set. This right does not apply to a very narrow category of medical information referred to as "psychotherapy notes".

If you request a copy of your medical information, we may charge a fee of 25 cents a page. If you request a copy of a film, we may charge the actual cost of reproduction, not to exceed $5.00. We also may charge for postage if you request that we mail the information. We may deny your request to inspect and/or copy your medical information in certain circumstances. If you are denied access, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information that we created is incorrect or incomplete, you may request that we amend your information by adding clarifying language. We cannot delete or destroy any information already included in your medical record. *You must provide a reason that supports your amendment request.*

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask to amend information that:

- We did not create, unless the person or entity that created the information is not available to make the amendment;
- Is not part of the medical information that we maintain;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request one free list of disclosures every 12 months. There are several categories of disclosures that we are not required to list in the accounting. For example, we do not have to keep track of disclosures made for treatment, payment or health care operations or for those disclosures that are authorized. *Your request must state a time period, which may not be longer than 6 years and may not include dates before April 14, 2003.*

If you request more than 1 accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you unless our use and/or disclosure is required by law. You also have

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the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *For example*, you may want to pay cash for certain services instead of having information submitted to your insurance company for payment. *We are not required to agree to your request.* If we agree, we will comply with your request unless the information is needed to provide emergency treatment to you. You must specify the type of restriction you want and to whom it applies.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. *For example*, you can ask that we only contact you at work or by mail. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. Copies of this Notice always will be available at our registration desk and posted in our office and on our website *[if applicable]*.

Can you change this notice?

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. Copies of the current notice will be posted in our office and on our website *[if applicable]* and will be available for you to pick up on each visit to our office.

What if I have questions or need to report a problem?

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services.

To file a complaint with us, or if you would like more information about our privacy practices, contact our Privacy Official at (405) 376-5439. The Privacy Official's mailing address is: 500 Park Place, Mustang, OK 73064.

To file a complaint with the Secretary of the Department of Health and Human Services, you must submit the complaint within 180 days of when you knew or should have known of the circumstance that led to the complaint. The complaint must be submitted in writing. Our Privacy Official can provide you with current contact information.

You will not be penalized for filing a complaint.

OKLAHOMA STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ Medical Record #:_____

Date of Birth:_____ Social Security #:_____

I hereby authorize _____
Name of Person/Organization Disclosing PHI

to release the following information to _____
Name and Address of Person/Organization Receiving PHI

Information to be shared:

☐ Psychotherapy Notes (if checking this box, no other boxes may be checked) ☐ Entire Medical Record

☐ Billing Information for_____ ☐Mental Health Records

☐ Substance Abuse Records ☐ Medical information compiled between_____ and _____

☐ Other:_____

The information may be disclosed for the following purpose(s) only:

☐ Insurance ☐ Continued Treatment ☐ Legal ☐ At my or my representative's request

☐ Other:_____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea or HIV or AIDS and/or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature or upon the occurrence of the following event:_____

_____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Description of Legal Representative's Authority Expiration date (if longer than one year from date of signature or no event is indicated)