UTICA Pediatrics
GROWING WITH YOU

Authorization for Consent to Medical Treatment of Minor Child

If your child needs emergency medical care and you aren't available to give formal consent to medical authorities, care may be unnecessarily delayed. To protect your child, leave a completed **EMERGENCY CONSENT FORM** with your baby-sitter, day care center or temporary guardian. In the event of a medical emergency, the form should accompany your child to the hospital.

I/we hereby authorize _____ to give consent for all medical and/or surgical treatment that may be required for our child during our absence.

Child/Children's Full Name _____

Date of birth _____

Child's Physician: _____

Child's Allergies _____

Medications child is taking: _____

Important medical history _____

Date of last Tetanus Immunization _____

Home address of parent/guardian: _____

_____

Parent/guardian Phone # : _____ Phone # _____

Emergency contact (*other than parent/guardian*): _____

Telephone: _____ Cell: _____

Primary Medical Insurance Carrier _____

Member's Name _____

ID# _____ Group # _____

Signature of parent/guardian(s) _____

Date signed _____

Signature of adult witness _____

HIPAA Acknowledgement and Consent Form

Utica Pediatrics' Notice of Privacy Practices provides information about how we may use or disclose protected health information (PHI).

I understand that I have certain rights to privacy with regards to my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose PHI as needed for treatment, payment, and/or healthcare operations. I understand that I have the right to revoke this consent in writing, however such a revocation will not be retroactive from the date signed.

I have also been informed of and given the right to review and secure a copy of Utica Pediatrics' Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Utica Pediatrics reserves the right to change the terms of this notice as allowed by law.

I also give consent for my PHI to be discussed with the following individuals:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

May a representative of Utica Pediatrics contact you via phone, email, or text?

YES NO

May a representative of Utica Pediatrics leave a message on your voicemail if you are unavailable?

YES NO

Print Patient's Name (list all active patients): _____

_____

Signature of Patient (do not sign if minor child): _____

Is patient a minor child? YES NO If yes, please complete the following:

Print Parent/Guardian's Name: _____ Relationship to Patient: _____

Parent/Guardian's Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's and/or parent's signature in acknowledgement of receipt of Utica Pediatrics' Notice of Privacy Practices but was unable to do so.

_____ _____ _____

Date Initials Reason:

In some situations, a signed authorization form is required for uses and disclosures of your PHI, including:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures for marketing purposes
- Disclosures that constitute the sale of PHI
- As required by privacy law. The confidentiality of substance use disorder and mental health treatment records, as well as HIV-related information maintained by us, is specifically protected by state and/or federal law and regulations. Generally, we may not disclose such information unless you consent in writing, the disclosure is allowed by a court order, or in other limited, regulated circumstances

YOUR RIGHTS

Access to your PHI. Generally, you can access and inspect paper or electronic copies of certain PHI that we maintain about you. You may access your information by signing a Protected Health Information Release Form at our office. In line with set fees under federal and state law, we may charge you for a copy of your medical records.

Amendments to Your PHI. You can request amendments, or changes, to certain PHI that we maintain about you. All requests for changes must be in writing, signed by you or your representative, and state the reasons for the request. If we decide to make an amendment, we may also notify others who have copies of the information about the change. Note that even if we accept your request, we may not delete any information already documented in your medical record.

Accounting for Disclosures of Your PHI. In accordance with applicable law, you can ask for an accounting of certain disclosures made by us of your PHI. This request must be in writing and signed by you or your representative. This does not include disclosures made for purposes of treatment, payment, or health care operations or for certain other limited exceptions. An accounting will include disclosures made in the six years prior to the date of a request.

Restrictions on Disclosures to Health Plans. You can request a restriction on certain disclosures of your PHI to your health plan. We are only required to honor such requests when services subject to the request are paid in full. Such requests must be made in writing and identify the services to which the restriction will apply.

Confidential Communications. You can request that we communicate with you through alternative means or at alternative locations, and we will accommodate reasonable requests. You must request such confidential communication in writing.

Breach Notification. We are required to notify you in writing of any breach of your unsecured PHI without unreasonable delay and no later than 60 days after we discover the breach.

Copy of Notice. You may obtain either a paper or electronic copy of this Notice.

ADDITIONAL INFORMATION

Complaints. If you believe your privacy rights have been violated, you can file a complaint to Utica Pediatric Office Manager, 1589 E 19th St, Tulsa, OK 74120.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services (HHS), Office of Civil Rights (OCR), in Washington D.C. Visit hhs.gov/hipaa/filing-a-complaint.

A complaint must be made in writing and will not in any way affect the quality of care we provide you.

For Further Information. If you have questions about this Notice, or requests regarding privacy, please contact the Utica Pediatrics Office Manage at 918-743-8941.

Effective Date: September 1, 2023

UTICA Pediatrics GROWING WITH YOU

HIPAA Notice of Privacy Practices

Updated: 9/2023

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 YOUR PRIVACY

We understand that information about you and your health is very personal. We strive to protect our patients' privacy. We are required by law to maintain the privacy of our patients' protected health information (PHI). We are also required to provide notice of our legal duties and privacy practices with respect to PHI and to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of this Notice and to make a new Notice effective for all PHI we maintain.

WHO THIS NOTICE APPLIES TO

This Notice applies to the physicians, licensed professionals, employees, volunteers, and trainees seeing and treating patients at Utica Pediatrics.

USES AND DISCLOSURES OF YOUR PHI THAT DO NOT REQUIRE AN AUTHORIZATION

Treatment. For example, physicians, nurses, and other staff members involved in your care will use and disclose your PHI to coordinate your care or to plan a course of treatment for you.

Payment. For example, we may disclose information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you.

Health Care Operations. For example, we may disclose your PHI for billing support. We may use your PHI to conduct an evaluation of the treatment and services provided or to review staff performance. We may disclose your PHI for education and training purposes to physicians, nurses, technicians, medical students, residents, and others.

To Persons Involved in Your Care. If you do not object, we may, based on our professional judgement, disclose your PHI to a family member or other person if they are involved in your care or paying for your care. Similarly, we may also disclose limited PHI to an entity authorized to assist in disaster relief efforts for the purpose of coordinating notification of your general condition or location to someone responsible for your care.

Communicating with You. We will use your PHI to communicate with you about several important topics including, but not limited to, information about appointments, your care, treatment options and other health-related services, and payment for your care. We may also contact you at the email, phone number, or address that you provide, including via text messages, for these communications.

If your contact information changes, it is important that you let us know. Texting and emailing are not 100% secure. Regarding text messages, standard data and messaging rates may apply.

Business Associates. At times, we need to disclose your PHI to persons or organizations outside Utica Pediatrics who assist us with our payment/billing activities and health care operations. We require these business associates and their subcontractors to appropriately safeguard your PHI.

Other Uses and Disclosures. We may be permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. Subject to conditions specified by law, we may release your PHI:

- For any purpose required by law
- For public health activities, including required reporting of disease, injury, birth and death, for required public health investigations, and to report adverse events or enable product recalls
- To government agencies if we suspect child abuse or neglect. We may also release your PHI to government agencies if we believe you are a victim of abuse, neglect, or domestic violence
- To your employer/school when we have provided screenings and healthcare at their request
- To a government oversight agency conducting audits, investigations, inspections, and related oversight functions
- In emergencies, such as to prevent a serious and imminent threat to a person or the public
- If required by a court or administrative order, subpoena, or discovery request
- For law enforcement purposes, including to law enforcement officials to identify or locate suspects, fugitives, witnesses, or victims of the crime
- To coroners, medical examiners, and funeral directors
- For national security, intelligence, or protective services activities

USES AND DISCLOSURES OF YOUR PHI BASED ON A SIGNED AUTHORIZATION

Except as outlined above, we will not use or disclose your PHI for any other purpose unless you have signed a form authorizing the use or disclosure. You may revoke an authorization in writing, except to the extent we have already relied upon it.

UTICA Pediatrics
GROWING WITH YOU

PAT DALEY, MD
SARAH HAYDEN, DO

1589 E. 19TH ST
TULSA, OK 74120

918.743.8941

FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing UTICA PEDIATRICS, LLC for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial and missed/no-show appointment policies.

Parent/Patient Financial Responsibilities:

- The parent or guardian bringing the child to the doctor is ultimately responsible for payment of treatment and care. This includes copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.

- Copays are due at the time of service. Please have your payment method ready at check-in; we accept all credit cards, cash and checks.

- We will bill your insurance for you. However, it is required for the parent or guardian to provide the most correct and updated information regarding insurance. We verify active coverage. Not all services are covered benefits with all policies. It is the responsibility of the insured to be aware of the services provided and their covered benefits under the insurance policy.

- Coinsurance, deductibles and non-covered items are due 30 days from receipt of billing.

- The parent or guardian will be responsible for payment of any additional charges incurred, if applicable. An example would be, charge for returned check or declined credit card - $30.00.

NO-SHOW/MISSED APPOINTMENT POLICY:

It is the policy of Utica Pediatrics, LLC to optimize the use of physician clinic time by working to ensure that all available appointment time are filled by scheduled patients. As a courtesy, and to help our parents remember their scheduled well child and recheck appointments we attempt to give reminder calls at least 24 hours in advance of the appointment time.

If you need to cancel or reschedule an appointment we ask you to provide us with 24 hours (one business day) notice so we would be able to accommodate those patients who are waiting for an appointment.

If you do not cancel or reschedule your appointment with at least a 24 hour notice (one business day), we may assess a $50.00 "no-show" service charge to your account. This "no-show" charge is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive "no-show" appointments, our practice can choose to terminate its relationship with you.

Utica Pediatrics Office Policies

Please sign to confirm you received and agree to the following policies.

Well Checks

At Utica Pediatrics, we feel strongly about children having routine check-ups. Children should receive preventative health care at the following ages:

- Newborn
- 1 month of age
- 2 months of age
- 3 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15 months of age
- 18 months of age
- 24 months of age
- 30 months of age
- Yearly from age 3 - 22

During a Well Check your physician will assess your child's development, eating habits, sleep patterns, and more. We will review any daily medications and offer refills and/or changes as appropriate. Vaccines will also be offered when appropriate. We request that primary caregivers are available for these appointments.

We expect our parents to follow these guidelines so we may continue to provide quality healthcare to our patients. Failure to do so may result in being discharged from the practice. Both telehealth and after-hours care will be limited if Well Checks are not being attended as stated above.

A Well Check appointment will address the issues listed above. If further issues are discussed, you may also be charged for a sick visit appointment, for which a copay might apply.

Walk-Ins

Utica Pediatrics is not a walk-in clinic. We work very hard to accommodate all our patients with timely appointments. If you choose to arrive without a scheduled appointment, you will be scheduled at an available appointment time and asked to wait.

Medication Check-Ups

Patients that take a daily medication- ADHD stimulant or non-stimulant or medications for mental health diagnoses- must be seen in office every 6 months for alternating Well Checks and Medication Checks. Refills of these medications will not be given if this schedule is not followed.

Mutual Respect of Time

Utica Pediatrics prides ourselves on punctuality. There can be unforeseen circumstances that are out of our control that result in our running behind schedule, but we pledge to provide quality care with minimal wait times to the best of our ability. To respect your time, we ask the following:

- Arrive early or on time for your appointment. We may have to reschedule or squeeze you into an available appointment spot if you are more than 15 minutes late.
- If you plan on having an additional child seen during an appointment, please notify us in advance so that we can provide sufficient time on your concerns.
- If you are running late, call the office. We may be able to accommodate you with advance notice.

Payment

Payment is required at the time of service. This includes applicable coinsurance, copayments, and payments for services not covered or denied by the insurance company, including for previous visits. If you participate in a High Deductible Insurance Plan, we require full payment at the time of service.

Outstanding Balances

Outstanding balances are due within 30 days of receipt of the bill or at the next scheduled appointment, whichever comes first. Balances not paid within 90 days will be submitted to collections and you will not be allowed to schedule further appointments with Utica Pediatrics.

Self-Pay Accounts

If you do not have insurance, please come prepared to pay your visit in full. We offer a 20% discount for all self-pay services that are paid in full on the day of the visit.

Copays

We are required by our insurance contracts to collect all copayments at the time of service. Failure to collect copayments puts the responsible party and Utica Pediatrics in default of the insurance contract.

Missed Appointment Fee

Cancellations are required 24 hours prior to the scheduled appointment. Appointments not cancelled 24 hours in advance will result in a "No Show" fee of $50. This fee must be paid before a new appointment is scheduled. Patients with three "No Show" appointments within a 12-month period are subject to potential dismissal from the practice.

Signature of Parent/Guardian: _____ Date: _____

Intake Form

1) Patient's Legal Name: _____

Date of Birth: _____ Sex (circle one): M F Prefer not to Answer

2) Patient's Legal Name: _____

Date of Birth: _____ Sex (circle one): M F Prefer not to Answer

3) Patient's Legal Name: _____

Date of Birth: _____ Sex (circle one): M F Prefer not to Answer

4) Patient's Legal Name: _____

Date of Birth: _____ Sex (circle one): M F Prefer not to Answer

For this document, "sex" refers to gender assigned at birth.

Primary Address: _____

_____

City, State, Zip: _____

Secondary Address: _____

_____

City, State, Zip: _____

Only list two addresses if there are separate households. The primary address is the address of the party responsible for medical payment.

Do biologic parents live together (circle one)? Yes No

Do biologic parents have shared custody and shared medical decision making (circle one)? Yes No

If answer is no, please provide legal documentation stating as such.

Financially Responsible Guardian's Legal Name (this is the guardian that holds the primary insurance policy): _____ DOB: _____

Phone: _____ Email: _____

Second Guardian's Legal Name: _____ DOB: _____

Phone: _____ Email: _____

Emergency Contact Name: _____

Phone: _____ Email: _____

By signing below, I hereby authorize UTICA PEDIATRICS, LLC and the physicians, staff, and hospitals associated with UTICA PEDIATRICS, LLC to release medical and any other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in the care of the above listed patients and in accordance with state and federal law.

Signed: _____ Date: _____

I authorize payment directly to UTICA PEDIATRICS, LLC for services rendered and I understand that I am financially responsible for charges not covered by this assignment.

Signed: _____ Date: _____