817 S. Elm Pl. Ste. 106 | Broken Arrow, Ok. 74012 | (p) 918-928-5437 (f) 918-615-9352

Patient Information

PATIENT LAST NAME _____ **MI** ____ **PATIENT'S FIRST NAME** _____

PATIENT ADDRESS _____ **CITY**_____ **STATE** _____ **ZIP** _____

BIRTHDAY: _____ GENDER ON BIRTH CERTIFICATE: Male ☐ Female ☐

PATIENT IS: *(check all that apply)*
Hispanic/Latino ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐
Hawaiian Native/Pacific Islander ☐ Prefer not to Say ☐

How did you hear about us?
Google ☐ Instagram ☐ Facebook ☐ Drive By ☐ Radio Ad ☐ Magazine ☐ Billboard ☐ Other _____

Primary Contact/ Legal Guardian

Last Name: _____ First Name: _____
Relationship to Child: _____ Does child reside with this person? Yes ☐ No ☐
Mobile Phone # _____ Can we Text this number? Yes ☐ No ☐
Email Address _____ Can we email this address? Yes ☐ No ☐
Preferred method of contact for Appointments, results, referrals, refills? *Call mobile* ☐ *Text* ☐ *Email* ☐
Preferred Method of Contact for Portal, Promo and Parent Education? *Call mobile* ☐ *Text* ☐ *Email* ☐
Is this person a guarantor or financially responsible for this child's medical expenses? *Yes* ☐ *No* ☐
SSN# _____ DOB _____ Employer: _____

Secondary Contact/Legal Guardian

Last Name: _____ First Name: _____
Relationship to Child: _____ Does Child Reside with this person? *Yes* ☐ *No* ☐
Mobile Phone # _____ Can we Text this number? *Yes* ☐ *No* ☐
Email Address _____ Can we email this address? *Yes* ☐ *No* ☐ Preferred
method of contact for Appointments, results, referrals, refills? *Call mobile* ☐ *Text* ☐ *Email* ☐
Preferred Method of Contact for Portal, Promo and Parent Education? *Call mobile* ☐ *Text* ☐ *Email* ☐
Is this person a guarantor or financially responsible for this child's medical expenses? *Yes* ☐ *No* ☐
SSN# _____ DOB _____ Employer: _____

Emergency Contact Name: _____ Relationship to patient: _____
Mobile #: _____ Email: _____

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Insurance & Financial Policy

Patient Name: _____DOB:_____

Primary Insurance _____

Member # _____ Group #/Name _____

Subscriber Name _____ Date of Birth _____

Secondary Insurance_____
Member # _____ Group #/Name_____
Subscriber Name_____ Date of Birth _____

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE Payment is required at the time services are rendered. The person who brings the patient to the office is responsible for payments due at the time of service unless arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Bright Future Pediatrics accepts cash, personal checks, check cards, VISA, MasterCard and Discover. There is a service charge for returned checks. If there is a returned check on file all future payments must be made by cash, money order, cashier's check or accepted credit cards.

SELF PAY We will collect our average level of service payment upon your arrival, If anything else is done such as lab, immunizations, etc., or the visit requires more than the average level of service, you will be expected to pay the difference upon checking out.

ASSIGNED GUARANTOR The billing statement will be sent to the house in which the patient resides. If payment responsibility has been otherwise designated, it will be the responsibility of the statement recipient to properly communicate to that party. We will not be the mediator, get in the middle of divorce or parental separation agreements.

OUTSTANDING BALANCES Our Practice makes every effort to collect what is owed to us, including engaging the services of a collection agency for bills that go unpaid. Therefore, if bills go unpaid for more than 60 days, such debts may be transferred to the collection agency. Additionally, patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling their next appointment(s).

REFUNDS will be promptly refunded to the credit card on file.

INSURANCE We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance and copayments at the time of service. Our office asks you to pay $20.00 per visit if your deductible has not been met to reduce the deductible amount and help your insurance company pay for the dates of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

MISSED APPOINTMENTS/LATE CANCELLATIONS Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. **Cancellations** are requested **24 hours** prior to the office visit or well visit appointment, **48 hours** for **consult appointments**. We reserve the right to charge **$25.00** for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

☐ I have read and understand the Financial Policy. I agree to assign insurance benefits to the Bright Future Pediatrics practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of guarantor or authorized representative: _____
Date: 02/28/2022

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General Consent

Patient's Name: _____ Date of Birth: _____

Consent for Treatment. I consent for Bright Future Pediatrics, LLC. to administer treatments, tests and/or diagnostic tests to treat the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment the patient receives. In compliance with state law, if another individual is accidentally exposed to the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to the patient's BBF, Bright Future Pediatrics, LLC. may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at Bright Future Pediatrics, LLC. expense.

Guardian or Patient Initial: _____

Disclosure of Medical Information. I understand that patient's medical records and billing information are made and retained by Bright Future Pediatrics (BFP) and are accessible to office personnel. BFP may obtain, use and disclose medical information for operations, functions and to other physicians or healthcare personnel involved in my continuum of care. Safeguards are in place to discourage improper access. BFP and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of BFP charges and to any healthcare provider who is or may become involved with my care. Oklahoma law requires that BFP advise you that the information authorized for use of disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug substance or alcohol abuse (63 O.S. § 1-502.2(A) this information will be released in such a way that no person can be identified unless otherwise provided for in such paragraph or by law. Further, such information shall not be released except as required by state law. The provisions for release are included herein by signing this agreement, you are consenting to such disclosure.

There ARE / ARE NOT (circle one) restrictions to use and or disclosure of patients health information.

I request the following restrictions to the use and/or disclosure of patients health information:

_____

Guardian or Patient Initial: _____

By signing this agreement, you are consenting on behalf of yourself or your minor child to such disclosure I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future.
I further certify that I am the patient or 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.

This consent shall become effective on 02/28/2022 , and shall remain effective for one year unless sooner revoked in writing, delivered to said provider or to said persons entrusted with the custody, care and control of said minor child (children).

Parent/Legal Guardian Signature: _____ Date: 02/28/2022

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Authorization for Release of Medical Information

Patient Name: _____ DOB: _____ Date: 02/28/2022

- ○ Please fax or mail my records to the Physician/Facility listed below
- ◉ I authorize BFP to obtain information from provider listed below
- ○ I will pick up copies of my records (additional fees may apply)

Name of Doctor/Facility: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone:

Fax:

Purpose for this request: (check one) Specialists ☐ Transfer of Care ☐ Personal ☐ Other ☐

Requested Information:

- ☑ Entire Medical Record
- ☑ X-Ray/Radiology Reports
- ☑ Lab/Pathology Reports
- ☑ Immunization Records
- ☐ Billing Records
- ☑ Most recent Progress Notes
- ☑ Mental Health Records (ADD/ADHD)
- ☐ Other _____

I hereby request access to the protected health information in my health record. I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.
- The information authorized for release may include records that may indicate the presence of a communicable disease or non-communicable disease and/or may indicate that I have been treated for a psychological or psychiatric condition(s).
- I understand there may be a charge for the requested records and will pay all fees for said records, starting at $1.00 for the first page and .50¢ for each additional page plus mailing costs. There will be charge for records sent to another physician and no charge for updated immunization records given at the time of vaccine administration.

Signature of Parent/Legal Guardian _____ Date 02/28/2022

Relationship to Patient: _____

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Pediatric Medical History Form

Your answers on this form will help your provider understand your child's medical history.

Child's Name: _____ DOB: _____

Medication **Allergies**: ☐No ☐Yes

If yes, to what medication(s) _____ what was the reaction _____

Environmental/Food **Allergies**: ☐No ☐Yes

If yes, to what elements/ food(s) _____

what was the reaction. _____

Personal Medical History:

Has your child been told they need to wear glasses? ☐No ☐Yes Last eye exam? _____

Eye Dr name: _____ Phone #: _____

Does your child have a dentist? ☐No ☐Yes Last dental exam? _____

Dentist name: _____ Phone #: _____

Please check if your child has had any of the following medical problems

☐ ADD/ADHD	☐ Chicken pox	☐ Headaches	☐ Liver disease/Hepatitis
☐ Allergies	☐ Concussion	☐ Hearing problems	☐ Recurrent ear infections
☐ Anemia	☐ Diabetes	☐ Heart murmur	☐ Reflux/GERD
☐ Asthma	☐ Eczema	☐ Congenital heart disease	
☐ Seizures	☐ Bleeding disorder	☐ Fracture	☐ High blood pressure
☐ Urinary Tract Infections		☐ Bronchiolitis	☐ Handicaps/Disabilities
☐ Kidney disease	☐ Vision problems		

Other issues _____

Hospitalizations: Has your child every stayed overnight in a hospital? ☐No ☐Yes

If yes, when and why? _____

Surgical/Outpatient procedure History: (ex: ear tubes, tonsillectomy, etc) ☐No ☐Yes

Please indicate any surgeries or procedures your child has had. Please include the year the surgery/procedure was performed.

_____

_____.

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Family Medical History Form

Patient Name: _____ DOB: _____

Please indicate if your child has a family history (parents, siblings, maternal/paternal grandparents, aunts, or uncles) of any of the following: **Please specify maternal/paternal relation**

Medical History	Mom	Dad	Sibling	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Nasal allergies or other allergies	☐	☐	☐	☐	☐	☐	☐
Asthma/lung disease	☐	☐	☐	☐	☐	☐	☐
Heart disease or heart condition	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐
Diabetes, other endocrine problem	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Anemia, Bleeding disorders	☐	☐	☐	☐	☐	☐	☐
Epilepsy or convulsions	☐	☐	☐	☐	☐	☐	☐
Mental retardation or developmental disorders	☐	☐	☐	☐	☐	☐	☐
Neurological disorders	☐	☐	☐	☐	☐	☐	☐
ADHD/ADD	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐
Other GI disease / disorder	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐
Bed-wetting (after age 10)	☐	☐	☐	☐	☐	☐	☐
Hearing impairment	☐	☐	☐	☐	☐	☐	☐
Vision impairment or eye disorder	☐	☐	☐	☐	☐	☐	☐
Immune problems, recurrent infections or HIV-AIDS	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Other Issues:	☐	☐	☐	☐	☐	☐	☐

Does anyone in your home smoke? ☐ No ☐ Yes
Is your child around secondhand Smoke? ☐ No ☐ Yes
Are there pets in the home? ☐ No ☐ Yes

Are Guns in a locked location? ☐ Not in home ☐ No ☐ Yes
How oftent is child cared for by anyone other than the biological parents? ☐ Never ☐ Sometimes ☐ Often

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Birth History Form

Patient Name: _____ DOB: _____

OBGYN: _____ Phone # _____

During pregnancy or childbirth, were you told you were Group B Positive and given antibiotics? Y ☐ N ☐

Please list any medications taken during the pregnancy_____

Any drug or alcohol use during the pregnancy ☐ No ☐ Yes If yes what? _____

Where was your child born? _____

Was your child adopted or fostered? Y ☐ N ☐

Delivered by: ☐ vaginal delivery ☐ elective C-section ☐ emergent C-section ☐ forceps ☐ vacuum extraction

Number of weeks gestation _____ wks Birth weight _____ lbs_____ oz Discharge weight _____ lbs_____ oz

Birth Length_____ Head Circumference _____

NEWBORN HISTORY-while in hospital

☐ No ☐ Yes Needed antibiotics while in nursery
☐ No ☐ Yes Apnea (stopping breathing)
☐ No ☐ Yes Resuscitation at delivery (Needed help to start breathing/crying)
☐ No ☐ Yes Circumcision
☐ No ☐ Yes Delayed passage of first bowl movement
☐ No ☐ Yes Feeding Problems in Infant
☐ No ☐ Yes Needed head ultrasound
☐ No ☐ Yes Hypoglycemia (low blood sugar)
☐ No ☐ Yes Hypothermia (low temperature)
☐ No ☐ Yes Elevated Bilirubin (jaundice)
☐ No ☐ Yes Heart Murmur
☐ No ☐ Yes Needed ophthalmologic (eye) exam
☐ No ☐ Yes Needed oxygen or help breathing
☐ No ☐ Yes Premature Infant
☐ No ☐ Yes Received vitamin K and/or eye prophylaxis If No, why? _____
☐ No ☐ Yes Respiratory problems(TTN/RDS)
☐ No ☐ Yes Sepsis screening lab work (to check for infection)

☐ No ☐ Yes Did the baby receive the Hepatitis B vaccine If yes, date given _____

Is there anything else regarding your child's health that you think we should know that has not already been asked?

_____

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Patient Name: _____ DOB: _____

MOTHER'S PRENATAL HISTORY

Yes	No	Prenatal History	If YES why?
☐	☐	Absence of prenatal care	
☐	☐	Amniocentesis/CVS	
☐	☐	Antibiotics during labor	
☐	☐	Assisted conception (had to have help getting pregnant)	
☐	☐	Delivery by C-Section	
☐	☐	High risk pregnancy	
☐	☐	Labor induced (started by medications)	
☐	☐	Maternal use of alcohol	
☐	☐	Maternal use of tobacco	
☐	☐	Medications taken during pregnancy	
☐	☐	Meconium at delivery	
☐	☐	Other medications during labor	
☐	☐	Problems with fetus	
☐	☐	Problems with maternal health	
☐	☐	Prolonged rupture of membranes	

Is there anything else regarding your prenatal health that you think we should know that has not already been asked?

_____

_____.

I attest that all of the medical history information is true and correct to the best of my knowledge.

Signature:_____ Relationship to patient:_____

Print Name:_____ Today's Date: 02/28/2022

_

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Medical Home Agreement

PatientName_____ DOB_____

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL of your Healthcare Needs.

As your Medical Home Primary Care Provider (PCP), we agree to:

1. Honor your rights as a patient. Treat you with dignity and respect.
2. We will focus on listening to your concerns, educating you on your health care needs and preventive services. 3. Focus on treating you as a whole person: physically, mentally and emotionally.
4. Focus on providing you with **ongoing, quality** and **safe** medical care, including prevention of future health complications.
5. Work to schedule timely office appointments for your chronic and urgent healthcare needs.
6. Be available to you 24 hours a day, by office appointment, phone calls and/or other electronic communication.

7. Provide you with other healthcare resources when we are absent or unavailable.
8. Provide you with referrals to specialist as deemed **medically necessary** by your PCP.
9. Provide you with treatment, medications, equipment and any other resources deemed **medically necessary** by your PCP.

As a Medical Home Patient, your responsibility is the following:

1. Work with us, as your **PCP,** to meet **all** of your health care needs.
2. Communicate with us about all your healthcare concerns and goals.
3. Report **any** changes related to your health, treatments, medications, etc.
   This includes use of **all medications** - prescription, over-the-counter, herbal and street drugs.
   This also includes any medical equipment being used or that has been ordered or recommended for use.
4. Call us **before** going to the Emergency Room, unless it is life threatening.
5. Notify us **after** any Emergency Room, Urgent Care Clinic or Hospital visit.
6. Schedule medical appointments in a timely manner, including **follow-up** appointments.
7. Keep appointments as scheduled with us and any appointments scheduled with a specialist.
8. If you cannot keep an appointment call **before** your appointment time to cancel or reschedule the appointment.
9. You may be dismissed from your PCP if you repeatedly miss appointments without notice or do not follow the responsibilities listed in the medical home agreement.

☐ I **DO NOT** want Bright Future Pediatrics to be my Medical Health Home or this does not apply to patient.

Patient or Guardian Signature _____Date 02/28/2022

Provider Name _____

Provider Signature_____Date 02/28/2022

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PatientName_____ DOB_____

Medication List/Care Coordination

Preferred Pharmacy: _____ Phone #: _____

Address:_____ City: _____ Zip code: _____

Medications including prescriptions, over the counter medications, and herbal supplements. (List none if none)

Drug Name/Strength/Dose/Route/Frequency	Start Date	Stop Date	Reconciliation Date	Provider Initials

Other Providers-Including counseling, therapies, specialists, urgent care, hospitals, and any other healthcare related providers. (List none if none)

Provider Name/Reason for Care	Last seen Date	Still under Care? Y/N	Provider Phone #	Provider Initials

The list of Medications and Providers provided is complete and accurate. I authorize Bright Future Pediatrics to obtain prescription history and updates from providers and any pharmacies.

Parent/Guardian Signature: _____ Date: 02/28/2022

ACKNOWLEDGEMENT
OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name_____ DOB _____

I have received a copy of Bright Future Pediatrics, LLC's Notice of Privacy Practices ("Notice"), which describes how patients PHI is used and shared. I understand that Bright Future Pediatrics, LLC has the right to change the Notice at any time, and that I may obtain a current copy of the Notice by contacting Bright Future Pediatrics, LLC's designated Privacy Officer or by visiting Bright Future Pediatrics,LLC's website. **My signature below confirms that I have received a copy of the Notice of Privacy Practices and agree to be bound thereby, including any changes or updates thereto.**

_____ 02/28/2022

Signature of Patient or Personal Representative Date

_____

Print Representative's Name

_____

Personal Representative's Relationship to Customer (e.g., Parent, Guardian, Executor, Administrator, Power of Attorney)

For Provider's Use Only:

If the Patient or Personal Representative is unable or unwilling to sign this Acknowledgement, or this Acknowledgement is not signed for any other reason:

1. State the reason this Acknowledgment is not signed:
   _____
2. Describe the steps taken to obtain the Patient's (or Personal Representative's) signature on this Acknowledgement:
   _____

Signature_____ Date_____

Printed Name_____

_____ _____

Proivider Signature Date

_____

Provider Name