Patient Demographics

Date: _____

_____ **Male / Female** _____

Patient's Legal Name **Nickname**

_____ _____ _____ - _____ - _____

Date of Birth **Age (weeks, months or years)** **Patient's Social Security No.**

_____

Patient's Address

_____

Reason for Referral

_____ _____

Primary Care Physician (PCP) **Tel #** **Referring Physician (if different from PCP)** **Tel #**

Who carries the insurance? _____ Name of insurance? _____

_____ _____ - _____ - _____ _____

Guarantor's Date of Birth **Guarantor's SSN** **Guarantor's Contact Numbers**

Patient is a ☐ Natural Child ☐ Adopted Child ☐ Foster Child (in DHS custody) ☐ Other: _____

Parents are: ☐ Married ☐ Divorced ☐ Never Married ☐ Separated

Custody (if applies): Mom has _____ % Dad has _____ % Documentation available: ☐ yes ☐ no

For patient's parents / legal guardians:

_____ _____

Name **Relation to patient** **Name** **Relation to patient**

_____ _____

Date of Birth **Social Security Number** **Date of Birth** **Social Security Number**

_____ _____

Address if different from patient's **Address if different from patient's**

_____ _____

Address **Address**

_____ _____

Home Tel # **Mobile Tel #** **Home Tel #** **Mobile Tel #**

_____ _____

Employer **Work Tel #** **Employer** **Work Tel #**

_____ _____

Emergency Contact #1 other than parents/guardians Tel # **Emergency Contact** #2 other than parents/guardians Tel #

Has patient had any tests for this problem? EEG MRI CT Labs: Where? _____When? _____

Is patient's problem related to an injury or accident? ☐ No ☐ Yes: _____

If yes, do you plan a lawsuit or is a lawyer involved? ☐ No ☐ Yes: Atty: _____# _____

Child Neurology of Tulsa

6465 South Yale Suite 320 Tulsa, Oklahoma 74136 tel: (918) 493-3300 fax: (918) 493-3315 kidnoggin.com

Child Neurology Of Tulsa Policies

Patient name: _____ DOB _____

Policies are intended to focus on patient care. Please read the following and sign below:

- I've received the Notice of Privacy Practices and I understand how medical information about me/my child may be used and disclosed and how I can get access to the information.
- I agree to allow CNOT* to use email, facsimile and telephone as a means to provide care.
- I agree to assign insurance payments for provided services directly to CNOT.
- I accept the financial responsibility for services provided by CNOT in the case that my insurance denies payments for uncovered services or were not authorized.
- Appointment dates and times are considered confirmed at the time the appointment is booked
- Appointment "reminder" calls are a courtesy; You are expected to attend appointments as scheduled
- I agree to pay applicable charges at the time of service including co-pays, co-insurance and other fees
- I understand and am aware of the following uncovered (by insurance) fees:
    - Not paying copay/co-insurance at time of service (additional $25 processing fee)
    - Late cancellations (less than 2 working days): minimum $25 for Brief/Follow Up visits, $50 for an EEG, $100 for new or prolonged visits.
    - Failing to show to appointments or call doubles the above minimum fees
    - Minimum $25 charge for non-urgent after-hour calls, forms, letters, bounced checks.
    - $10 for each prescription refill between visits (for lost prescriptions and missed appointments)
- I understand repeated missed appointments, failure to pay outstanding balance, rude or inappropriate behavior by patient or parent or parental conflict may result in termination of my child's neurologic care with CNOT
- I understand that if I must call CNOT to obtain prescription refills if needed and pharmacy initiated refill requests are discarded as automated requests.
- I understand that only legal guardians will be included in the patient's care and any additional people I wish to be involved requires written legal notification and is subject to Dr. Siegler's approval
- I agree to comply with requests to assist CNOT in confirming identity of guardians including legal papers confirming guardianship and a copy of parents/guardian's driver's license
- I understand that for legal matters, my attorney is to arrange payment for Dr. Siegler before care begins
- I agree to update CNOT of telephone #, address and insurance changes as soon as they occur
- I, hereby, give CNOT consent to ongoing evaluation, treatment and prescribing of said patient. Any change to this consent requires notarized written notification.
- I have read the above and understand and agree to all the statements as evidenced by my signature:

_____

Signature Relationship to Patient Date

_____

Signature Relationship to Patient Date

Child Neurology of Tulsa reserves the right to not initiate care to a not-yet-established patient if the above is not signed.

*CNOT = Child Neurology of Tulsa Policy 01-12

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