**Patient Information**

**ATTN: DIVORCED or SEPERATED PARENTS**

**THE PARENT THAT BRINGS CHILD IN FOR TREATMENT IS RESPONSIBLE FOR THE BILL**

Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name­­­­\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M or F

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Race : Caucasion African American Indian Asian Hawaiian Native Other

 Other includes Latino / Mexican descent

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Father’s name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone

Cell Phone \_\_\_\_Other

Father’s SS# \_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone \_\_\_\_Cell Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s maiden name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip

Employer \_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***For the purpose of contacting you for appointments or payment collections we may use“Automatic Dialing Systems”; if you object to this on your***

***cell phone initial here \_\_\_\_\_\_\_\_\_\_\_\_\_***

**Please list the date of birth, name, and gender of other children in the home:**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact person outside of home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***WE MUST HAVE A WAY TO CONTACT YOU IF NECESSARY. PHONE OR OTHER CONTACT:***

**If the patient is covered by insurance under anyone not living in the home above, it is important that we have their address,**

**date of birth, and social security number below: If you are on Sooner Care and have primary insurance, WE MUST KNOW.**

**It Is ILLEGAL for us to file with Sooner Care if there is other primary insurance coverage.**

**Medical History**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_/\_\_\_\_/\_\_\_\_

|  |
| --- |
|  **Hospitalizations** |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  **Surgeries** |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
|  **Medications** |
| Name | Dose/strength | Frequency taken |
| *(example) Aspririn* | *3 mg* | *1 x a day* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  **Medication allergies** |
| Name of Drug | Reaction |
|  |  |
|  |  |
|  |  |
|  |  |

Any further information you feel we need to know

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices 2023**

Paul Firth, MD, PC, reserves the right to modify the privacy practices outlines in the notice.

**Signature required**

I have received a copy of the Notice of Privacy Practices for Paul Firth, MD, PC

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

                                                         Signature of Patient or Representative                                                     Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient

**Authorization**:  The patient/guarantor has the right to see and obtain copies of their medical records and request corrections if errors are identified.  Due to privacy practice requirements, if you want to allow us to speak with any person(s) about your medical information including making appointments, spouses/step-parents/aunts/uncles/grandparents/parent’s significant other asking for refills, lab results, anything**… you must authorize us to speak with them**.  **We will always attempt to contact you, the patient first or the parent/guardian in case of a child**, but if you are unavailable, please list below those individuals/designees (spouse, adult child, relative, or friend) with whom we can leave a message with or briefly discuss your medical information.

List those you give permission to see or access you or your child’s medical information:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I will be financially responsible for any balances on my children’s accounts; either**

**deductible or patient remainder, past or present.  I agree to pay promptly.**

**I further give consent to Paul Firth MD to access my child’s past electronic prescriptions.**

   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

             Signature                                                        Date

Paul Firth MD PC

Pediatrics

Parent Immunization Agreement

Immunizations have been undeniably proven to be safe and effective in preventing serious diseases in children. There is no evidence that shows any link between immunizations and autism or any other childhood disease. The only way to protect some children against these diseases is to ensure that all eligible people are immunized. If you do not immunize your children then you are refusing to believe the most fundamental, most provable science of childhood healthcare that exists. This belief makes it impossible to have an effective doctor-patient relationship since we try to only base our decision on scientifically proven data.

Not vaccinating your child is a personal decision. But if you decide not to immunize then we will not be able to continue to care for your medical needs; the doctor-patient relationship requires a certain level of trust that is obviously not present.

In order to care for all of our children, we require that everyone living in the household receive their required childhood immunizations. These include: polio, diphtheria, tetanus, pertussis, Hemophilus influenza, pneumococcal, rotavirus, chicken pox, measles, mumps, rubella, and hepatitis A and B.

The following vaccines are highly recommended but not required: Influenza, Meningococcal (prevents meningitis in teenagers and young adults), and Gardasil (prevents cervical cancer).

Child(ren) that are in your household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign one of the following below: Date of this agreement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Do agree to immunize** all members of my household in the time-frames and schedule recommended by the American Academy of Pediatrics unless there is a clear medical reason not to:

Printed name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I Do Not agree to immunize** my family. If I am already a patient, then I have 30 days to find another physician. After that time, I will not be seen at this facility any further.

Printed name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send my records to (New Physician Name and Address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Home Agreement**

**Principles of Medical Home**

As identified by the patient centered Medical Home collaborative and adopted by OHCA,

the principles of a Medical Home are as follows:

A**. Personal Physician/Provider** – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

B. **Physician/Provider Directed Medical Practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

C**. Whole Person Orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

D. **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

E. **Quality and safety** are hallmarks of the medical home.

F**. Enhanced access to care** is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

**Patient Information and Responsibilities**

**As a SoonerCare member, there are rules you must follow**.

**It is your responsibility to:**

* Be aware of PCP’s office hours so you will know when you can be seen.
* Call for an appointment as early as possible, keep your appointments.
* You may have to wait up to three (3) weeks to be seen for checkups and shots.
	+ - 1. ***Even if you have an appointment, you may have to wait past that time to see your PCP. You should ask to***
			2. ***reschedule if you cannot wait.***
			3. ***If you cannot keep your appointment, you MUST call the provider’s office at least 24 hours before***
	1. ***your appointment. Your provider may ask to dismiss you as a patient if you continually miss appointments.***

**When you call your PCP you should always:**

* Tell the staff why you need an appointment.
* Have your medical ID card available.
	+ - * 1. Call your PCP’s office if your problem gets worse before your scheduled visit. Ask to speak to the nurse.

Tell the nurse what symptoms you have and ask if you should be seen sooner because of them.

**Medical Home Agreement**

During your PCP visit you should always:

* Give staff the information they need to help you. This includes telling them about your symptoms.
* Tell your PCP your medical history.
* Take shot records to PCP appointment.
* Inform PCP of all prescription drugs, over-the-counter medications, and herbal supplements you are taking.
* Inform PCP of any medical equipment you are using.
* Inform PCP of any other health care appointments.
* Follow the treatment plans and guidelines that your PCP gives you.

Please also keep in mind:

* Your PCP will refer you to a specialist as needed. You will get a referral only if indicated by your PCP. The specialist

must be a SoonerCare provider.

* You must get a referral BEFORE you go to a specialist.
* Do not ask your PCP for a referral AFTER you have seen specialist.
* If your PCP gives you a referral for a service that is not covered under SoonerCare, you will have to pay.
* If you do not keep your appointment, the specialist may not give you another one.
* Provider will not give a prescription he/she does not determine is needed.
* Sick visits will be seen the same day or the next day (first available appointment), for well child care you may need to

be seen the following week.

* SoonerCare allows unlimited PCP visits monthly.

After-Hours Coverage:

* For after-hours assistance call 580-225-4466, and follow the directions, to reach the provider on call.
* If you think you have a true medical emergency, go to the nearest emergency room or call 911 or call

Great Plains Regional Medical Center emergency room at 580-225-2511.

* As a patient you should expect Provider and staff to treat you professionally and respectfully. It is also expected that

you and your family members will treat the Provider and office staff respectfully and will refrain from using rude, offensive, or threatening behavior. You may call the Sooner Care Helpline to report complaints or concerns regarding provider and staff: 1-877-252-6002

I have read and understand the Patient Rights and Responsibilities. I agree to follow the rules as

listed above and as stated in the SC Member Handbook.

Patient Name(s Printed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/parent/guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider/representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_