Canadian Valley Pediatrics

PATIENT INFORMATION

Patient Name : ☐MALE ☐FEMALE

Date of Birth: _____ **E-MAIL:** _____

Address: _____

PRIMARY NUMBER : _____

_____

SECONDARY NUMBER: _____

_____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ **Cell:** _____

NAME RELATIONSHIP

FINACIALLY RESPONSIBLE PARTY

Name: _____ **Occupation:** _____

Address: _____

ADDRESS LINE 1 **CELL:** _____

_____

ADDRESS LINE 2 **DOB:** _____

_____

CITY ST ZIP CODE _____

E-Mail: _____

INSURANCE INFORMATION

Primary Insurance: ..... **Effective:** .....

Carrier's Name: ..... **Date of birth:** .....

ID Number: ..... **Group Number:** .....

Secondary Insurance: ..... **Effective:** .....

Carrier's Name: ..... **Date of birth:** .....

ID Number: ..... **Group Number:** .....

Please sign and date below.

Sign: _____ **Date:** _____

DR. DINA BOWEN, MD CANADIAN VALLEY PEDIATRICS* * 1804 COMMONS CIRCLE STE B. YUKON, OK 73099* *(405)577-6700* *FAX (405)265-4135*

Canadian Valley Pediatrics

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2020

Child's Name: ..... **Date of Birth:** .....

I understand and agree that all co-pays and outstanding balances are due at the time of my appointment. I may be charged $25 for any calls after regular business hours that are considered ***non- emergent*** in nature, this does include medication refills. If your child has a true medical emergency and needs immediate treatment, call 911 or go to the OU Children's hospital or Integris Baptist hospital on NW Expressway. Dr. Bowen and staff reserve the right to terminate patient care at any point.

The Practice is authorized to disclose my child's medical information and remind me of appointments on my home answering machine, voicemail, text or email. ***Please note: any appointment reminder given to the patient by our practice is a courtesy.*** It is the patients responsibly to be aware and keep all appointments. There may be a $25 charge for ALL missed appointments, if a 24 hour notice is **NOT** given.

I understand and agree I will be held responsible for all charges incurred for services rendered. Regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. If I am unable to pay for services rendered in a timely manner, all claims will be turned over to collections. I authorize direct payment to be made to the office of Dr. Dina Bowen, M.D. (the Practice) for any and all medical services rendered. **Please note:** Your insurance plan is a contract between you and your insurance company. Our office provides the medical service and file claims on your behalf. We do our best to provide any information available to us from your insurance company. However, it remains the policy holder's responsibility to know their policies and specific coverage. You will be responsible for any services that your insurance does not cover. You should familiarize yourself and anyone listed below, that has permission to bring your child to the doctor, with the insurance policy

I hereby authorize the office of Dr. Dina Bowen to release any information concerning my health care, advice, treatment or services provided. This information is to be used in administering medical claims and/or discussing treatment options with insurers and/or other medical providers outside of the Practice, when necessary, so that these providers may treat my child; seek payment for treatment and for the purpose of their health care operations. I authorize the Practice to disclose my child's medical information so that the Practice may treat my child, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g. quality assurance).

The following family members/ friends have my permission to accompany my child to his/her medical appointment: (please print only people over the age of 18 and their relationship to the patient. For example: Tom Jones, grandfather)

_____

_____

_____

I have reviewed the Notice of Privacy Practice. I understand I may receive a printed copy of this information upon verbal or written request now or in the future. To the best of my knowledge, all of the preceding answers are correct. ***If I have any changes in my health status, medication changes, address changes, phone numbers or insurance changes, I shall inform the doctor and staff at the next appointment without fail.***

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Sign: _____ **Date:** _____