OLIVE TREE PEDIATRICS

Oklahoma Personalized Pediatric Care

Shagufta Yousaf MD

Tel. (405)- 208-7849
Fax.(405)- 212-2861

2225 SW 59th Street
Oklahoma City,OK 73119
info@olivetreepediatrics.com
www.olivetreepediatrics.com

New Patient Information (Please Print)

Date ____________________

Name ____________________
Birthdate ____________________
Address ____________________
City ____________________ State ______

Sex/Gender M/F
Ethnicity ____________________
Phone ____________________
Zip ____________________

Parent/Guardian Information

Guardian's name ____________________ Relationship to patient ____________
Birthdate ____________ Phone ____________ Email ____________________
Address ____

2nd Guardian's name ____________________ Relationship to patient ____________
Birthdate ____________ Phone ____________ Email ____________________
Address ____

Insurance/Payment Information

Primary Policy (insurance company) ____
Address ____________________ City ____________________ State ____________
Name of Insured ____________________ Relationship ____________ DOB ____________
Policy # ____________________ Group ____________________ Co-Pay ____________
Employer ____________________

Secondary Policy (insurance company) ____
Address ____________________ City ____________________ State ____________
Name of Insured ____________________ Relationship ____________ DOB ____________
Policy # ____________________ Group ____________________ Co-Pay ____________
Employer ____________________

Pharmacy

Name ____________________ Location ____________________
(approximate location okay)

List any Additional Children

Child's name	DOB	Gender	Insurance Card #
1. ____________	____________	______	____________
2. ____________	____________	______	____________
3. ____________	____________	______	____________

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CONSENT FOR TREATMENT OF MINOR CHILD

Patient for whom consent is given:

X ______________________________ X ____________________
Full Legal Name Birth Date

As the parent(s) of the minor child listed above, I (we) hereby consent to any radiology or lab testing, medical or surgical treatment, or other medical service rendered to my (our) minor child under the care of any qualified physician, as well as any assistant, designee, or employee on the staff of Olive Tree Pediatrics Pediatrics.

My (our) consent is given in advance of a specific medical diagnosis or treatment that may be required, and is given to encourage each physician as well any assistant, designee, or employee of Olive Tree Pediatrics Pediatrics to exercise his/her best judgment in ordering tests or treatment appropriate to the child's medical needs.

This consent is effective on the date below and will be updated if the medical history or information of the child or parent(s) change.

Emergency Contacts, other than parents:

1: ______________________________ *Phone*: (___) ____ - __________
Relationship to patient: ____________________
2: ______________________________ *Phone*: (___) ____ - __________
Relationship to patient: ____________________

Persons Age 18 or over authorized to bring your child(ren) to the physician:

1: ______________________________ *Relationship to patient*: ______________
Phone: (___) ___ - __________

2: ______________________________ *Relationship to patient*: ______________
Phone: (___) ___ - __________

X ____
Signature of Parent/Guardian

Date.

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Accepting New Patients!

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: X ____________________ Date of Birth: X ____________

Parent/Guardian Name: X ____________________

Phone #: X ____________________ Work or Wireless #: ____________________

Patient Social Security #: N/A

Reason for request: ____________________

Date(s) of service needed:
From: ____________________ To: ____________________

Parent/Guardian of Minor Child ✓ Emancipated Minor ____

I authorize ____________________ to release

X ____________________ medical records to: Olive Tree Pediatrics
(Patient Name)

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. You may refuse to sign the authorization.

Parent/Patient Signature: X ____________________ Date Signed: X ____________

Expiration date is one year from date signed unless otherwise stated: ____________________ * A photocopy or fax of this authorization is as valid as the original.

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our Website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient/Guardian understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient/guardian may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

This HIPAA Consent was signed by: X________________________ ____________________

Signature of patient or guardian Printed name

Relationship to the patient (if other than patient):____________________ ____________________

Please Print Today's Date

Signature of practice representative:____

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INSURANCE FILED BY THIS OFFICE IS DONE AS A COURTESY. HOWEVER, GUARDIAN IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS THE GUARDIAN'S RESPONSIBILITY TO BE AWARE OF BENEFITS THAT THEIR INSURANCE PROVIDES FOR VISITS. ALL INSURANCE CO-PAYS AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

- I request that payment of authorized benefits be made to Olive Tree Pediatrics PLLC.
- I further authorize the release of any medical information necessary to process insurance claims or any medical information that is required for any healthcare related utilization review or quality assurance activities or any healthcare professional requiring this information.

This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Parent/Guardian Date

Relationship to patient

This is to acknowledge that I have received or seen a copy of the office's Notice of Privacy Practices.

X

Parent/Guardian Signature
Date

Medical Home Agreement

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, and 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.

Your Healthcare is a TEAM Approach involving BOTH YOU and YOUR PROVIDER.

X ______________________________ Patient or Guardian Signature

______________________________ Date

______________________________ Provider Signature

______________________________ Date

Your Information.
Your Rights.
Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Olive Tree Pediatrics,PLLC

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

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July,2018