PATIENT INFORMATION

Full Name (First Middle Last)		Maiden Name (If Applicable)	
AKA Name		Gender (Circle One) Male Female	Date of Birth (MM/DD/YYYY)
Sexual Orientation: ☐Lesbian, gay or homosexual ☐Straight or heterosexual ☐Bisexual ☐Do not know ☐Choose not to disclose ☐Other: _____		Gender Identity: ☐ Male ☐ Female ☐ Female to Male/Transgender Male/Trans Man ☐ Male to Female/Transgender Female/Trans Woman ☐ Genderqueer, neither male nor female ☐ Choose not to disclose ☐ Other: _____	
Phone Number	Phone Type (Circle One) Mobile Home Work Other	Phone Number	Phone Type (Circle One) Mobile Home Work Other
Email 1		Email 2	
Marital Status (Check one): ☐ Married ☐ Single ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Life Partner ☐ Unknown			
RACE (Check all that apply): ☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐Decline			
Are you Latino or Hispanic (Circle One)? YES NO DECLINE	Are you a U.S. Citizen? YES NO	Are you a Military Veteran (Circle One)? YES NO	Do you have an advance directive? YES NO Please understand, we can keep a copy on your chart, but we DO NOT HONOR Do Not Resuscitate orders
Do you work in Agriculture as a ***SEASONAL*** worker? YES NO	Current living arrangement: ☐ Homeless ☐ Not Homeless	What is your preferred method of contact for appointment reminders? ☐ Text ☐ Phone Call	
Primary Language ☐ English ☐ Spanish ☐ Other:	Social Security Number (SSN)	Driver License Number	DL State
Physical Address (Street, City, State, and Zip)			
Mailing Address (Street/PO Box, City, State, and Zip)			
Emergency Contact Name (First Middle Last)	Emergency Phone 1	Emergency Phone 2	Emergency contact relationship to patient
What is your preferred Pharmacy: (Please list pharmacy name and city)?			Pharmacy phone number

RESPONSIBLE PARTY INFORMATION (parent, guardian, patient, etc…)

Responsible Party's Name (First Middle Last)		Relationship to Patient	Phone Numbers
Mailing Address (Street/PO Box, City, State, and Zip)			
Social Security Number (SSN)	Date of Birth	Driver License Number	State Driver License Issued
Spouse's Name	Spouse's Date of Birth	Spouse's Phone Number	State Driver License Issued

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private/Commercial ☐ None			
Insurance Payer/Plan:	Insurance Payer/Plan Address:		
Employer:	Employer Address:		
Subscriber Name:	Subscriber relationship to insured:		
Subscriber DOB	Policy Number	Group Number	Phone Number

SECONDARY INSURANCE

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Private/Commercial ☐ None			
Insurance Payer/Plan:	Insurance Payer/Plan Address:		
Employer:	Employer Address:		
Subscriber Name:	Subscriber relationship to insured:		
Subscriber DOB	Policy Number	Group Number	Phone Number

FOR OFFICE STAFF USE ONLY

Patient Name: _____ **Date of Birth:** _____ **MRN:** _____

As your Health Care providers, we need to know what other health care providers you see to be able to coordinate your care. Please list the providers outside of this facility that care for you (Additional space on the back of this form).			
Physician Name	Primary Care Physician	City/State	Phone Number
Physician Name	Specialty	City/State	Phone Number
Physician Name	Specialty	City/State	Phone Number
Physician Name	Specialty	City/State	Phone Number

AUTHORIZATION FOR COMMUNICATION REGARDING PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of Protected Health Information (oral or recorded information) **to be released to those individuals listed below** (usually family members in the event of an emergency) by Central Oklahoma Family Medical Center regarding all aspects of my protected health information:

1) _____ Relation: _____ Phone #: _____

2) _____ Relation: _____ Phone #: _____

3) _____ Relation: _____ Phone #: _____

I understand:

_____ *(initials*) My medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

_____ *(initials*) I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse

_____ *(initials)* I may revoke this authorization at any time, in writing, the revocation will not pertain to information already used or disclosed in response to my authorization.

Consent to Treat Minors (Authorization for NON-parent/Guardian)

There may be a time in which the parent is unable to bring the minor patient, (age 17 and under) to obtain medical care at Central Oklahoma Family Medical Center. An adult **MUST** be present unless certain circumstances are present. If you would like to give consent for another individual to bring your child to the doctor, please complete the section below:

I hereby authorize the following individual(s) to seek medical care for _____ (print name of minor) as described in the "Consent Provisions" section (this consent remains in effect until revoked in writing):

1. _____ (print name) _____
   (Relationship to patient)

2. _____ (print name) _____
   (Relationship to patient)

_____ _____ _____
Signature of Parent/ Legal Representative | Date | Relationship

_____ _____ _____
Signature of Witness | Date | Printed Name of Witness

FOR OFFICE STAFF USE ONLY

Patient Name: _____ **Date of Birth:** _____ **MRN:** _____

Income Guidelines

The Clinic & The KIDS Clinic @ Central Oklahoma Family Medical Center offers a **discount** on medical and dental bills to patients if they qualify for our **sliding fee scale**. EVEN IF YOU HAVE INSURANCE COVERAGE YOU MAY BE ELIGIBLE. The discount percentage is based on the GROSS income of ALL members of the household and the number of members in the home and the annual Federal Poverty Guidelines. If you wish to apply for the discount, we will need a proof of the household income. This income must also be updated every year. By providing additional information along with the proof of income, our staff will calculate to determine your eligibility for the sliding scan discount.

Please indicate your family size and Total Estimated Annual Income Household income to help us with our Grant requirements.

Your income information is held confidentially and is utilized solely for the purpose of qualifying for discount and evaluating the effectiveness of our sliding fee discount program.

REQUIRED: According to *2024* Federal Poverty Guidelines.

	100% and below	101-125%	126-150%	151-175%	176-200%	Over 200%
Number in Household	At least- But not more than	At least- But not more than	At least- But not more than	At least- But not more than	At least- But not more than	
1	$0 - $15,060	$15,061-$18,825	$18,826-$22,590	$22,591-$26,355	$26,356-$30,120	$30,121+
2	$0-$20,440	$20,441-$25,550	$25,551-$30,660	$30,661-$35,770	$35,771-$40,880	$40,881+
3	$0-$25,820	$25,821-$32,275	$32,276-$38,730	$38,731-$45,185	$45,186-$51,640	$51,641+
4	$0-$31,200	$31,201-$39,000	$39,001-$46,800	$46,801-$54,600	$54,601-$62,400	$62,401+
5	$0-$36,580	$36,581-$45,725	$45,726-$54,870	$54,871-$64,015	$64,016-$73,160	$73,161+
6	$0-$41,960	$41,961-$52,450	$52,451-$62,940	$62,941-$73,430	$73,431-$83,920	$83,921+
7	$0-$47,340	$47,341-$59,175	$59,176-$71,010	$71,011-$82,845	$82,846-$94,680	$94,681+
8	$0-$52,720	$52,721-$65,900	$65,901-$79,080	$79,081-$92,260	$92,261-$105,440	$105,441 +
Each Additional Person	Add $5,380					

Circle the appropriate box. You may indicate your desire to refuse to give this information by signing in the box below. By Signing below, I acknowledge that this is the best estimate of my total annual household income:

Signature: _____ Date: _____

☐ I decline to provide my household income: _____ and do not want to be evaluated for possible discounts. Signature: _____ Date: _____

FOR OFFICE STAFF USE ONLY

Patient Name: _____ **Date of Birth:** _____ **MRN:** _____

CONSENT TO TREAT and ACKNOWLEDGEMENTS

I hereby and voluntarily consent to authorize the center's healthcare providers to provide health care services to me at the center's service locations, the health care services may include, without limitation, routine physical and mental assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; obtaining my electronic medication history, photograph for documentation purposes; administration of medications; and procedures and treatments prescribed by the center's healthcare providers. The health care services also may include counseling necessary to receive appropriate services including family planning (as defined by federal laws and regulations). I understand that there is a separate consent form that I may be asked to sign to be tested for infectious conditions, or to have additional invasive procedures. I understand that if my insurance company sends a check to me (the patient), I am responsible to endorse that check and forward it to THE CLINIC & THE KIDS CLINIC @ CENTRAL OKLAHOMA FAMILY MEDICAL CENTER for payment. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this. I understand THE CLINIC & THE KIDS CLINIC @ CENTRAL OKLAHOMA FAMILY MEDICAL CENTER may participate in healthcare collaborates by transmitting healthcare data through a secure network and that more information regarding this (including the opportunity to opt out of the exchange) will be made available to me upon request. I understand that this consent is valid and remains in effect as long as I am a patient of the center, until I withdraw my consent, or until the center changes its services and asks me to complete a new consent form.

Consent Provisions

My signature indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that mid-level providers (Physician Assistants and Advanced Practice Registered Nurses) may be involved in my treatment, and I consent thereto.
4. I understand that I may be asked to sign a separate informed consent form for certain treatment(s) that require such.
5. I hereby voluntarily give my consent to Treatment at the center.
6. I also authorize this office to download my medication history through a secure manner so that my providers will have the most up-to-date medication history.
7. I authorize this office to release any information necessary to expedite insurance claims.
8. I understand that I am responsible for all charges, regardless of insurance coverage.
9. I acknowledge that the Rights and Responsibilities of Central Oklahoma Family Medical Center are available to me upon request.
10. I acknowledge that the Notice of Privacy Practices of The CLINIC & The KIDS Clinic @ Central Oklahoma Family Medical Center are available to me upon request.
11. By signing below, I am indicating that the information above is accurate to the best of my knowledge.

Signature: _____ Date: _____

FOR OFFICE STAFF USE ONLY

Patient Name: _____ **Date of Birth:** _____ **MRN:** _____

PATIENT-CENTERED MEDICAL HOME AGREEMENT

This Medical Home Agreement Concept is an AGREEMENT between YOU and YOUR PROVIDER, to focus on meeting ALL 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 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. Arrive to appointments at least 10 minutes prior to your scheduled appointment time. Arriving 10 minutes after the scheduled appointment time will be considered a missed appointment and require that you reschedule your appointment for another time.
10. 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.

Patient Signature: _____ Date: _____

FOR OFFICE STAFF USE ONLY

Patient Name: _____ **Date of Birth:** _____ **MRN:** _____

CONTROLLED SUBSTANCE AGREEMENT

I, _____ understand that in order to receive care for the treatment of pain or the use of controlled medications, either now or in the future course of treatment, I agree to and will comply with the following:

> USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with my The Clinic provider before making any change in either dosage or frequency of my medications. I will inform The Clinic of all medications I take in order to ensure the safety and efficacy of any new prescriptions which my provider may prescribe. There will be no early refills of controlled medications without prior authorization. It is *recommended* that Narcotic pain medications be obtained from the same pharmacy each time.

>LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by my The Clinic provider and understand that lost, stolen, or damaged medications will not be replaced.

>DRIVING AND OPERATING EQUIPMENT: I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication and whenever I feel drowsy.

> MENTAL HEALTH AND/OR PAIN MANAGEMENT CONSULTANT: In order to best support my treatment, a mental health assessment and/or continuing psychological therapy may be required. If I am currently involved in mental health therapy, or if I enter such therapy, I will authorize my mental health provider to exchange unrestricted information regarding my condition and treatment with my The Clinic provider.

>DRUG SCREENING: I will participate in drug screening as part of my treatment plan. I understand that observed and/or non-observed drug screening may be conducted at the discretion of my The Clinic provider. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time requested may result in termination of service.

>SEEKING PRESCRIPTIONS: I will neither seek, nor fill prescriptions, for any controlled medication from any other health care provider unless authorized by my The Clinic provider. I will not harass or repeatedly speak with pharmacist about refills which may be early and I will not call the physician after hours about my controlled substance prescription refills. I also understand that I may be subject to a "pill count", which means my provider and/or nurse may ask to count the number of pills in my prescription bottle.

> ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand that the use of any controlled medication not prescribed by my The Clinic provider may result in termination of care. I understand that The Clinic must cooperate fully with any city, state or federal law enforcement agency, including this Oklahoma's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled medicines. I also understand that the use of any illegal substance, including marijuana, may result in the termination of care.

> MEDICAL RECORDS RELEASE: I will inform all of my healthcare providers that I receive controlled substances. To ensure the seamless transfer regarding my health information and support the safety and efficacy of my care, I will maintain an unrestricted and current medical records release on file with any providers not associated with The Clinic.

>TERMINATION: I will no longer be eligible for care from The Clinic for care if I am:

- ***** in possession of illicit drugs or substance,
- ***** trafficking controlled or illegal substances,
- ***** altering my prescription in any way,
- ***** selling or sharing my medications.

I understand and agree to the conditions of care described above and will comply with them. All of my questions about the terms of this agreement have been answered to my satisfaction. Failure to comply with any of these terms may result in immediate termination of services.

Patient name:_____ DOB: _____

Patient Signature: _____ Date: _____

FOR OFFICE STAFF USE ONLY

Patient Name: _____ **Date of Birth:** _____ **MRN:** _____