Valerie N. Ritter, DO | 10507 E. 91st Street, Suite 150 | Tulsa, OK 74133 | (918) 806-8800 | info@ritterpediatrics.com

PATIENT REGISTRATION

Name: ______________________ (Who is filling out this form?) ____/____/____ (Today's Date)

CHILDREN

Child 1:

Last Name | First Name | Middle Initial

___/___/___ Date of Birth | MALE FEMALE Sex | Primary Language

Ethnicity: HISPANIC NON-HISPANIC UNKNOWN

Race: ASIAN BLACK AMERICAN INDIAN WHITE

Parent's Names | YES NO Biological

Child 2:

Last Name | First Name | Middle Initial

___/___/___ Date of Birth | MALE FEMALE Sex | Primary Language

Ethnicity: HISPANIC NON-HISPANIC UNKNOWN

Race: ASIAN BLACK AMERICAN INDIAN WHITE

Parent's Names | YES NO Biological

Child 3:

Last Name | First Name | Middle Initial

___/___/___ Date of Birth | MALE FEMALE Sex | Primary Language

Ethnicity: HISPANIC NON-HISPANIC UNKNOWN

Race: ASIAN BLACK AMERICAN INDIAN WHITE

Parent's Names | YES NO Biological

ADDRESS

Mailing Address:

Street | ( ) Phone No.

City | State | Zip

Physical Address:
if different than mailing address

Street | ( ) Phone No.

City | State | Zip

Who lives in household? ______________________

INSURANCE

Primary:

Policy Holder's Name: ____________ Sex: MALE FEMALE Policy Holder's Date of Birth: ___/___/___

Primary Insurance Carrier: ____________ Policy Holder's SSN: ____________

ID#: ____________ Group#: ____________

Secondary:

Policy Holder's Name: ____________ Sex: MALE FEMALE Policy Holder's Date of Birth: ___/___/___

Secondary Insurance Carrier: ____________ Policy Holder's SSN: ____________

ID#: ____________ Group#: ____________

CONTACTS

Contact 1:

Name: ____________ Sex: MALE FEMALE Date of Birth: ___/___/___

Relationship to Patient: ____________ Lives with Patient: YES NO SSN: ____________

Home Phone: (   ) ____________ Email Address: ____________

Work Phone: (   ) ____________ Mobile Phone: (   ) ____________

How would you ideally prefer to be contacted regarding (choose one):

Medical Issues:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Appointment Reminders:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Recall Notices:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Billing Statements:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
General Practice Notices:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Patient Portal Notifications:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL

May we leave medical information in a voicemal box or via email message? ☐ YES ☐ NO

Contact 2:

Name: ____________ Sex: MALE FEMALE Date of Birth: ___/___/___

Relationship to Patient: ____________ Lives with Patient: YES NO SSN: ____________

Home Phone: (   ) ____________ Email Address: ____________

Work Phone: (   ) ____________ Mobile Phone: (   ) ____________

How would you ideally prefer to be contacted regarding (choose one):

Medical Issues:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Appointment Reminders:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Recall Notices:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Billing Statements:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
General Practice Notices:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL
Patient Portal Notifications:	☐ HOME PHONE	☐ WORK PHONE	☐ MOBILE PHONE	☐ EMAIL

May we leave medical information in a voicemal box or via email message? ☐ YES ☐ NO

ADDITIONAL CONTACT QUESTIONS

Who should receive billing statements? ______________________________

May all contacts have access to the patient's records electronically? ______________________________

If parents are divorced or separated, please fill out this section:

Who has custody? ______________________________

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? ☐ YES ☐ NO

If yes, please explain and provide a copy of any legal paperwork that supports this restriction: ______________________________

____

EMERGENCY CONTACTS (other than parents)

Name	Relationship	Phone No.
		( )
		( )

AUTHORIZATION FOR TREATMENT OF A MINOR

Although we prefer that the child(ren)'s parent or guardian bring them to their doctor's appointments (and may require that they be present for well visits), we understand that sometimes someone else may need to bring your child to be seen by the doctor.

Please list anyone who may bring the child(ren) to the doctor and consent for treatment including vaccines, medications, and well and/or sick care, etc. If the persons listed are not authorized for ALL of your children, please note that accordingly. If this information changes, please let us know immediately.

Name	Relationship

Thank you for choosing Ritter Pediatrics for your child(ren)'s primary care provider. We are committed to providing excellent medical care to your children. Please read our financial policy below, initial each item and sign at the bottom. Please don't hesitate to ask if you have any questions regarding this policy.

1 **Authorization for Medical Treatment:** Ritter Pediatrics, PLLC and its personnel are hereby authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

__________ Initial

2 **Disclosure of Information:** I understand that my child's medical records and billing information are made and retained by Ritter Pediatrics, PLLC and are accessible to office personnel. Office personnel may use and disclose medical information for office operations and functions and to any other physician or health care personnel involved in my child's continuum of care. Ritter Pediatrics, PLLC and its medical staff are authorized to disclose all or part of my child's medical record to any insurance carrier, workers' compensation carrier or self-insured employer group liable for any part of Ritter Pediatrics, PLLC charges and to any health care provider who is or may become involved with my child's care. Oklahoma law requires that Ritter Pediatrics, PLLC advise you of the following:

a **The information authorized for disclosure may include medical records which may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). By initialing and signing this agreement below, you are consenting to such disclosure.**

__________ Initial

3 **Insurance:** We participate in most insurance plans, including Medicaid/Soonercare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with but do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company regarding any questions about your coverage/benefits.

a **Proof of Insurance:** All patients must have a proof of insurance form completed before seeing the doctor. We will also need a copy of the parent/guardian's driver's license and the child's valid insurance card.

b **Co-payments, deductibles, and payments due:** All co-payments, deductibles, and payments due must be paid at the time of service. This is required by the contract with your insurance company. Not collecting the required co-payment and/or deductible from patients is considered insurance fraud.

c **Claims submission:** We will submit your claims on your behalf and assist you in any way we can to help get your claims pain. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

d **Coverage Changes:** If your insurance has changed, please notify us prior to your next appointment so we can make the appropriate changes. If your insurance company does not pay your claim within 45 days after the claim submission, the balance will be automatically billed to you.

e Please contact our billing office staff should you need to set up a payment plan or have questions regarding your account.

f **I hereby authorize Ritter Pediatrics, PLLC to furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to the physician all payments for medical services rendered to my child. I understand that I am ultimately responsible for any amounts not covered by insurance. I further authorize a copy of the authorization to be used in place of original.**

__________ Initial

4 **Non-covered services:** Please be aware that some or even all of the services you receive may not be covered by your insurance. You must pay for these services in full at the time of the visit.

__________ Initial

5 **Non-payment/Collections:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and a fee of 25% will be applied to cover the cost of collections. All immediate family members may also be discharged from this practice for non-payment. If this occurs you will be notified by mail that you have 30 days to find another physician. During that 30 day period we will provide only acute care treatment (i.e. no well visits).

__________ Initial

6 **After hours calls:** Most insurance companies have a nurse triage line that is included with your insurance plan. Please use that number after hours if you have medical questions. This number can usually be found on the back of the card or on your insurance company's website. Dr. Ritter uses a private nurse triage line after hours to answer urgent/emergent phone calls only. If non-urgent issues are called to the private triage line after hours you may be charged up to $25 for

the phone call. For medication dosing questions after hours, please call the pharmacy; for acute care after hours please visit a pediatric after hours clinic; for appointment questions, please call during office hours; for an emergency, please call 911 or go to the nearest emergency room.

______________ Initial

7 **Missed appointments:** Our policy is that appointments must be cancelled at least 24 hours in advance, if you do not adhere to this policy you may be charged a fee. This fee will not be filed with your insurance, but will be directly billed to you. Please keep your appointment cards/times in a safe place and arrive on time for your appointment.

______________ Initial

8 **Automatic Dialing System:** Our office may use an automatic dialing system to contact you. By signing this agreement, you give consent to allow calls from an automatic dialing system to all phone numbers associated with your account.

______________ Initial

9 **Confirmation of Appointments via Texting:** I hereby authorize Ritter Pediatrics, PLLC to notify me of my child's appointments via texting. I am aware my child's name and time of appointment will appear on the text.

______________ Initial

- I consent to treatment for the minor child(ren) listed above and on attached sheets.
- I consent to allow those listed in the Authorization for Treatment of a Minor section above to bring my child for treatment and allow them to consent for any treatment deemed necessary.
- I have read and understand the above financial policy and agree to abide by its guidelines.
- I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have received a copy of the Patient Agreement (if requested).
- I have been offered a copy of Ritter Pediatrics, PLLC HIPAA Privacy Policy and have declined to receive a copy for my personal use, but may request a copy at any time.
- I have received a copy of Ritter Pediatrics, PLLC HIPPA Privacy Polic

______________________________ Signature of Parent or Responsible Party

____ / ____ / ____ Date

______________________________ Printed Name of Signee