PATIENT REGISTRATION

VARIETY CARE

First Name _____ Middle Name(s) _____ Last Name _____

Date of Birth _____ Social Security Number _____ Aliases/Other Names _____

Mobile ☐* Home ☐* Work ☐* *Please check preferred phone _____ Email

Address _____ City, State, Zip Code _____ Legal Sex: ☐ Female ☐ Male

Type of Home:

☐ Public Housing ☐ House/Apt ☐ Transitional Program ☐ Homeless Shelter ☐ Other _____

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Domestic Partner
- ☐ Widowed
- ☐ Divorced
- ☐ Legally Separated

Language:

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ French
- ☐ German
- ☐ American Sign Language
- ☐ Other: _____

Demographic Information

Race:

- ☐ American Indian
- ☐ Alaska Native
- ☐ Native Hawaiian
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Pacific Islander
- ☐ Multiple Races
- ☐ Other: _____

Ethnicity:

- ☐ Another Hispanic/Latino
- ☐ Cuban
- ☐ Mexican
- ☐ Mexican American
- ☐ Chicano(a)
- ☐ Puerto Rican
- ☐ Non-Hispanic/Latino
- ☐ Patient Refused
- ☐ Unknown

Military Status:

- ☐ Active Duty
- ☐ Inactive Duty
- ☐ Veteran
- ☐ No Previous Experience

Migrant Farmworker:

- ☐ Migrant
- ☐ Seasonal
- ☐ Neither

Insurance Information

☐ Self-Pay

PRIMARY

Insurance Carrier | Copay $ | Co Ins%

Group No. | Policy No.

Insurance Address | Insurance Phone Number

Name of Policy Holder | Date of Birth

Phone Number | Employer | SSN

Legal Sex: ☐ Female ☐ Male

Relationship to Insured:

☐ Patient ☐ Parent ☐ Ward of the Court
☐ Spouse ☐ Stepchild ☐ Grandchild
☐ Child ☐ Foster Child ☐ Other: _____

SECONDARY

Insurance Carrier | Copay $ | Co Ins%

Group No. | Policy No.

Insurance Address | Insurance Phone Number

Name of Policy Holder | Date of Birth

Phone Number | Employer | SSN

Legal Sex: ☐ Female ☐ Male

Relationship to Insured:

☐ Patient ☐ Parent ☐ Ward of the Court
☐ Spouse ☐ Stepchild ☐ Grandchild
☐ Child ☐ Foster Child ☐ Other: _____

Emergency Contact

PRIMARY

Name | Phone Number

Relation to Patient | Zip Code

SECONDARY

Name | Phone Number

Relation to Patient | Zip Code

Parent(s) or Guardian(s) Information

Is patient a minor and/or under the care of a legal guardian? ☐ Yes ☐ No

First Name | Middle Name(s) | Last Name | Primary Phone Number | Secondary Phone Number

Date of Birth | Email | Relation to Patient | Social Security Number

Patient Lives With: ☐ Both Parents ☐ One Parent ☐ Family/Friends ☐ Legal Guardian ☐ Other

Patient Responsibility Agreement And Insurance Policy

Most insurance plans do not cover 100% of the cost of treatment. Because of this we ask our patients to pay their estimated co-pay the day service is rendered. We will estimate as closely as possible: however, we do not guarantee any estimates or actual amounts. In the case insurance does not reimburse the full amount, I understand that I am responsible for payment of services rendered and responsible for paying any co-payment and deductibles that my insurance does not cover. If after 90 days, the insurance company does not pay the claim I will be responsible for the total balance.

Signature: _____ **Date:** _____

☐ Signed by Patient ☐ Signed by Patient or Guardian ☐ Signed by Caregiver ☐ Signed by Other: _____

VARIETY CARE

CHILD'S HISTORY QUESTIONNAIRE

Name of person completing this questionnaire and relationship _____ Today's Date _____

CONTACT INFORMATION:

Parent / Legal Guardian's **(Please circle one)** Full name _____ Date of Birth _____

Address _____

Phone Number _____ Profession and/or work activity _____

Parent / Legal Guardian's **(Please circle one)** full name _____ Date of Birth _____

Address _____

Phone Number _____ Profession and/or work activity _____

Other primary caregiver/ legal guardian full name _____ Date of Birth _____

Address _____

Phone Number _____ Profession and/or work activity _____

EMERGENCY CONTACT:

Name _____ Phone Number _____

Address _____

Primary care physician's name: _____ Phone Number: _____

ARE THERE OTHER FAMILY MEMBERS WHO ARE CURRENT PATIENTS AT VARIETY CARE TURTLE CREEK-EDMOND (PREVIOUSLY STANBRO HEALTHCARE GROUP)?:

☐ No ☐ Yes **(If yes, please list below)**

_____

_____

What are the main concerns that you have about your child? **(REQUIRED)**

_____

_____

_____

Are you seeking therapy? ☐ Yes ☐ No

VARIETY CARE

CHILD'S RELIGION:

☐ Buddhist ☐ Christian Catholic ☐ Christian Protestant ☐ Hindu

☐ Jewish ☐ Muslim ☐ Other ☐ None

Is the child adopted? ☐ No ☐ Yes

Other children in the family?

Name	Sex (as assigned at birth)	Date of Birth	Age	Relation to child

Other people living in the home (significant other, friend, grandparents, foster child, etc…)

Name	Sex (as assigned at birth)	Date of Birth	Age	Relation to child

LANGUAGES SPOKEN IN THE HOME: _____

LIST ANY AGENCIES OR PROFESSIONALS CURRENTLY PROVIDING SERVICES TO YOUR CHILD AND FAMILY:

Agencies or professional	Age of child when services began

PREGNANCY HISTORY:

During pregnancy with this child did the mother experience any of the following:

☐ Medical problems _____

☐ Special diet _____

☐ Medications _____

☐ Full-term (38-42 weeks) ☐ Other than full-term _____

Number of weeks at birth: _____ Any accidents/injuries? ☐ No ☐ Yes _____

BIRTH HISTORY:

Age of mother at birth of child? _____ Complications for mother during delivery? ☐ No ☐ Yes _____

Child's birth weight: _____ Was oxygen needed? ☐ No ☐ Yes _____

Special care? ☐ No ☐ Yes _____

How long did the child stay in the hospital after birth? _____

How long did the mother stay in the hospital after birth? _____

Describe your child in the first 6 months:

Easy baby	☐ No	☐ Yes
Enjoys people	☐ No	☐ Yes
Irritable	☐ No	☐ Yes
Difficult to soothe	☐ No	☐ Yes
Sleep/wake cycle poorly regulated	☐ No	☐ Yes
Unusually quiet	☐ No	☐ Yes
Unusually sick	☐ No	☐ Yes
Feeding difficulties	☐ No	☐ Yes
Strong reaction to light/sound/touch	☐ No	☐ Yes
Colic	☐ No	☐ Yes

FAMILY HISTORY:

Please list any medical or psychiatric illness in your family:

CHILD'S EARLY DEVELOPMENT (specify age)

	AGE
Sat without support	
Crawled	
Walked without support	
Used single words (other than mama or papa)	
Used 2-3 word sentences	
First began to sleep through the night	
Daytime wetting stopped	
Bed-wetting stopped	
Bowel control	

CHILD'S MEDICAL HISTORY

Health Care Providers: _____

Child's Primary Care Physician: _____

Address: _____

Phone Number: _____ Fax Number: _____

Date of last complete physical examination: _____

Does your child have any allergies (environmental, food, medication)? ☐ No ☐ Yes _____

_____

_____

Does your child take any medications (include vitamins, over the counter drugs, and herbal medications)

☐ No ☐ Yes

Name	Dosage	Frequency	Date Began

PAST MEDICATIONS

(Please list below)

If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write what you do remember).

ANTIDEPRESSANTS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil (paroxetine)			
Celexa (citalopram)			
Lexapro (escitalopram)			
Effexor (venlafaxine)			
Cymbalta (duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Anafranil (clomipramine)			
Pamelor (nortriptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			

MOOD STABILIZERS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Tegretol (carbamazepine)			
Lamictal (lamotrigine)			
Topamax (topiramate)			
Other			

ANTIPSYCHOTICS/MOOD STABILIZERS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			

SEDATIVE/HYPNOTICS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			

ADHD MEDICATIONS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Vyvanse (lisdexamfetamine)			
Intuniv (guanfacine, er)			
Kapvay (clonidine, er)			
Strattera (atomoxetine)			
Other			

Has your child ever been hospitalized for any reason? ☐ No ☐ Yes

REASON	DATES	WHERE	LENGTH OF STAY

Does your child have a current or past history of any of the following:

Head injury ☐ No ☐ Yes _____

Broken bones ☐ No ☐ Yes _____

Surgeries ☐ No ☐ Yes _____

Birth defects ☐ No ☐ Yes _____

Poisoning ☐ No ☐ Yes _____

Heart problems ☐ No ☐ Yes _____

Kidney problems ☐ No ☐ Yes _____

Liver disease ☐ No ☐ Yes _____

Lung disease ☐ No ☐ Yes _____

Blood disease ☐ No ☐ Yes _____

Cancer ☐ No ☐ Yes _____

Seizure ☐ No ☐ Yes _____

Other neurological problems ☐ No ☐ Yes _____

Genetic disorder ☐ No ☐ Yes _____

Diabetes ☐ No ☐ Yes _____

Thyroid ☐ No ☐ Yes _____

Does your child have a current or past history of any of the following:

Skin problems	☐ No	☐ Yes	_____
Lyme disease	☐ No	☐ Yes	_____
Impaired sight	☐ No	☐ Yes	_____
Impaired hearing	☐ No	☐ Yes	_____
Speech difficulty	☐ No	☐ Yes	_____
Sleeping difficulty	☐ No	☐ Yes	_____
Eating disorder	☐ No	☐ Yes	_____
Sleep Apnea	☐ No	☐ Yes	_____
Severe vomiting	☐ No	☐ Yes	_____
Choking events	☐ No	☐ Yes	_____
Other problems	☐ No	☐ Yes	_____

CHILDHOOD DISEASES: (child's age in years)

Chicken Pox	☐ No	☐ Yes	Age _____
German Measles/Rubella	☐ No	☐ Yes	Age _____
Measles	☐ No	☐ Yes	Age _____
Scarlet Fever	☐ No	☐ Yes	Age _____
Whooping Cough	☐ No	☐ Yes	Age _____
Strep throat	☐ No	☐ Yes	Age _____

SOCIAL DEVELOPMENT:

Does your child make friends easily?	☐ No	☐ Yes
Does your child have difficulty interacting with other children?	☐ No	☐ Yes
Does your child have difficulty interacting with adults?	☐ No	☐ Yes
Does your child have a "best friend?"	☐ No	☐ Yes

BEHAVIORAL DEVELOPMENT:

Does your child exhibit aggression to people or animals?	☐ No	☐ Yes	If yes, please explain:
Does your child often bully, threaten or intimidate others?	☐ No	☐ Yes	If yes, please explain:
Has your child deliberately destroyed others' property?	☐ No	☐ Yes	If yes, please explain:
Does your child often lie to obtain goods or favors or to avoid obligations?	☐ No	☐ Yes	If yes, please explain:
Has your child ever run away from home?	☐ No	☐ Yes	If yes, please explain:
Is your child often truant from school?	☐ No	☐ Yes	If yes, please explain:

PRESCHOOL/SCHOOL HISTORY:

Is your child attending preschool/school? ☐ No ☐ Yes

If yes, name of school: _____ Grade _____

Does your child attend any special classes or receive any special education services? ☐ No ☐ Yes

If yes, please name: _____

Has your child ever repeated a grade in school or been "held-back" for any reason? ☐ No ☐ Yes

If yes, please explain: _____

Does your child have any learning or behavioral problems in school? ☐ No ☐ Yes

If yes, please explain: _____

SLEEP HABITS:

What time does your child generally go to bed? _____ pm/am

What time does your child generally wake up? _____ pm/am

On average, how many hours does your child sleep per night? _____ Hours

Does your child snore or seem to gasp for air during the night? ☐ No ☐ Yes

STRESSORS:

Is your family facing any significant stressors at this time? ☐ No ☐ Yes

If yes, please describe: _____

Is there anything else you would like us to know that would assist us in understanding your child?

PERSONAL AND FAMILY MEDICAL HISTORY:

Thyroid Disease	☐ You	☐ Family	Family Member: _____
Anemia	☐ You	☐ Family	Family Member: _____
Liver Disease	☐ You	☐ Family	Family Member: _____
Chronic Fatigue	☐ You	☐ Family	Family Member: _____
Kidney Disease	☐ You	☐ Family	Family Member: _____
Diabetes	☐ You	☐ Family	Family Member: _____
Asthma/Respiratory	☐ You	☐ Family	Family Member: _____

PERSONAL AND FAMILY MEDICAL HISTORY:

Stomach/Intestinal	☐ You	☐ Family	Family Member: _____
Cancer (type) _____	☐ You	☐ Family	Family Member: _____
Fibromyalgia	☐ You	☐ Family	Family Member: _____
Heart Disease	☐ You	☐ Family	Family Member: _____
Epilepsy/Seizures	☐ You	☐ Family	Family Member: _____
Chronic Pain	☐ You	☐ Family	Family Member: _____
High Cholesterol	☐ You	☐ Family	Family Member: _____
High Blood Pressure	☐ You	☐ Family	Family Member: _____
Head Trauma	☐ You	☐ Family	Family Member: _____
Liver Problems	☐ You	☐ Family	Family Member: _____
Other	☐ You	☐ Family	Family Member: _____

Is there any additional personal or family medical history? ☐ No ☐ Yes

If yes, please explain: _____

Current Weight: _____ Current Height: _____

PAST PSYCHIATRIC HISTORY:

Outpatient treatment? ☐ No ☐ Yes If yes, please describe when, by whom, and nature of treatment:

REASON	DATES TREATED	BY WHOM

Psychiatric Hospitalization? ☐ No ☐ Yes If yes, please describe for what reason, when and where:

REASON	DATES TREATED	BY WHOM

SNAP-IV TEACHER AND PARENT RATING SCALE

James M. Swanson, Ph.D., University of California, Irvine CA 92715

Name	Sex (as assigned at birth)	Age/Date of Birth
Completed by	Date	Rx

For each item, check the column which best describes this child:	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks	☐	☐	☐	☐
2. Often has difficulty sustaining attention in tasks or play activities	☐	☐	☐	☐
3. Often does not seem to listen when spoken to directly	☐	☐	☐	☐
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties	☐	☐	☐	☐
5. Often has difficulty organizing tasks and activities	☐	☐	☐	☐
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort	☐	☐	☐	☐
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)	☐	☐	☐	☐
8. Often is distracted by extraneous stimuli	☐	☐	☐	☐
9. Often is forgetful in daily activities	☐	☐	☐	☐
TOTAL				

INATTENTION AVERAGE SCORE (TOTAL/9) (2.56; 7.18P):

10. Often fidgets with hands or feet or squirms in seat	☐	☐	☐	☐
11. Often leaves seat in classroom or in other situations in which remaining seated is expected	☐	☐	☐	☐
12. Often runs about or climbs excessively in situations in which it is inappropriate	☐	☐	☐	☐
13. Often has difficulty playing or engaging in leisure activities quietly	☐	☐	☐	☐
14. Often is "on the go" or often acts as if "driven by a motor"	☐	☐	☐	☐
15. Often talks excessively	☐	☐	☐	☐
For each item, check the column which best describes this child:	**Not At All 0**	**Just A Little 1**	**Quite A Bit 2**	**Very Much 3**
16. Often blurts out answers before questions have been completed	☐	☐	☐	☐
17. Often has difficulty awaiting turn	☐	☐	☐	☐
18. Often interrupts or intrudes on others (e.g., butts into conversations/games)	☐	☐	☐	☐
TOTAL				

HYPERACTIVE/IMPULSIVE AVERAGE SCORE (TOTAL/9) (1.78T;1.44P):

	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
19. Often loses temper	☐	☐	☐	☐
20. Often argues with adults	☐	☐	☐	☐
21. Often actively defies or refuses adult requests or rules	☐	☐	☐	☐
22. Often deliberately does things that annoy other people	☐	☐	☐	☐
23. Often blames others for his or her mistakes or misbehavior	☐	☐	☐	☐
24. Often touchy or easily annoyed by others	☐	☐	☐	☐
25. Often is angry or resentful	☐	☐	☐	☐
26. Often is spiteful or vindictive	☐	☐	☐	☐
TOTAL				

ODD AVERAGE SCORE (TOTAL/8) (1.38T; 1.88P):

	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
27. Has difficulty getting started on classroom assignments	☐	☐	☐	☐
28. Has difficulty staying on task for an entire classroom period	☐	☐	☐	☐
29. Has problems in completion of work on classroom assignments	☐	☐	☐	☐
30. Has problems in accuracy or neatness of written work in the classroom	☐	☐	☐	☐
31. Has difficulty attending to a group classroom activity or discussion	☐	☐	☐	☐
32. Has difficulty making transitions to the next topic or classroom period	☐	☐	☐	☐
TOTAL				

ACADEMIC AVERAGE SCORE (TOTAL/6):

For each item, check the column which best describes this child:

	Not At All 0	Just A Little 1	Quite A Bit 2	Very Much 3
33. Has problems in interactions with peers in the classroom	☐	☐	☐	☐
34. Has problems in interactions with staff (teacher or aide)	☐	☐	☐	☐
35. Has difficulty remaining quiet according to classroom rules	☐	☐	☐	☐
36. Has difficulty staying seated according to classroom rules	☐	☐	☐	☐
TOTAL				

DEPORTMENT AVERAGE SCORE (TOTAL/4)	
ADHD AVG SCORES (IN; H-I)	
ADHD-C AVERAGE SCORE (TOTAL/2) (2.00T; 1.67P)	

New Patient Forms

Treatment Consent, Disclosure and Personal Representative

Patient Name:_____ **DOB:** _____ **Date:**_____

Name of person giving consent (if not patient): _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Primary Caregiver ☐ Other: _____

PERMISSION FOR DISCLOSURE OF INFORMATION AND APPOINTMENT OF PERSONAL REPRESENTATIVE

Person's Name (Print): _____ Relationship: _____

Person's Name (Print): _____ Relationship: _____

Person's Name (Print): _____ Relationship: _____

I give Variety Care permission to share my information and/or coordinate with the persons listed as provided above. I understand that I may revoke my permission at any time by notifying Variety Care in writing.

I give the following permissions (check all that apply):

☐ General information: To make, confirm or cancel appointments, be told I am a patient, and that I am in my appointment

☐ To obtain copies of my medical records as my Personal Representative under HIPAA

☐ To relay messages to my (or my child/wards') provider/staff

☐ To receive information regarding my medications

☐ To receive information regarding my diagnosis and treatment

☐ To receive information about test or lab results

☐ To bring my child's/ward's to appointments and consent for treatment

OR ☐ **All the rights and permissions listed above**

OR ☐ **I *do not want* my information given to *anyone.***

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I consent to treatment by Variety Care providers and staff. There are risks and dangers with any type of treatment. I give my consent assuming those risks. I know my provider will discuss with me any risks of treatments and alternatives and that I may ask any questions or refuse treatment if I choose. I understand this consent will be effective until I revoke it or I am required to give consent due to a change in circumstances.

I consent for Variety Care to submit for payment of authorized benefits for my insurance and release any information required for payment. I know I am responsible for all deductibles and/or copayments. I also understand that I am responsible for any charges or amounts that are not paid by my insurance. I know that some lab work or other tests, such as x-rays, are not included in my regular medical visit and may require me to go to an outside provider. I know that I may receive a separate bill for those services.

Signature: _____Date: _____

Notice of Privacy Practices

Effective Date: 01/01/2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Who We Are:

This Notice describes the privacy practices of **Variety Care, (all locations)** and the privacy practices of:

- all of our doctors, nurses, and other health care professionals authorized to enter information about you into your medical chart.
- all of our departments, including, *e.g.*, our medical records and billing departments.
- all of our Variety Care sites.
- all of our employees, staff, volunteers and other personnel who work for us or on our behalf.

Our Pledge: We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information. Variety Care is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Variety Care, OCHIN supplies information technology and related services to Variety Care and other OCHIN Participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practices standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Variety Care with OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

For More Information, Contact Us:

Privacy Officer
Variety Care
3000 N. Grand Blvd
Oklahoma City, OK 73107
405-632-6688

We are required by law to:

- make sure that health information that identifies you is kept private in accordance with relevant law.
- give you this notice of our legal duties and privacy practices with respect to your personal health information.
- follow the terms of the notice that is currently in effect for all of your personal health information.

How We May Use and Disclose Your Health Information:

We may use and disclose your personal health information for these purposes:

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to the doctors, nurses, technicians, medical students and others who are involved in your care. They may work at Variety Care, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy or other health care provider to whom we may refer you for treatment, consultation, x-rays, lab tests, prescriptions or other health care service. They may also include doctors and other health care professionals who work at Variety Care, or elsewhere, whom we consult about your care. For example, we may consult with a specialist who lends his/her services to Variety Care about your care or disclose to an emergency room doctor who is treating you for a broken leg that you have diabetes, because diabetes may affect your body's healing process.

For Payment. We may use and disclose health information about you to bill and collect payment from you, your insurance company, including Medicaid and Medicare, or other third party that may be available to reimburse us for some or all of your health care. We may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you need to obtain your health plan's prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for our day-to-day operations, and may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations. These uses and disclosures are necessary to run Variety Care and to make sure that all of our patients receive quality care, and to assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients with health information from other health care providers to decide what additional services Variety Care should offer, what services are not needed, whether new treatments are effective or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our patients are.

Appointment Reminders. We may use and disclose health information about you to contact you as a reminder that you have an appointment at Variety Care.

Health-Related Services and Treatment Alternatives. We may use and disclose health information to tell you about health-related services or recommend treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use a different address when sending this information to you.

Fundraising Activities. We may use health information about you to contact you in an effort to raise money for our not-for-profit operations. We may disclose health information about you to a foundation related to Variety Care so that the foundation may contact you in

raising money for Variety Care. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services from us. Please let us know if you do not want us to contact you for fundraising efforts.

Individuals Involved in Your Care or Payment for Your Care. We may release health information about you to a friend or family member who is involved in your health care or the person who helps pay for your care.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with a patient's need for privacy. Before we use or disclose health information for research, the project will have been approved through this special approval process, although we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care.

Organ and Tissue Donation. If you are an organ donor, we may disclose health information about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

As Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or separated/ discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities. We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability.
- to report births and deaths.
- to report child, elder or vulnerable population abuse, neglect or exploitation.
- to report reactions to medications or problems with products.
- to notify people of recalls of products.
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information about you to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process that is not accompanied by a court or administrative order, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information about you if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process.
- to identify or locate a suspect, fugitive, material witness or missing person.
- under certain limited circumstances, about the victim of a crime.
- about a death we believe may be the result of criminal conduct.
- about criminal conduct at the Variety Care
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime;

Coroners, Health Examiners and Funeral Directors. We may release health information about our patients to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as may be necessary for them to carry out their duties.

National Security and Intelligence Activities. We may release health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the corrections institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) for the safety and security of the correctional institution.

Special Protections for People with Substance Use Disorders

The federal privacy protections for substance use disorder (SUD) treatment information, 42 CFR Part 2, are the federal privacy protections for substance use disorder (SUD) treatment information. These provisions provide

strict privacy protections to your treatment. Unlike HIPAA, which often permits the sharing of certain health information without patient authorization, 42 CFR Part 2 generally requires your written consent to disclose any of your information. With few exceptions, NorthCare will ask for your written consent to disclose your information. Some exceptions to written consent include medical emergencies, court orders, reporting child abuse and neglect, and reporting criminal behavior on our property. Note: NorthCare will not share records or testify in civil, criminal, administrative, and legislative proceedings against you unless you provide written consent or we receive a court order.

Reproductive HealthCare

In accordance with CMS rules and regulations, Variety Care will not release any information related to Reproductive Health Care unless it is clearly attested that the release of the information is not for any prohibited purposes including (1) conducting a criminal, civil or administrative investigation into any person for the mere act of seeking, obtaining, providing or facilitating lawful reproductive health; (2) to impose criminal, civil or administrative liability on any person for the mere act of seeking, obtaining, providing or facilitating lawful reproductive health; or (3) to identify any person for any purpose described in either (1) or (2). No information regarding reproductive health care for reasons of health care oversight, judicial or administrative proceedings, law enforcement purposes or regarding decedents will be released without an attestation.

Digital Scribing Technology

Variety Care providers and staff use digital scribing and recording technology in certain circumstances to document events and patient encounters and assist in documentation. These recordings are not part of a patient's medical record and will not be used for any purpose other than review by staff of Variety Care. They will not be released to the patient or any third parties and are only administrative.

Patients may request, either in writing or by telling the Variety Care staff directly, that they do not wish for the scribing technology to be used during their visit and it will be documented.

YOUR RIGHTS

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them:

Right to Inspect and Copy: You have the right to inspect and copy the personal health information in your medical and billing records, or in any other group of records that we maintain and use to make health care decisions about you. This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request and on payment of the applicable fee, provide you with a summary of these notes.

To inspect and copy your personal health information, you must submit your request in writing to our privacy contact person identified on the first page of this notice. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. The person conducting the review will not be the same person who denied your request. We will comply with the outcome of this review. Certain denials, such as those relating to psychotherapy notes, however, will not be reviewed.

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for any information that we maintain about you. To request an amendment, your request must be made in writing, submitted to our privacy contact person identified on the first page of this notice, and must be contained on one piece of paper legibly handwritten or typed. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or organization that created the information is no longer available to make the amendment,
- is not part of the health information kept by or for the Variety Care
- is not part of the information which you would be permitted to inspect and copy, or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to the health care professionals involved in your care and to others to carry out payment and health care operations, as previously described in this notice.

Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your health information that we have made. Any accounting will not include all disclosures that we make. For example, an accounting will not include disclosures:

- to carry out treatment, payment and health care operations as previously described in this notice.
- pursuant to your written authorization.
- to a family member, other relative, or personal friend involved in your care or payment for your care when you have given us permission to do so.
- to law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to our privacy contact person identified on the first page of this notice. Your request must state a time period which may not be more than six (6) years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; this date will not exceed 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you may request that we not disclose information about you to a certain doctor or other health care professional, or that we not disclose

information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request or if we believe that it will negatively impact our ability to care for you. If we do agree, however, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our privacy contact person identified on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way. For example, you can ask that we only contact you at work or by mail to a specified address.

To request that we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from our privacy contact person identified on the first page of this notice. You may also obtain a copy of this notice at our website, at www.varietycare.org

Complaints or Questions:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by filing a complaint online through our reporting system at www.varietycare.org, mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

Privacy Officer
Variety Care
3000 N. Grand Blvd

Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

If you **are not satisfied** with the manner in which this office handles a complaint, you may submit a complaint to:

Department, Health & Human Services
Office of Civil Rights
Herbert H. Humphrey Building
Room 509F
200 Independence Avenue, SW
Washington, D.C. 20201

You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information:

Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care that we have provided to you.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility Our notice will indicate the effective date on the first page, in the top right-hand corner. We will also give you a copy of our current notice upon request.

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information.
- how we may use and disclose the health information that we keep about you.
- your rights relating to your personal health information.
- our rights to change our Notice of Privacy Practices.
- how to file a complaint if you believe your privacy rights have been violated.
- the conditions that apply to uses and disclosures not described in this Notice.
- the person to contact for further information about our privacy practices.

I have received a copy of the Notice of Privacy Practices.

Signature:_____

Date: _____



NOTICE OF PRIVACY PRACTICES

For Variety Care Health Center Locations

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Medication Use Agreement

I, (patient name)_____, agree:

- Controlled Substance
  - My medication: _____is a controlled substance.
  - The medication will be prescribed only by my provider: _____
  - I will take the medication only as directed.
  - I will not take any other controlled substances without approval from my provider.
- Purpose
  - The controlled substance is necessary for treating my medical condition.
  - This medication is to help me to be able to do my daily activities.
  - My provider talked with me about goals for treatment.
  - My provider talked with me about other options for treatment.
- Risks
  - My provider talked with me about the risks of this medication.
  - This medication can lead to addiction.
  - There is a risk of overdose and death.
  - I will tell my provider if I have misused alcohol or drugs in the past.
  - For my safety, I will tell my provider if I take:
    - herbal remedies
    - over-the-counter medication
    - other prescribed medication
    - alcohol
- Clinic Visits
  - My provider has told me how often I must have clinic visits.
  - My provider has told me how often I can get refills.
  - I will not ask for an early refill.
  - I will keep my appointments.
  - If I miss my appointment, I may not get refills.
- Pharmacy
  - My provider will only send electronic refills.
  - I will not use more than one pharmacy.
  - My provider will not send refills to a pharmacy in another state.
  - My provider checks PDMP (Prescription Drug Monitoring Program). My PDMP report will show if I get other controlled medications.
- Safety
  - I will keep the medication safe.

    - I will keep the medication out of reach of children.
    - Lost or stolen medication will not be refilled for any reason.
- Pill Counts
    - My provider may ask for a pill count at any time.
    - If I do not bring my medication for the pill count, I may not get refills.
    - If the pill count does not match with records, I may not get refills.
- Drug Tests
    - My provider may ask for drug tests at any time.
    - Drug tests may be urine or blood.
    - I will cooperate with drug tests.
    - If I refuse to do the drug tests, I may not get refills.
    - If the drug test shows a controlled substance not approved by my provider, I may not get refills.
- Specialists
    - My provider may require a specialist to check my medical condition.
    - If so, I will keep appointments with the specialist.
    - My provider will share my health records with the specialist. A copy of this agreement may be sent to the specialist.
- Provider Rights
    - My provider is not required to prescribe the medication for me.
    - My provider has the right to stop prescribing the medication if:
        - I ask for any other controlled substance from anyone other than my provider.
        - I get any other controlled substance from anyone other than my provider.
        - I give my medication to any other person.
        - I sell my medication to any other person.
        - I share my medication with any other person.
        - I try to forge a prescription in any way.
        - I try to alter a prescription in any way.
    - My provider will stop prescribing the medication if my provider decides:
        - Taking this medication is not safe for me.
        - This medication is not helping my medical condition.
- My provider answered all my questions about the medication.

Patient Signature_____ Date _____

Telemedicine Informed Consent

Patient Name: _____ DOB: _____

Telemedicine services involve the use of secure audio and video connections that allow your providers and care team to deliver health care services to patients when located at different sites to help you access care how and when you would like it.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I agree that the Variety Care Patient Rights and Responsibilities also apply to telehealth. I agree that:
    a. I will be in a private, set location during my visit;
    b. I will be properly dressed during my visit;
    c. I will follow all rules of conduct required and be respectful during my visit as required by Variety Care; and
    d. I understand that if I do not follow the rules for my visit that my provider may warn me or end my visit and I will still be billed.
4. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
5. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Variety Care at 405-632-6688.
    b. I agree that this consent will continue until I revoke it.
6. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services and Variety Care's privacy practices regarding my protected health information (PHI) will still apply. I know that I may get a copy of the notice of privacy practices upon request from Variety Care.
7. I understand that this document will become a part of my medical record.
8. I understand that I am responsible for any payment required for my telemedicine, including the copay or visit cost if I am not covered by insurance. I understand that the Variety Care sliding fee discount will be applied to telehealth visits if I have provided all the documentation required for that program.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Oklahoma and will be in Oklahoma during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Signature Date

Patient Form Discounted Fee Application

☐ **I decline to apply for the Sliding fee scale program. I understand that I am responsible for the full cost of the services provided, with no discounts applied. If I am unable to pay in full, I acknowledge that I can arrange a payment plan or reschedule non-emergency appointments.**

- ✓ Variety Care offers patients a sliding fee discount on guarantor balances, after all other payers' sources (if applicable), and if they qualify for our sliding fee scale. The discount percentage is based on the **GROSS income of all adult members of the household** and the **number of dependents** in the household.

- ✓ The required documentation **must be renewed each year** unless there is a financial change or household member change prior to the annual renewal, in which case you must notify Variety Care at the time of service at the next visit and complete a new Sliding Fee Application and provide proof of the financial change if applicable.

- ✓ **Proof of Income must be verified within 30 days from the date of service to submit to qualify for the Sliding Fee Scale** and will be required to pay the sliding fee discount prices at the time services are rendered. Failure to provide all the required documentation will result in being responsible for the full amount of all charges without discount.

Proof of Income (Employed)
- Current 1040, W-2 or other tax return
- Recent Pay stub (last 30 days)
- Written and Signed document from
- Employer – form available.

Proof of Income (Unemployed)
- Public Assistance statement of benefits
- Proof of Social Security, Disability, or Pension
- Letter from Non-Profit Org. (e.g., Church)
- Other approved by Billing.

- ✓ If any information provided proves to be fraudulent, the Sliding Fee Scale status will be canceled, and you will be billed for all previous visits.

Names of Head of Household and All Dependents: **Date of Birth:** **Monthly Income** **Annual Income**

Self (Guarantor)

Spouse and/or Partner

Child

Child

Child

Child

Child

Child

Relatives (explain relationship)

Relatives (explain relationship)

Office Use Only > Total Calculated Annual Income:$_____

Total number of family members living in household:_____

A MINIMUM NOMINAL FEE OF $35.00 WILL BE COLLECTED BEFORE YOUR PRIMARY MEDICAL OFFICE VISIT.
A MINIMUM NOMINAL FEE OF $40.00 WILL BE COLLECTED FOR PRIMARY DENTAL; $30.00 FOR PERIODIC VISITS.
ANY LAB, X-RAYS, MEDICAL PROCEDURE, OR INJECTIONS MAY BE AN ADDITIONAL FEE. ALL FEES ARE BASED ON INCOME.

NO DISCOUNT WILL BE APPLIED IF PROOF OF INCOME IS NOT RETURNED WITHIN 30 DAYS

Patient or Parent/Guardian Signature:_____ **Date:** _____