♥ WELCOME ♥

WELCOME!

It is our pleasure to welcome your family to *The Children's Clinic of Klamath*!

We are very excited that you have chosen us, and can't wait to get-to-know you and and your health goals… ***"Growing up Together", we can offer you the best care possible for your child/children!***

PRIMARY CARE MEDICAL HOME

We want you to feel welcome, cared for, and respected **at every appointment**… just like you do in your own home! That's why we make it easy and comfortable for you to get the care you need, in the way that works best for your family.
As your Medical Home, we will:

- ♥ Listen to you and answer your questions.
- ♥ Connect you to care, information, and services to keep you healthy.
- ♥ Encourage you to have an active role in your own health.
- ♥ Help and support you in any way we can!

- In return, we ask that you get involved in your care, team up with us to meet your health goals, and let us know when you have questions or concerns.

Immunizations are an essential part of well child care. CCK follows the national immunization guidelines set forth by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the Centers for Disease Control, and the American Academy of Family Physicians.

APPOINTMENTS

On weekdays, we are available by phone between 7:30am and 5:30pm, and see patients starting at 8:30am.

We do our best to accommodate same-day appointments. Call early as openings tend to fill quickly.

Well Care
Please schedule check-ups 2 to 4 months in advance, so you can reserve a time that works best with your schedule and with the provider you choose.

Cancellations
We ask that you kindly give us 24-hour notice when canceling or rescheduling appointments.

Preparation
At the time of your visit, you will be asked to present the following:

- ❑ copay, if applicable
- ❑ enclosed forms, completed
- ❑ health insurance card(s) & photo ID
- ❑ current medications, including dosage and strength & current immunization records
- ❑ previous medical records, or arrange for your previous physician to send records

24/7 ADVICE & SUPPORT

During business hours, we are happy to answer general questions over the phone. Urgent matters will be addressed before the day is over.

For less urgent matters, we will return your call within 24-48 hours.

For after-hours advice, we offer a live answering service that can assist you, or connect you with on-call advice for guidance.

Reach Advice anytime, day or night, by calling your clinic's daytime phone number.

If you feel your child has a medical problem that cannot wait until Monday, please call us to reserve an appointment. Phones open at 8:00am for scheduling.

Please contact us before going to an urgent care clinic or the ER! In most cases, we can treat your child in our clinic, saving you time and worry.

Location
2580 Daggett Avenue
Klamath Falls, OR 97601
541-884-1224

Hours
Monday – Friday:
8:00 AM – 5:30 PM*
Scheduling starts at 7:30 AM

visit us online at:
www.cckonline.com

The Children's Clinic of Klamath

Patient Information

2580 Daggett Avenue
Klamath Falls, OR 97601
541-884-1224/fax 541-884-1637
www.cckonline.com

PARENT INFORMATION

Name: ______________________________________
Last First MI

SSN: ________________DOB: ___/___/___ ❑ M ❑ F

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Address: ______________________________________

City/State/Zip: ________________________________

Email: ____

Home: (_____)____________ Cell: (_____)____________

How did you hear about us? ____________________

OTHER PARENT INFORMATION

Name: ______________________________________
Last First MI

SSN: _______________ DOB: ___/___/___ ❑ M ❑ F

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Address: ______________________________________

City/State/Zip: ________________________________

Email: ____

Home: (_____)____________ Cell: (_____)____________

PATIENT INFORMATION

New Patient? ❑ Y ❑ N

Name: ______________________________________
Last First MI

SSN: ________________ DOB: ___/___/___ ❑ M ❑ F

OTHER CHILDREN IN FAMILY

Patient Here? ❑ Y ❑ N

Name: ______________________________________
Last First MI

SSN: ________________ DOB: ___/___/___ ❑ M ❑ F

……..…………..Patient Here? ❑ Y ❑ N…………………..

Name: ______________________________________
Last First MI

SSN: ________________ DOB: ___/___/___ ❑ M ❑ F

……..…………..Patient Here? ❑ Y ❑ N…………………..

Name: ______________________________________
Last First MI

SSN: ________________ DOB: ___/___/___ ❑ M ❑ F

EMERGENCY CONTACT (other than spouse)

Name: ______________________________________
Last First MI

Relationship to Patient: ________________________

Home: (_____)____________ Cell: (_____) ____________

BILLING INFORMATION

❑ Private Pay (no insurance)

❑ Insurance (primary) Eff. Date: ___/___/___

Insurance Co: ________________________________

Employer: ___________________________________

Policyholder: _________________ DOB: ___/___/___

Policy #: ____________________________________

Group #: ________________ Copay: $ ____________

❑ OHP (circle one): CHA | OMAP

❑ Insurance (secondary) Eff. Date: ___ /___ /___

Insurance Co: ________________________________

Employer: ___________________________________

Policyholder: _________________ DOB: __/___/_____

Policy #: ____________________________________

Group #: __________________ Copay: $___________

CONSENT FOR TREATMENT: I authorize the physicians and clinic personnel of The Children's Clinic of Klamath to conduct physical examinations and routine services, order and perform tests, and administer treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks involved. I will be given the opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me and that additional consent(s) may be required .

FINANCIAL RESPONSIBILITY: I understand that I am responsible for all charges resulting from treatment provided by The Children's Clinic of Klamath, as well as any agency and/or legal fees incurred should my account be placed in a collection status. I agree to pay the balance due within 30 days of statement billing unless I have made other payment arrangements.

ASSIGNMENT OF BENEFITS: I authorize my insurance carrier(s) to remit payment of benefits for any claim to The Children's Clinic of Klamath I understand that any ineligible or non-covered expenses are my responsibility.

I assign The Children's Clinic of Klamath, as an Authorized Representative to: (1) Submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) Submit any and all requests for benefit information from my insurance company, (3) Initiate formal complaints to any state or federal agency that has jurisdiction over my benefits, and (4) Release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy, and/or settlement information upon written request from Metropolitan Pediatrics, LLC. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

X_________________________________ _______________________________ X______/_______/________

Signature of Patient/Parent/Legal Guardian Print Name | Relationship to Patient Date