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PEDIATRICHEALTHCARE

from infants to teenagers

42141 Mound Road, Suite B
Sterling Heights, Michigan 48314
586.254.7593
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YEARLY FAMILY DEMOGRAPHICS UPDATE

Home Address ____**City**________________________**State**_____**Zip**_________

Main Phone Number (Test Results/Reminder Calls): (_____)__________________________**Texting Ability? Yes / No**

Main E-mail Address____

Please list all children in your family that are patient's at Pediatric HealthCare (Name & Date of Birth)

NAME	DOB	NAME	DOB

PARENT OR GUARDIAN INFORMATION

Last Name: ____First Name:____
Relationship: Mother / Father / Other (Relationship to child) ____
Address (if different than above): ____
Phone (_____)______________________________□Cell □Home □Work

Last Name: ____First Name:____
Relationship: Mother / Father / Other (Relationship to child) ____
Address (if different than above): ____
Phone (_____)______________________________□Cell □Home □Work

If there are custody arrangements, please notify front staff upon check in and provide documentation.

EMERGENCY CONTACT INFORMATION

Last Name: ______________________________First Name:_____________________ Relation:_______________________

Phone (_____)____________________________ □Cell □Home □Work

Is this individual able to bring your child(ren) to appointments? □Yes □No Parent/Legal Guardian Intial:______
Is this individual authorized to make medical decisions on your behalf? □Yes □No Parent/Legal Guardian Intial:______
Is this individual authorized to receive protected health information? □Yes □No Parent/Legal Guardian Intial:______

I/We being the parent(s) or legal guardian(s) of the previously named minor child(ren) hereby acknowledge the information that is provided here is true and accurate.

______________________________	______________________________	____________________
Parent/Guardian Name (Print)	**Parent/Guardian Name (Signature)**	**Date**

PEDIATRIC HEALTHCARE

THE FOLLOWING DOCUMENT INCLUDES CONSENT FOR THE FOLLOWING:

- **Patient Consent for use and Disclosure of Protected Health Information**
- **Acknowledgment of Review of Notice of Privacy Practices**
- **Acknowledgment of Review of Michigan Laws Related to Right of a Minor**
- **Medical Consent for Proxy of Minor Children**
- **Medical Consent to Testing**

______*initials*

DISCLOSURE OF PROTECTED HEALTH INFORMATION:

With my consent, Pediatric HealthCare may use and disclose protected information (PHI) about me or my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric HealthCare's Notice of Privacy Practices for a more complete description of uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric HealthCare reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric HealthCare's Privacy Officer, Diana Koehler at the practice address.
With my consent, Pediatric HealthCare may call my home or other designated location and leave a message on my voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's or my clinical care, including laboratory results among others.
With my consent, Pediatric HealthCare may mail to my home or other designated location any items that assist the practice in carrying out TPO.
I have the right to request that Pediatric HealthCare restricted how it used or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
By signing this form, I am consenting to Pediatric HealthCare's use and disclosure of my PHI to carry out TPO.
If I revoke my consent in writing and do not sign this consent, Pediatric HealthCare may decline to provide treatment to my child.
Services are provided without regard to sex, race, color, religion, national origin, or disability.

______*initials*

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES & THE MICHIGAN LAWS RELATED TO RIGHT OF A MINOR:

The undersigned Parent or Legal Guardian of the Patient acknowledges that he/she personally received or reviewed a copy of the Pediatric HealthCare Notice of Privacy Policies on the date indicated below, and received or reviewed a copy of the Michigan laws related to the right of a minor.

______*initials*

MEDICAL CONSENT FOR PROXY OF MINOR CHILDREN:

I/We being the parent(s) or legal guardian(s) consent to the attached document (YEARLY FAMILY DEMOGRAPHICS UPDATE) of which include the (EMERGENCY CONTACTS INFORMATION) to act in my/our behalf in authorizing unexpected medical care for my minor child(ren) during the period of my/our absence. I understand that the appointed will be required to show proof of ID upon bringing in my child(ren) for treatment. This document shall be presented to the physician at such time as unexpected medical care may be required.

______*initials*

MEDICAL CONSENT TO TESTING:

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues or products may be obtained and that tests will be performed upon such fluids, tissue and products, and I consent to this. I understand that if it becomes necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV, the virus that causes AIDS), I will be counseled by my physician and I will be given the choice of consenting in writing to such testing. I have been informed that written consent to testing for HIV antibody of other communicable diseases is not required by law situations where a health care provider sustains an exposure to my blood or body fluids.

____

PARENT / GUARDIAN PRINT NAME *PARENT / GUARDIAN SIGNATURE* *DATE*

____

WITNESS PRINT NAME *WITNESS SIGNATURE* *DATE*

PEDIATRIC HEALTHCARE
FINANCIAL POLICIES

Our goal at Pediatric HealthCare is to provide and maintain a good physician-patient relationship. We would like to remind you that it is ultimately your responsibility to pay for our services as they are rendered.

INSURANCES:
I agree that I shall be legally responsible for any medical charge incurred in excess of any hospitalization or health insurance that might be applicable.
I assign payment of authorized benefits to Pediatric HealthCare on behalf for services rendered through Pediatric HealthCare.
I understand that I am responsible for the charges not covered by my policy.
I authorize Pediatric HealthCare to release any medical information required by my health insurance company to process a claim.

1. Upon request, please be prepared to present your insurance card at every visit. We reserve the right to not bill claims to an insurance, if we do not have a current copy of your insurance card.
2. **NEWBORNS** must be added to an insurance plan no later than 30 days from birth. If this is not completed, your child's insurance may refuse to make payment for services already provided at the hospital and in the office. If the insurance company refuses, you will be responsible for all charges for the services rendered on those dates. This is the rule from your insurance company.
3. Our office is in-network with many different insurance companies. While our providers' names may show up as in-network, please remember that our providers see patients at the hospital and may not be in-network at our office location.
4. If your child's insurance is a HMO, your child is assigned to a Primary Care Physician (PCP), and must be assigned to a provider at our office before services are rendered. If the PCP effective date is after a date of service, your child's insurance may not pay for services and you will become fully responsible for all charges. In most cases, if your child has to see a specialist or have a procedure you will need a referral before your appointment. We request 4-7 business days for non-emergent referrals. In some cases, insurance companies will not approve referrals if the date of service is in the past, and we reserve the right to deny referrals requested after an appointment was completed with a specialist.
5. Insurance co-payment, coinsurance and deductible amounts are due at the time services are provided unless other arrangements are made with our office. We accept cash, check, and credit cards (Visa, MasterCard, Discover, American Express).

APPOINTMENTS:

1. We respectfully request a 24 hour notice if you are unable to make it to your scheduled appointment.
2. If you are more than 15 minutes late for an appointment, we will do our best to accommodate your child. However, if our schedule does not allow for it – you may be asked to see another physician with an opening or reschedule.
3. We reserve the right to charge a $25 fee (*per child, per appointment*) for “no-show” appointments.
4. We strive to minimize wait times; however, emergencies do occur and will take priority over schedule appointments.

BILLING & COLLECTIONS:

1. Billing statements will be sent monthly to the home of the primary health insurance subscriber, or guarantor. If the subscriber changes from one parent to another, please notify us at check-in. If a child's parents are divorced, regardless of a divorce decree (*which is document between the two parents and the court system)*, the parent who is the insurance subscriber, is the guarantor.
2. Pediatric HealthCare must, under federal law, accurate report all services provided to your child during their visit. Your insurance company may not pay for all services rendered. Pediatric HealthCare cannot change the level of service or diagnosis codes (*unless it was initially reported incorrectly during the billing process)* in an attempt to make a service become “covered” by your health insurance plan benefits.
3. Our office will send a minimum of three (3) statements, before being referred to our collection agency. In addition to the amount you owe Pediatric HealthCare, the amount charged by the collection agency for their services will be added to your family account and become your responsibility. If you are unable to make payment in full, please contact our office to make alternative payment arrangements. It is best to make payment arrangements and dates for payments with our office to prevent your account from going into collections. Depending on the circumstances, a financial hardship form may need to be filled out with account explanations and payment arrangement options.

MISCELLANEOUS:

1. There is a $5 fee charged for school and work forms not completed during an office visit. This includes, but is not limited to Health Appraisal Forms, Sports Physical Forms, Asthma Forms, FMLA paperwork, and any special letters

that must be completed for your child.

2. There is a minimum charge of $15, per patient for a copy or transfer of medical records.
3. Personal checks returned for Non-Sufficient Funds (NSF), will be charged $25, plus any bank fees incurred.

MICHIGAN MEDICAID:

Pediatric HealthCare certifies that this office has an established policy for billing all patients (including Medicaid) for services not covered by their insurance carrier. In accordance with State Medicaid provider billing guidelines, the patient/responsible party has been cautioned that the charges may not be paid for the following reasons:

1. Patient/Responsible Party has been told that (a) The doctor accepts Medicaid patients but does not participate with the patient's Medicaid HMO, Managed Care and/or Michigan Medicaid's ESO plan (b) Patient agrees to accept financial responsibility for any services not paid by Medicaid.
2. Patient/Responsible Party identifies themselves as Medicaid eligible; however, the patient was not eligible for Medicaid on this date of service.
3. Patient/Responsible Party identified themselves as Medicaid clients verbally, but did not have current Medicaid ID card. Patient is responsible for services if it is determined that they are not eligible for Medicaid on this date of service.

I am the patient/responsible party. I understand my Medicaid plan may not pay for the services rendered at Pediatric HealthCare. I have been informed and have signed this agreement before receiving services. I understand Pediatric HealthCare accepts Medicaid patients but may not participate with my Medicaid HMO, Managed Care and/or Michigan Medicaid ESO Plan.

<Signature is valid for 1 year from date signed per family>

____

PARENT / GUARDIAN PRINT NAME *PARENT / GUARDIAN SIGNATURE* *DATE*

____

WITNESS PRINT NAME *WITNESS SIGNATURE* *DATE*

PEDIATRIC HEALTHCARE
HEALTH HISTORY

Child's Name:	*DOB:*	*Age:*
Your Name:	*Relationship to child:*	
Today's Date:		

Where was your child born? (Birth Hospital Location) ____

Is the child yours by: ___birth ___adoption ___stepchild ___other

Delivery by: ___vaginal ___c-section (Reason)
Complications ____

Was your child premature? ___No ___Yes, born at _______weeks
Complications ____

Birth Weight: ____________ Length: _____________

List anything your child has been treated for or diagnosed with: __________________________________

Has your child had any vaccines in the past month? Type ______________________ Any reactions? ______________________

Hospitalizations (Reasons and Age): ____

Previous Surgeries (List Dates): ____

Specialists Seeing and Reason: ____

Medications: ____

Allergies: ____

FAMILY MEDICAL HISTORY

	Mother	*Father*	*Child's Sibling*	*Maternal Grandma*	*Maternal Grandpa*	*Paternal Grandma*	*Paternal Grandpa*
Allergies (type:_______________________________)							
Asthma							
Anemia							
Blood disorder (type:___________________________)							
Cancer (type:________________________________)							
Heart (diagnosis:_____________________________)							
Age of Premature Heart Disease							
High Cholesterol							
High blood pressure							
Stroke							
Diabetes							
Thyroid disease							
Kidney disease							
Seizures							
Migraines							
Anxiety							
Depression							
Alcoholism							
ADD / ADHD (please circle)							
Cardiomyopathy / Sudden Death							
Autoimmune (Lupus, Crohns, etc) **Other:**							