NAME OF PATIENT(S) WITH APPOINTMENTS TODAY	

FAMILY INFORMATION

Please include all children who are patients of Pediatric HealthCare – <u>including those being seen in the office today</u>.

First & Last Name	Date of Birth	Gender
		☐ **Boy** ☐ **Girl**
		☐ **Boy** ☐ **Girl**
		☐ **Boy** ☐ **Girl**
		☐ **Boy** ☐ **Girl**
		☐ **Boy** ☐ **Girl**

Patient's Home Address:	Primary Patient Contact Phone Number: ( ) - ☐ Cell ☐ Home
	Contact's relationship to patient: ☐ MOTHER ☐ FATHER ☐ OTHER:
	☐ **Please sign me up for text appointment reminders, if available**

ETHNICITY	**RACE**
☐ Non – Hispanic/Latino ☐ Hispanic / Latino ☐ Middle Eastern	☐ American Indian/ Alaskan Native ☐ Asian ☐ Hispanic or Latino ☐ Native Hawaiian ☐ Black or African American

PARENT INFORMATION: ☐ MOTHER ☐ FATHER	**PARENT INFORMATION:** ☐ MOTHER ☐ FATHER
Name:	Name:
Date of Birth:	Date of Birth:
Social Security:	Social Security:
Phone Number:	Phone Number:
Email:	Email:
Occupation:	Occupation:
Address if different than patient:	Address if different than patient:
REFERRED BY:	

CONTINUED ON THE NEXT PAGE – SIGNATURE REQUIRED

AUTHORIZED CARE GIVERS (OTHER THAN PARENTS)		
Please list all persons authorized to consent to treatment for the patient. This can include grandparents, nanny or other care givers.		
Name	**Relationship to child**	**Phone Number**

FINANCIAL RESPONSIBILITY

Insurance: I agree that I shall be legally responsible for any medical charges not covered by my individual health insurance policy. Newborns must be added no later than 30 days from birth. If this is not completed, your child's insurance company my refuse to make payments for services rendered. If your child's insurance is an HMO, your child must be assigned to a Pediatric Healthcare Primary Care Physician (PCP). If a PCP is not chosen, insurance companies may not pay, and you will be responsible for all charges. Insurance copay, coinsurance and deductible amounts are due at the time services are provided. We accept cash, check, and most major credit cards.

Missed Appointments: We at PHC value your time and will make every effort to minimize wait times. Missed appointments are costly to us, you, and other children who could have used the time that was set aside for your child. PHC will charge a $25 fee for missed appointments. After 3 "no show" appointments, your family may be discharged from the practice.

Form Fee: 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 Physicals, FMLA paperwork, and special letters.

CONSENT TO TREATMENT

Consent: I authorize medical treatment as may be deemed necessary and appropriate by the physician, and his/her designees and assistants participating in my care. This care may include diagnostic, laboratory, and/or therapeutic procedures, drugs, and medical procedures.

Human Immunodeficiency Virus (HIV) and Hepatitis B/C Testing: I understand and agree that, in accordance with State law, an HIV, HBV or HCV test may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of any test will be treated confidentially.

Patient Rights. I know a patient's rights and responsibilities statement will be given to me upon admission or if I ask for one.

Protected Health Information: PHC is committed to ensuring the confidentiality, privacy and security of individually identifiable information. Protecting the privacy of our patients' health information is an integral part of PHC's business practices and in accordance with State regulations, the HIPAA privacy. The information may relate to the past, present or future physical or mental condition of that individual, the provision of health care to the individual, or payment for the provision of the individual's health care. As physicians, we are responsible for protecting the privacy of our patients' PHI and for reporting any activity that violates our policies.

PARENT/GUARDIAN SIGNATURE:	
PARENT/GUARDIAN NAME (PRINTED):	
DATE:	

Financial Responsibility:

Insurance: I agree that I shall be legally responsible for any medical charges not covered by my individual health insurance policy. Newborns must be added no later than 30 days from birth. If this is not completed, your child's insurance company my refuse to make payments for services rendered. If your child's insurance is a HMO, your child must be assigned to a Pediatric Healthcare Primary Care Physician (PCP). If a PCP is not chosen, insurance companies may not pay, and you will be responsible for all charges. Insurance copay, coinsurance and deductible amounts are due at the time services are provided. We accept cash, check, and most major credit cards.

Missed Appointments: We at PHC value your time and will make every effort to minimize wait times. Missed appointments are costly to us, you, and other children who could have used the time that was set aside for your child. PHC will charge a $25 no show appointment. After 3 "no show" appointments, your family may be discharged from the practice.

Form Fee: 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 Physicals, FMLA paperwork, and special letters.

Consent to treatment:

Consent: I authorize medical treatment as may be deemed necessary and appropriate by the physician, and his/her designees and assistants participating in my care. This care may include diagnostic; laboratory procedures; therapeutic procedures; drugs; and medical procedures.

Human Immunodeficiency Virus (HIV) and Hepatitis B/C Testing: I understand and agree that, in accordance with State law, an HIV, HBV or HCV test may be performed in the event a health care worker sustains a significant exposure to blood or body fluids. The results of any test will be treated confidentially.

Patient Rights. I know a patients' rights and responsibilities statement will be given to me upon admission or if I ask for one.

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Parent/Guardian Signature: _____

Parent/Guardian Name (Printed): _____

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
from infants to teenagers

PHC PATIENT HEALTH HISTORY

CHILD'S NAME	D.O.B.	AGE
YOUR NAME	**YOUR RELATIONSHIP TO CHILD**	**TODAY'S DATE**

BIRTH HISTORY

Where was your child born? (Birth hospital location)

Is the child yours by: ☐Birth ☐Adoption ☐Stepchild ☐Other:

Delivery by: ☐Vaginal ☐C-Section – Reason:

Was your child premature? ☐No ☐Yes, born at ____ weeks.
Please list any complications:

Birth Weight: lbs	Birth Length: inches	List anything your child has been treated for/diagnosed with:

Has your child had any vaccines in the past month? ☐Yes ☐No

If **yes**, list type(s) of vaccine(s) received: If **yes**, please list any reactions:

Hospitalizations? ☐Yes ☐No If **yes**, please list reasons and age:

Previous surgeries? ☐Yes ☐No If **yes**, please list surgeries and dates:

Please list any specialists your child is seeing and the reason:

MEDICATIONS	ALLERGIES

FAMILY MEDICAL HISTORY

Description	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 when diagnosed with Premature Heart Disease							
High Cholesterol							
High Blood Pressure							
Stroke							
Diabetes							
Thyroid Disease							
Kidney Disease							
Seizures							
Migraines							
Anxiety							
Depression							
Alcoholism							
Please circle: ADD/ADHD							
Cardiomyopathy/Sudden death							
Autoimmune (Lupus, Crohn's, etc.) Other:							

part of the quality care we provide. We also feel that the relationship we have with you and your child is a two way street. We respect your need to love and advocate for your children, but we also hope that you respect the years we have put into our education so that we know and are able to provide the best care. There are those who choose not to vaccinate their children. While we understand the fear that has been offered up by much anecdotal information freely published on the internet, it is not scientific fact. While vaccines are not free of adverse events (just as driving home in your car on a dry day is not), the events are continuously monitored and reported. Scientific studies show that vaccines continue to be a safe, effective, and vital part of a child's health.

Starting November 1, 2019, there will be a new vaccine policy at Pediatric HealthCare. We do not enter in to this decision lightly but with the knowledge and the need for reciprocated respect for the medical care we provide. We recommend care that we know to be the best for your child and our own. In choosing to deny that fundamental care, we feel that there has been a loss of trust in our medical knowledge and ability.

Starting November 1, 2019:

-We will no longer accept new patients who are refusing all vaccinations.

-We will accept those who are uncertain about vaccines and continue to request/require ongoing education regarding vaccines.

-All those who are uncertain or delayed, we expect to be caught up on their vaccines by their 2nd birthday. For those who are older than 2 years when they start, we expect them to be caught up on vaccines within 6 months of joining our practice.

-We will continue to see our existing patients and continue to educate them regarding vaccines.

Our hope is to continue to create a place where you feel that your child is in the most capable, knowledgeable, and supportive hands. We will continue to strive to make this a place of trust and respect to assist you in raising children who are happy and healthy.

Kindest regards,

The Staff and Physicians of Pediatric HealthCare

Vaccine Announcement

Vaccines continue to be a hot topic of discussion for parents. For those of us in medicine, though, we consider them a wonderful scientific advancement. After putting in many years in the study of medicine and learning not only how the body works, but how the things around us affect our bodies and our minds, we appreciate having those advancements in medicine that allow us protection from things we do not have control over like infections and cancer.

Whitney Houston sang about how the "the children are our future." At Pediatric HealthCare, children are our past, present, and future. We have spent many years educating ourselves on how to provide the best care to help them today, so that they live a happy and healthy tomorrow. We have worked to ensure that we stay up to date on medicine that is scientifically proven to minimize the risk of illness and treat disease.

The first vaccine known in history was a live attenuated vaccine developed for smallpox in 1798. A rabies vaccine followed almost 100 years later in 1885. Subsequently, killed vaccines were developed for typhoid, cholera, and the plague in the late 1800s. However, we tend to remember one of the greatest advancements in vaccines with the development of the polio virus vaccine, which was the first vaccine to be developed in in-vitro culture (without the assistance of an animal host). Since that time, scientists have continued to develop and refine vaccines to make them safer and more effective.

In caring for your children, we use evidence-based medicine. This involves research that is done by a scientific method that is free of bias or prejudice, controlled for factors that are irrelevant to the study, and widespread enough to be attributable to the whole population. It allows us to come up with information that is rational, objective, testable and provable or disprovable. It then involves translating that information into clinical reasoning and use. This does not allow for anecdotal evidence, which is information that is not necessarily true or factual, but instead based on someone's beliefs.

Vaccines in medicine are based on evidence-based science. Vaccinations have been proven to reduce disease, disability, and death from a variety of infectious diseases. Vaccines not only have been shown to provide individual protections for those persons who are vaccinated, they can also provide community protection by reducing the spread of disease within a population.

Simply put…VACCINES SAVE LIVES!

We, at Pediatric HealthCare love our jobs. We love the people we care for. We love their families. We have spent years working to provide the best care for all of you. We feel that vaccines are an essential part of the quality care we provide. We also feel that the relationship we have with you and your child is a two-way street. We respect your need to love and advocate for your children, but we also hope that you respect the years we have put into our education so that we know and are able to provide the best care. There are those who choose not to vaccinate their children. While we understand the fear that has been generated by anecdotal information freely published on the internet, it is not scientific fact. While vaccines are not free of adverse events (just as driving home in your car on a dry day is not), the events are continuously monitored and reported. Scientific studies show that vaccines continue to be a safe, effective, and vital part of a child's health.

On July 1, 2019, Pediatric HealthCare implemented a new vaccine policy. We did not arrive at this decision lightly, but with the knowledge and the need for reciprocated respected for the medical care we provide. We recommend care that we know to be the best for your child and our own. When choosing to deny that fundamental care, we feel that there is a loss of trust in our medical knowledge and ability.

Therefore, effective November 1, 2019:

- We will no longer accept new patients who are refusing all vaccinations.
- We will accept those who are uncertain about vaccines and continue to request/require ongoing education regarding vaccines.
- All those who are uncertain or delayed, we expect to be caught up on their vaccines by their 2nd birthday. For those that are older than two (2) years when they start, we expect them to be caught up on vaccines within 6 months of joining our practice.
- We will continue to see our existing patients and continue to educate them regarding vaccines.

Our hope is to continue to create a place where you feel that your child is in the most capable, knowledgeable, and supportive hands. We will continue to strive to make this a place of trust and respect to assist you in raising children who are happy and healthy.

Kindest Regards,

The Physicians and Team Members of Pediatric HealthCare

Vaccine Policy for New Patients

I agree that I have read the Pediatric HealthCare Vaccine Statement of November 1, 2019.

I agree to follow the vaccine schedule as scientifically studied and approved by the Academy of Pediatrics, Center for Disease Control, and World Health Organization and licensed and regulated by the U.S. Food & Drug Administration.

I am aware that if my child is delayed in vaccines upon starting at Pediatric HealthCare, it will be expected that my child is caught up on their vaccines by their 2nd birthday. If my child is delayed and older than 2 years old, my child will be expected to be caught up on vaccines within six (6) months of joining Pediatric HealthCare.

If my child is not compliant with the vaccine schedule, it will require a consultation visit with a Pediatric HealthCare physician/provider. Further noncompliance may result in dismissal from Pediatric HealthCare.

I am aware that exceptions will be made for those children who have a medical condition that precludes the safe use of vaccines as noted by my physician or other specialty MD/DO.

I am aware that I am free to discuss any questions or concerns that I have about vaccines with my physician at any time. I am aware that I am free to ask for a copy of the vaccine schedule at any time.

PARENT/GUARDIAN SIGNATURE:	
PARENT/GUARDIAN NAME (PRINTED):	
WITNESS SIGNATURE:	
WITNESS NAME (PRINTED):	
DATE:	