CHILDREN'S HEALTH CARE, PLLC, MT PLEASANT, MI

Authorization for Use and/or Disclosure of Protected Health Information

PATIENT INFORMATION SHEET (Please Print)

Last Name	First Name	Middle Initial		Gender
Address	City	State	Zip Code	Phone Number
Date of Birth	Social Security Number(optional)		Email Address(optional)	

Please check/specify the information which you want to be used and/or disclosed as a result of this Authorization. Failure to specify (including dates) will render this Authorization invalid.

Dates of Treatment/Particular Illness/Admission Requested: _____

If request for entire medical records please circle one: Yes No

If request for specific parts of medical record please indicate below:

[] Discharge summary
[] History & Physical
[] Operative Reports
[] Emergency Department Record
[] Consultation Reports
Specify MD_____

[] Outpatient Clinic Notes
Specify Clinic_____
[] X-Ray reports, Labs or Other tests
[] Registration Sheets
[] Immunizations
[] Other_____
[] Other_____

Purpose For Disclosure
[] Medical Care
[] Attorney/Legal
[] Personal
[] Insurance
[] Disability/SSI
[] Other_____

DISCLOSE RECORDS TO (NAME, ADDRESS, FAX #)	**RECEIVE RECORDS FROM** (NAME ,ADDRESS, FAX #)
TO CHILDREN'S HEALTH CARE, PLLC 709 S ADAMS, MT PLEASANT, MI 48858 P=989-772-7774 F=989-772-7220	FROM

Information May Be: [] Mailed [] Reviewed Only [] Picked Up By whom:_____ [] In-Person Meeting

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on _____, or _____(event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department. Please refer to Children's Healthcare (CHC) Notice of Privacy Practices.

CHC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations.

I, the undersigned, hereby authorize Children's Healthcare to use and/or disclose information from my (or give relationship) _____ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol use, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature:_____ **Date:**_____ **[] Patient [] Parent [] Legal Guardian**

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CHC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form. *Documentation regarding guardianship must be provided in order to comply with the above requested.

Request Has Been Fulfilled: [] Yes, Initials:_____Date:_____

CHILDREN'S HEALTH CARE

We want to provide you with the very best health care possible. We realize your time is valuable, and our staff will try to attend to you as quickly as possible. Would you please take a minute to fill out the demographic information for our computer file.

PATIENTS NAME:_____
(Last) (First) (M.I.)

BIRTH DATE: _____SS#:_____PHONE:( )_____

ADDRESS:_____CITY:_____ZIP:_____

SEX: (Please circle one) MALE / FEMALE

RACE: (Please choose one) ☐White ☐Black or Afr Amer ☐Amer Indian or Alaskan Native
☐Asian ☐Native Hawaiian or Pacific Islander ☐ Decline to Report

ETHNICITY: (Please choose one): ☐Hispanic or Latino ☐Non Hispanic or Latino

LANGUAGE : ☐English ☐Other : please specify _____

EMERGENCY CONTACT INFO:_____
(name and phone #)

MOTHERS NAME:_____
(Last) (First) (M.I.)

BIRTH DATE:_____ SS#:_____

EMPLOYER'S NAME:_____

WORK PHONE:_____EXT_____

FATHERS NAME:_____
(Last) (First) (M.I.)

BIRTH DATE:_____SS#:_____

EMPLOYER'S NAME:_____

WORK PHONE:_____EXT:_____

PRIMARY INSURANCE:_____

POLICY HOLDER:_____DATE OF BIRTH:_____

CONTRACT #:_____GROUP#:_____

SECONDARY INSURANCE:_____

POLICY HOLDER:_____DATE OF BIRTH:_____

CONTRACT #:_____GROUP #:_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

Signature of
Parent/Guardian:_____Date:_____

AUTHORIZATION:
I authorize Children's Health Care, PLLC to release medical information as it is necessary to bill my insurance carrier. In addition, I authorize my insurance carrier to release payments of insurance benefits directly to Children's Health Care, PLLC for services furnished to me by the clinic.

CO-PAYS:
All co-pays will be due before the doctor sees you. Co-pays are also collected even when visits are for immunizations, venipuncture and allergy shots only. Also if you have not met your deductible for the year, payment is required when services are rendered.

REFERRAL POLICY:
I agree to abide by my insurance policy's rules regarding referrals to specialists and ancillary services (i.e. using specialists and ancillary services within my insurance plan and network). I understand that Children's Health Care, PLLC has a policy, which includes requesting referrals at least one (1) week prior to your specialist visit. No post-dated referrals will be issued.

GUARANTOR LIABILITY RESPONSIBILTY:
I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have completed all of the above questions and I certify that the information is true and correct to the best of my knowledge. I will notify the office of any changes in the above information, insurance status or health status. I authorize payment of medical benefits to Children's Health Care, PLLC for services rendered to me. I also understand and agree that in case of default I will be responsible for all attorney fees and collection fees incurred on this account

I also understand that I am liable for knowing and understanding my insurance coverage. This includes that you must be the designated Primary Care Physician and/or primary site at the time services are rendered, or I will become responsible for my payment due. I am also responsible for knowing my insurance policies with regards to well and sick visits as well as immunization coverage. Please inform the office staff if you insurance policy does not have coverage for vaccines, or if you have no insurance coverage. Please note that your child may be eligible for State of Michigan Health Department vaccine coverage. I am also advised that my insurance carriers will only pay for services that it determines to be reasonable and necessary. Children's Health Care, PLLC believes that your physician is in the best position to know the clinical assessment needs of his or her patients. In some cases, when a physician orders a specific test to either detect presymptomic diseases as part of a process to help determine what the diagnosis is, some insurers will not pay for the test performed in this case you would be responsible for any charged incurred. (You may always check your coverage by calling your insurance carrier.)

Signature of
Parent/Guardian:_____Date:_____

CONSENT FOR MEDICAL TREATMENT OF A MINOR CHILD

ATTENTION PARENTS/CAREGIVERS

The following guidelines make a medical situation easier for your child in case of an illness or accident occurs given you are not immediately available. This completed form is good for BABY SITTERS, GRANDPARENTS, NEIGHBORS OR OTHERS if they are given the responsibility.

Remember: LIFE AND LIMB THREATENING EMERGENCIES WILL ALWAYS BE TREATED EVEN WHEN CONSENT IS UNAVAILABLE. This form is necessary for the minor illnesses when treatment is normally withheld until parental consent is obtained. This for may be duplicated.

I (We)_____ hereby state that I (We) am(are) the parent or legal guardian of:
Patient's Name:_____Date of Birth:_____

In the event the above mentioned minor child requires medical treatment and I(We) am(are) unavailable to accompany my child to CHC's medical office, I(We) hereby delegate my(our) parental rights only for the purposes of medical treatment to the following persons:

1:_____
2:_____
3:_____

I agree to be financially responsible for the services provided. I authorize the release of information to my insurance company and physician.

Signature of Parent/Guardian:_____
Date:_____ I can be reached at:_____

AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOU HEALTH INFORMATION

By signing below, I hereby authorize my child's _____ protected health information created or received by Children's Health Care, PLLC to be used or disclosed to the following person or class of person for the purpose of treatment, payment and heealth care operations:

Name: Relationship to patient:

_____
_____
_____
_____
_____

I understand that I may revoke this Authorization or any changes here into by delivering written notice to Children's Health Care, 709 S Adams, Mt Pleasant, MI 48858.
I acknowledge that I have read and understand this Authorization and authorize the use or disclosure of my child's protected health information to the name of person mentioned above.

Signature of Parent/Guardian;_____

PATIENT PORTAL

Dear Patients,

We have launched our patient portal, which will give you access to your child's medical records. This will also allow for our providers to directly message you with test results or answers to your questions. Please provide your email address, you will then receive an email with login instructions. If you do not have an email and would still like access please see the front desk to get your child's login info.

Thank you!

CHC Staff

Email:_____

Patient Name:_____

If you wish to not participate in patient portal please check the box to opt out. ☐

CHILDREN'S HEALTH CARE **PATIENT'S NAME:** _____

DATE OF BIRTH: _____

Dear Parents,

To help with our transition to EMR (Electronic Medical Records) please fill out the following form in regards to your child being seen today.

Family History:

Does any family member have the following illnesses? Please check the appropriate box and list relationship (include parents, siblings, grandparents (maternal/paternal), aunts and uncles:

[] Diabetes _____ [] Thyroid Disease _____
[] Cancer (list type)_____ [] Heart Disease _____
[] Mental/Pysch Disorder (list type)_____
[] High Blood Pressure_____
[] History of Alcohol/Drug Use by any family member_____
[] Other:_____
_____

[] None

Social History:

Please list everyone in the household as well as their age:

Mother: _____ Father: _____
Brother(s): _____ Sister(s): _____
Grandparents: _____ Other:_____

Are the parents married, divorced, separated, never married or live together?
Who has custody of the child(ren): _____

Does you child attend daycare? [] No [] Yes

Is the child in foster care? [] No [] Yes
If yes list the name of the foster family_____

Is the child adopted? [] No [] Yes
If yes list the name of the adopted family:_____

Has the child traveled outside of the US? [] No [] Yes
If yes list the date and location:_____

Smoking status: _____[] Not applicable [] Second Hand Smoke Exposure
Alcohol status: _____ [] Not applicable

*** Mothers Pregnancy/Child Delivery History:**

Check the appropriate regarding the delivery of the child:

[] Vaginal [] C-section
[] Full term [] Premature, gestational age:_____

Birth Weight:_____ Birth Height:_____

Mothers use of medications during pregnancy (if any, list)_____

Check any of the following that applied during pregnancy with the child:

[] High Blood Pressure [] High Blood Sugar [] Use of recreational drugs [] None
[] Smoking [] Use of alcohol [] Other:_____

Were there any problems during/directly after delivery? [] No [] Yes
If yes, describe:_____

CHILDREN'S HEALTH CARE **PATIENT'S NAME:** _____

DATE OF BIRTH: _____

***Past Medical History:** (include previous diagnosis & dates)
Has your child had any of the following conditions/illnesses?:
Please check the appropriate box and list the date first diagnosed with the condition

[] Asthma Date Diagnosed:_____
[] Allergies Date Diagnosed:_____
[] Seizures Date Diagnosed:_____
[] Thyroid Disorder Date Diagnosed:_____

[] Heart Disease Date Diagnosed:_____
[] Kidney Disorder Date Diagnosed:_____
[] Cancer Date Diagnosed:_____
[] Diabetes Date Diagnosed:_____
[] Mental Illness Date Diagnosed:_____
[] Other Date Diagnosed;_____

_____

_____

[] None

History of or presence of physical abuse [] Yes [] No
History of or presence of sexual abuse [] Yes [] No

***Hospitalizations:**
Has you child ever been hospitalized at any time? [] No [] Yes
If yes list what hospital, date of admission and reason:_____

_____

***Surgeries:**
Has your child every had surgery? [] No [] Yes
If yes list what hospital, date of surgery and kind of surgery:_____

_____

_____

Current Medications: (include doses & frequency)
Is your child currently taking any medications? [] No [] Yes

Medication:	**Dose:**	**Frequency:**

Allergies:
Is your child allergic to any medications? [] No [] Yes
If yes list the medication and reaction:_____

_____

_____

Does you child have any other allergies besides to medications? [] No [] Yes
If yes please list:_____

_____

Welcome To Our Practice
CHILDREN'S HEALTHCARE- A Patient Centered Medical Home
709 South Adams, Mt Pleasant, MI 48858, Tel 989-772-7774 Fax 989-772-7220

We appreciate and thank you for the opportunity to provide medical care and services to your child. This guide will describe some basic information about how we work and answer the questions most frequently asked by our patients. We want you to know and understand our policies and methods of practice. If you have any questions, please ask us.

The Patient Centered Medical Home (PCMH) we initiated is an approach to providing comprehensive primary medical care for our patients. The PCMH is a trusting partnerships between our patients, and our physicians, and when appropriate, the patient's family. It includes an agreement between our physicians and the patient that acknowledges the role of each in a total health care program.

As we build your child's Medical Home you will notice some changes in the way we provide care, but many things will stay the same.

We trust you, our patient's parent to:

- Tell us accurately your child past medical history and what you know about your child's health and illnesses
- Tell us about you and your child's needs and concerns
- Take part in planning your child's care
- Follow the care plan that is agreed upon- or let us know why you cannot so that we can try to help, or change the plan
- Tell us what medications your child is taking and ask for a refill at your child's office visit when you need one
- Let us know when your child sees other doctors and what medications they put your child on or change
- Ask other doctors to send us a report about your child's care when your child sees them
- Seek our advice before your child sees other physicians. We may be able to care for your child and we know about the strengths of various specialists.
- Learn about wellness and how to prevent disease
- Learn about your child's insurance so you know what it covers
- Respect us as individuals and partners in your child's care
- Keep your child's appointments as scheduled, or call and let us know when you cannot
- Pay your share of the visit fee when your child is seen in our office
- Give us feedback in our patient satisfaction form so we can improve our services
- Ask us about needed community resources

We will continue to:

- Provide your child with a care team who will know your child and your family
- Respect you and your child as an individual- we will not make judgements based on race, religion, sex, age, disability, etc
- Respect your privacy- your child's medical information will not be shared with anyone unless you give us permission or it is required by law
- Provide care by a team of people led by your child's physician
- Give the care your child needs when your child needs it
- Give care that meets your child's needs and fits with your child's goals and values
- Give care that is based on quality and safety
- Have a doctor on call 24 hours a day and 7 days a week
- Take care of short illness, long term disease and give advice to help your child stay healthy
- Tell you about your child's health and illness in a way you can understand
- To improve your child's care we are using technology- like e-prescription services, patient disease register and we will strive to continuously improve
- Provide you with requested community resource information
- Have same day appointments available

Over the next several months you may notice that:

- We ask what your child's goal is, or what you want to do to improve your child's health
- We ask you to help us plan your child's care, and let us know if you think you can follow the plan
- Written copies of care plans may be given in more complex illnesses
- The care team members are doing more and/or different parts of the care
- We remind you when tests are due so that you can receive the best quality care
- We may ask you to have blood tests done before your visit so that the doctor has the results at your visit

We are exploring methods to care for your child better; including ways to help you care for your child.

Practice Hours

This office is open: Monday and Thursday 8:30 AM to 6:00 PM, Wednesday and Friday 8.30 Am to 5.30 PM and Tuesday: 8:30 AM to 5:00 PM. Main phone number is 989-772-7774 to make appointments and answer general questions. If you require urgent care after regular business hours please call 989-772-7774 and you will receive our answering service who can connect you to the doctor on call 24 hours a day, 7 days a week. In the event of a medical emergency you may take your child to an urgent care in your area or the nearest emergency room.

Ready Care- Mt Pleasant 989-773-1166
Urgent Care- Clare 989-386-9911
Urgent Care- Alma 989-466-3332

Emergency Care and Urgent Care

CHC strives to accommodate patients who need more urgent care. Please call us to see if we can see your child or guide your child's care. Often we might guide your child to care that serves your child well. Emergency care is safer if we can guide the Emergency Department about your health situation. If you receive care at an emergency room or urgent care center, please let us know by calling 989-772-7774 within 24 to 48 hours so we can assist with the follow up care as needed. Also please have the emergency room or urgent care center send us the records from your visit by fax 989-772-7220 or mail to 709 S. Adams, Mt Pleasant, MI 48858.

Insurance Participation

Children's Health Care participated in many health plans. Some health plans are better for preventative care than others; some health plans offer more choices. Be sure to check with us to confirm that we accept your insurance before making an appointment. Please be prepared to pay (or co-pay) for services at the time of your appointment. If you have any questions about your bill or want to discuss your bill, please call us at 989-772-7774.

Laboratory and Test Results

Please try to use laboratories and other test facilities we use regularly to ensure better communication. We performed basic labs (CLIA Waived tests) in the office and will refer you for any tests that we do not perform in the office. We strive to get test results to patients. Please call if you haven't heard from us a week after the test was done.

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you. We desire to get better and better.