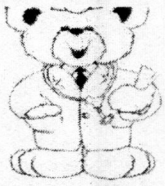
Huron Valley Pediatrics

PATIENT REGISTRATION



PATIENT NAME:_____ DOB:_____ SEX: ____M____F

HOME ADDRESS:_____ CITY:_____

STATE:_____ ZIP CODE:_____

PHONE NUMBER:_____ SECONDARY PHONE:_____

RECEIVE TEXT MESSAGES? **YES** or **NO**

EMAIL ADDRESS (*Required for Patient Portal*):_____

PARENT / GAURDIAN INFORMATION

MOTHER'S / GAURDIAN NAME:_____ DOB:_____

FATHER'S / GAURDIAN NAME:_____ DOB:_____

EMERGENCY CONTACT:_____ PHONE NUMBER:_____

PATIENT SIBLINGS (NAME & DATE OF BIRTH)

_____

_____

_____

HEALTH INSURANCE COMPANY:_____

CONTRACT OR ID NUMBER:_____

SUBSCRIBER / CARD HOLDER NAME:_____

DATE OF BIRTH:_____

PHARMACY NAME:_____ LOCATION:_____

PATIENT DEMOGRAPHICS

RACE: ____White/Caucasian ____Black/African American ____ American Indian / Alaskan Native ____Asian

____Native ____Hawaiian/Other Pacific Islander ____More Than One Race ____Prefer Not To Answer

Are You of Hispanic Origin? YES or NO **Preferred Language**:_____

Parent or Guardian Signature:_____ Date:_____

Huron Valley Pediatrics

2632 S Milford Rd, Highland, MI 48357
Phone: (248) 684-5510 **Fax:** (248) 684-5220
Yasser Hassane, MD F.A.A.P.
Lucila Olson, MD F.A.A.P.

Summary of Notice of Privacy Practices

The Notice of Privacy Practices contains a detailed description of how our office will protect your information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosures of Health Information We will use and disclose your health information in order to treat you or assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities, such as quality, assessment, licensing, accreditation, and training of students.

Uses and Disclosures Based on Your Authorization Except as stated in more detail the Notice of Privacy Practices; we will not disclose your health information without your written authorization.

Uses and Disclosers Not Requiring Your Authorizations In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends whom are involved in your health care
- For certain limited research purposes
- For purposes of public health and safety
- To government agencies for purposes of their audits, investigations, and other oversight activities
- To the FDA to report product defects or incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights As our patients, you have the following rights:

- To have access to and/ or a copy of your health information
- To receive an accounting of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of your Privacy Practices

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FINANCIAL AGREEMENT

1. Payment is expected at the time of service. This includes all co-payments, deductibles, and non-covered services. Services not covered by your insurance company are your responsibility.
2. Please be aware of specific maximum limits (on sick and well-child visits) and immunization coverage. It is your responsibility to know the limitations of your coverage and to communicate them with our office staff prior to delivery of services.
3. We would greatly appreciate 24-hour notice for all cancellations.
4. If your insurance a Managed Care Plan (HMO) and your child requires services that require a referral, adequate planning is essential. Referrals must be authorized by your physician and usually requires an office visit. Once the physician approves the referral, your insurance carrier must also approve it. Authorization from insurance plans can take up to one week. Please be aware that we may not be able to accommodate same day call-in requests for referrals. Upon receipt of a referral to a specialist or ancillary service it is your responsibility to be aware of what has been authorized. Subsequent visits, procedure, surgeries, and hospitalizations typically require additional referrals. Failure to obtain necessary authorizations often leads to out-of-pocket expense. We are happy to assist you in any way with your managed care plan.
5. If you cannot provide adequate proof of insurance, you will be responsible for the entire visit at the time services are rendered.

I understand and accept the above statements.

Parent/guardian signature:_____
Date:_____

Please print the name of each child:

_____
_____
_____
_____
_____
_____

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Notice of Privacy Practices

Patient Acknowledgement

Patient Name:_____ DOB:_____

I have received this practice's Notices of Privacy Practices written in plain language. The Notice provides in detail the used and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Parent/Gaurdian Signature:_____

Date:_____

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Patient Name:_____ DOB:_____

Our notice of privacy practices provides information about how we may use or disclose protected health information.

The terms of the notice may change, if so, you will be notified at your next appointment to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by the law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The patient may condition receipt of treatment upon execution of this consent.

May we call you to confirm appointments?	YES	NO
May we leave messages on your voicemail/ answering machine?	YES	NO
May we discuss your medical conditions with any family members, Or other physicians, imaging facilities or hospitals?	YES	NO

If so, please name the family members, physicians, imaging facilities, or hospitals allowed:

_____

_____

This consent was signed by:_____
(please print name)

Signature:_____ Date:_____

Huron Valley Pediatrics
Hassane, Yasser , M.D.
2632 S. Milford rd.
Highland, Mi 48357

NOTICE OF MISSED APPOINTMENT FEE POLICY.

In order to better serve our patients, the Practice will allow one missed appointment. After the first missed appointment, we reserve the right to charge a missed appointment fee of $25.00 for each scheduled, missed appointment. We will of course take into consideration emergencies and unforeseen circumstances. We understand that, at times, you may be unable to keep the appointment which you have reserved for yourself or your family member. In the case of such an event we require a 24- hour notice of the cancellation. We have made arrangements to have our phones answered 24 hours a day, 7 days a week to better serve you when you have an emergency or need to cancel/reschedule your appointment. There is No charge if a 24 hour notice is given for cancellation.

Thank you in advance for your courtesy.

I, _____, hereby acknowledge and agree to the terms and conditions listed above.

Signed:_____ Date: _____

If you are not the patient, please describe your relationship to the patient:_____

Patient Name:_____
DOB:_____

HISTORY

Birth History

Birth Weight:_____ Weeks of Gestation?_____ Was The Delivery? ____ Vaginal ____Cesarean

Did the mother have any illnesses or problems during the pregnancy? ____ YES ____ NO, Explain_____

During the pregnancy, did the mother Smoke? ____ YES ____ NO / Drink Alcohol? ____YES ____NO

Use Drugs? ____ YES ____ NO Take any Medication? ____ YES ____ NO, If yes; What?_____

When?_____

Did baby have any problems/ complications right after birth? ____ YES ____ NO, Explain_____

Initial Feeding? ____ Breast ____ Bottle Did baby go home from the hospital with mother? ____ YES ____ NO,

Household

*Please List All Those Living in the Child's Home.

Name	Relationship to Child	Date of Birth	Health Problems

Are there siblings not listed? ____ YES ____ NO

If Mother and Father are not living together or if the child does not live with parents, what is the child's custody status?_____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?_____

General

Do you consider your child to be in good health? ____ YES ____ NO, Explain_____

Does your child have any serious illness or medical conditions? ____ YES ____ NO, Explain_____

Has your child had any serious injuries or accidents? ____ YES ____ NO, Explain_____

Has your child had any surgeries? ____ YES ____ NO, Explain_____

Has your child ever been hospitalized? ____ YES ____ NO, Explain_____

Is your child allergic to any medications or have a specific drug allergy? ____ YES ____ NO, Explain_____

Patient
Name:_____
DOB:_____

Past History

Does Your Child Have, or Has He/She Ever Had:

Chickenpox	YES	NO	WHEN?_____
Frequent ear infections	YES	NO	Explain_____
Problems with ears or hearing	YES	NO	Explain_____
Nasal allergies	YES	NO	Explain_____
Problems with eyes or vision	YES	NO	Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia	YES	NO	Explain_____
Heart problems or murmur	YES	NO	Explain_____
Anemia or bleeding disorders	YES	NO	Explain_____
Received blood transfusion	YES	NO	Explain_____
Frequent abdominal pain	YES	NO	Explain_____
Constipation requiring office visit	YES	NO	Explain_____
Bladder or kidney infection	YES	NO	Explain_____
Bed wetting (after age 5)	YES	NO	Explain_____

Development

Are you concerned about your child's physical development?	YES	NO	Explain_____
Are you concerned about your child's mental or emotional development?	YES	NO	
Are you concerned about your child's attention span?	YES	NO	

***If your child is in school, please answer the following;**

How is his/her behavior in school?			Explain_____
Has he/she failed or repeated a grade or class in school?	YES	NO	Explain_____

Patient
Name:_____
DOB:

Family History

Have any family members had the following?

Deafness	YES NO	who?_____	Comment_____	
Nasal allergies	YES NO	who?_____	Comment_____	
Asthma	YES NO	who?_____	Comment_____	
Tuberculosis	YES NO	who?_____	Comment_____	
Heart disease (before age 50)	YES NO	who?_____	Comment_____	
High blood pressure (before age 50)	YES NO	who?_____	Comment_____	
High cholesterol	YES NO	who?_____	Comment_____	
Anemia	YES NO	who?_____	Comment_____	
Bleeding disorders	YES NO	who?_____	Comment_____	
Liver disease	YES NO	who?_____	Comment_____	
Kidney disease	YES NO	who?_____	Comment_____	
Diabetes (before age 50)	YES NO	who?_____	Comment_____	
Bed wetting (after age 10)	YES NO	who?_____	Comment_____	
Epilepsy or convulsions	YES NO	who?_____	Comment_____	
Alcohol abuse	YES NO	who?_____	Comment_____	
Drug abuse	YES NO	who?_____	Comment_____	
Mental illness	YES NO	who?_____	Comment_____	
Mental retardation	YES NO	who?_____	Comment_____	
Immune disorders, HIV, or AIDS	YES NO	who?_____	Comment_____	
Additional family history worth mentioning not listed above	YES NO	who?_____	Comment_____	

Release and Assignment

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my minor/child's medical status.

I certify that my minor/child is covered by insurance with _____
(name of insurance company)

and assign directly to Dr. _____ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether medical or electronic.

Parent/Guardian Signature _____ Date _____