WELCOME to Great Lakes Pediatrics!

Thank you for choosing our health care team to partner with you in caring for your child's health care needs.

Attached you will find all the required documents for your New Patient Appointment. Documents must be completed in their entirety. Within your new patient packet, you will find a medical release form. We will need a release form signed for your child's previous primary care doctor, as well as all specialists that they have received care from previously.

You may return the paperwork to us in person, via fax or mail. Once paperwork is complete and received by our office, you may expect a phone call from our receptionist within 5 business days to schedule your new patient appointment. We are currently scheduling new patient appointments 4 t 06 weeks out.

We strive to provide timely service. We ask that you help support us in this by arriving 15 minutes prior to your scheduled appointment time.

Thank you again for partnering with us in your child's care! We look forward to seeing you soon!

Great Lakes Pediatrics Staff

WELCOME to Great Lakes Pediatrics!

In an effort to offer you the most complete and up to date care, we have become a certified Patient Centered Medical Home (PCMH). What does this mean for you?

A medical home is a trusting relationship between the physician-led health care team and informed patient. We act as your home base to partner with you in navigating your child's care.

As a PCMH we:

- Offer same day sick appointments, evening appointments, and 24 hour afterhours on call phone service.
- Offer Care Coordination Services; assistance with coordinating your care with Specialists and other members of the health care team.
- Listen to you
- Remind you when preventative care is due.
- Encourage you to play an active part in your child's health care.

Services Offered:

- Well Child Exams & Immunizations
- School and sport physicals
- Vision & hearing testing
- Treatment of routine and many complex acute childhood illnesses
- ADD/ADHD & Behavioral health illnesses
- Asthma/Respiratory services
- Flexible Vaccine Clinics
- Telephone Triage
- Online Patient portal
- Electronic prescriptions
- Sick visits/Same day sick visits
- Acne/Skin care services

Clinic Hours:

Monday	8-5:30pm
Tuesday	8-4:30pm
Wednesday	8-5:30pm
Thursday	8-6pm
Friday	8-4:30pm

*Phones are available daily from 8a.m.-430p.m.

*Phones are off during the lunch hour from 12-1 p.m.

*After hour phone service after clinic hours can be reached by calling 517-887-3000 and leaving a message on the afterhours messaging system.

WELCOME to Great Lakes Pediatrics!

Local Urgent Care and Hospitals Information:

Sparrow East Lansing Urgent Care
Address: 2682 E Grand River Ave,
East Lansing, MI 48823
Hours: Open · 8AM–8PM DAILY
Phone: (517) 333-6562

Sparrow Grand Ledge Urgent Care
Address: 1015 Charlevoix St,
Grand Ledge, MI 48837
Hours: Open · 8AM–8PM DAILY
Phone: (517) 627-0100

Sparrow Mason Urgent Care
Address: 800 E Columbia St,
Mason, MI 48854
Hours: Open · 8AM–8PM DAILY
Phone: (517) 244-8900

Sparrow Hospital
Address: 1215 E Michigan Ave, Lansing, MI 48912
Hours: Open 24 hours
Phone: (517) 364-1000

Mclaren Greater Lansing Hospital
Address: 401 W Greenlawn Ave, Lansing, MI 48910
Hours: Open 24 hours
Phone: (517) 975-6000

Great Lakes Pediatric Associates PLLC

Today's Date is: _____ Provider Preference**:** _____

PLEASE PRINT CLEARLY

Name of Patient:

Last	First	Middle	Suffix	Sex	Date of Birth

Race	Ethnicity: 1. Hispanic or Latino 2. Not Hispanic or Latino 3. Undefined	Language (preferred)	Decline

***EMAIL ADDRESS for Patient Portal Account:**

***Emergency Contact (OTHER THAN PARENT):**

Name	Relationship	Phone Number

Patient Resides With: ☐ **Father** ☐ **Mother** ☐ **Both** ☐ **Other:** _____

( ) Father ( ) Guardian ( ) Other: _____ ( ) Mother ( ) Guardian ( ) Other: _____

(Last Name)	**(First Name)**	**(Last Name)**	**(First Name)**
Street Address		Street Address	
County / City / State / Zip		County / City / State / Zip	
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Home Phone / Work Phone / Cell Phone		Home Phone / Work Phone / Cell Phone	
Employed by	Occupation	Employed by	Occupation

( ) Step-Father ( ) Guardian ( ) Other:_____ ( ) Step-Mother ( ) Guardian ( ) Other: _____

(Last Name)	**(First Name)**	**(Last Name)**	**(First Name)**
Street Address		Street Address	
County / City / State / Zip		County / City / State / Zip	
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Home Phone / Work Phone / Cell Phone		Home Phone / Work Phone / Cell Phone	
Employed by	Occupation	Employed by	Occupation

Great Lakes Pediatric Associates PLL

Patient Name:_____DOB:_____

Insurance Coverage- Please list ALL active insurances

Primary Insurance Plan Name:_____
Policy Number: _____
Subscriber Name: _____

Secondary Insurance Plan Name: _____
Policy Number: _____
Subscriber Name: _____

Does Child Have:
Medicaid Yes ☐ No ☐
Children's Special Health Care Yes ☐ No ☐

Due to High Volume of No Shows/Late Cancelations

GREAT LAKES PEDIATRIC ASSOCIATES NO SHOW / LATE CANCELATION POLICY

If you must cancel/reschedule an appointment with Great Lakes Pediatric Associates, we require a minimum of 24 hours' notice for all appointments. We require 72 hours' notice of cancelations or rescheduled appointments for Asthma Clinic, as a Specialist is scheduled specifically for your child. Failure to keep your scheduled appointment may result in a $40.00 charge.

Failure to keep a New Patient appointment will result in an automatic discharge from the practice and the patient will not be scheduled with Great Lakes Pediatric Associates. Established patients with 3 or more no shows/late cancelations (less than 24 hours' notice) will also result in a discharge from the practice as well.

I understand that the information that I have given is correct to the best of my knowledge, and **it is my responsibility to inform this office of any changes in my child's medical or insurance status**. I authorize Great lakes Pediatric Associates PLLC to release all information necessary to secure payment from my/our insurance company and the payment of benefits. I also authorize the exchange of information with specialists involved in my/our child's health care.

Signature of Parent or Guardian **Date**

Great Lakes Pediatric Associates PLLC

Patient Name:_____DOB:_____

FINANCIAL POLICY

Payment of co-pays is expected in full at the time of each visit. Please be sure to know your co-pay amount.

You are responsible for providing us with accurate insurance information at the time of your visit. This includes providing current insurance card(s) and informing our staff of any recent changes, including employment, coverage, or address/phone number. **If we do not have current insurance information, you will be responsible for the entire amount of the visit, payable at the time of service, or you will have to reschedule your appointment.**

It is your responsibility to know ahead of time what your insurance policy covers. We participate in the Federal Vaccines for Children Program and can use Health Department vaccines for your child if your insurance doesn't cover this service. You will be responsible for a vaccine administration fee for each vaccine given, payable at the time of service. However, we can only use vaccines from this program if you inform the doctor at the time of your visit that you do not have coverage. Payment for any services not covered by your insurance, including vaccines, are your responsibility.

Our billing staff will process your claims for you and answer any questions you may have. Please be advised that, regardless of your insurance status, final responsibility for payment of our services is your obligation.

We are pleased to be able to accept most major credit and debit cards.

We are charged for checks returned due to insufficient funds (NSF); therefore if a check is returned unpaid, you will be responsible for a $30.00 Returned Check Fee and all fees incurred due to the NSF check.

Our receptionists will inform you of your outstanding balance when you check in for your visit. You are responsible for payment of your outstanding balances, which includes services not covered by insurance, at the time of service. If you need help in establishing a payment plan, our receptionists will tell you how to contact our billing specialist.

_____

Parent/Guardian Signature Date

Great Lakes Pediatric Associates PLLC

CONSENT FOR TREATMENT OF A MINOR

Child/Family Representative Consent to Treat without Parent/Guardian Present

Patient Name: DOB:

I, (Parent/Guardian Full Name)_____, permit the individuals listed below to make decisions on my behalf regarding medical treatment. These individuals are granted access to all medical and billing information necessary to make medical decisions for my minor child (Child's Full Name)_____at Great Lakes Pediatric Associates PLLC.

(List Name and Relationship to Child)

_____

_____

_____

_____

_____

_____

_____

_____

This authorization is valid from the date of signature until written notification is given to cancel this request.

_____ _____

Parent/Guardian Signature Date

Great Lakes Pediatric Associates PLLC

Authorization for Disclosure of Protected Health Information/Medical Records Release

Including Confidential and Restricted Confidential Information

Patient Name	Date of Birth	Social Security Number

Street Address	City	State	Zip Code

Home Phone Number	Work Phone Number

I authorize and request the described information to be disclosed under the following conditions:

1. **Name of persons or organizations to provide information (Include ADDRESS and PHONE NUMBER)**

2. Name of persons or organization to receive information

Great Lakes Pediatric Associates PLLC
3400 Pine Tree Rd. Suite 102 Lansing MI 48911
Phone: (517)-887-3000 Fax: (517) 887-6075

3. The purpose or need for such disclosure:

- ❑ Transferring into care with Great Lakes Pediatric Associates PLLC
- ❑ Transferring to new Primary Care Provider (Doctor's Office).
- ❑ Personal Needs
- ❑ Other: Specify _____

4. Specific "Confidential" information to be disclosed and time frame of information to be included:

Check all that apply: ❑Entire Record ❑Immunization Record ❑ Records from Date of Service:

5. If you **do not** wish any of the following "Restricted Confidential" information to be disclosed, please check the boxes below next to the items you wish not be disclosed as part of this request**. If any of the below boxes are unchecked, you are giving Great Lakes Pediatric Associates PLLC additional specific consent to disclose the below information that we may keep about you.**

❑ Alcohol or drug abuse, or mental health treatment information under Title 42 of the Code of Federal Regulation Part II.

❑ Serious communicable and infectious diseases as defined by the Michigan Department of Public Health Code 1989, Act 174 which includes venereal disease, tuberculosis, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), and hepatitis.

❑ Records and reports sent to Great Lakes Pediatric Associates PLLC from other health care providers, including hospitals and physicians.

6. Revocation of consent: This consent is subject to revocation at any time except to the extent action has been taken in reliance upon this consent. Any revocation of consent must be made in writing and delivered to this office at the above address.

7. This authorization is valid from the date of signature until written notification is given to cancel this request.

Printed Name / Signature	Date