Comprehensive Integrative Health Care
Dr. Koza & Dr. Park-Davis

Pediatric Health History Form

_____
Name (Parent)

CHILD'S NAME: _____ DATE OF BIRTH: _____ AGE: _____

CHILD'S PREVIOUS DOCTOR / PRIMARY CARE PROVIDER: _____

PRESENT HEALTH CONCERNS: _____

_____

MEDICINES/VITAMINS: _____

HERBS/HOME REMEDIES: _____

ALLERGIES/REACTIONS TO MEDICINES OR VACCINATIONS: _____

PREGNANCY & BIRTH

Is this child yours by: ❑ birth ❑ adoption ❑ stepchild ❑ other _____

Please indicate any medical problems during pregnancy ❑ none ❑ specify: _____

_____

Delivery by: ❑ vaginal birth ❑ caesarian If caesarian, why? _____

Birth weight: _____ Birth length: _____ APGAR score 1 min. _____ 5 min. _____

Please indicate any medical problems during the baby's newborn period ❑ none If premature, how early? _____

other problems: _____

_____

NUTRITION & FEEDING

Was your child breastfed? ❑ No ❑ Yes If so, how long? _____

Has your child had any unusual feeding/dietary problems? ❑ No ❑ Yes If yes, specify: _____

_____

Milk intake now: Type ❑ cow milk (❑ non-fat ❑ 1%fat ❑ 2%fat ❑ whole milk) ❑ soy milk ❑ rice milk

Average ounces per day (Note: 8 ounces are in 1 cup) _____

SLEEP

Hours per night _____ Naps (number & length) _____

Any sleep problems? _____

DEVELOPMENT

At what age did your child: sit alone _____ walk alone _____ say words _____ toilet train (daytime) _____

Girls only: Age at first menstrual period _____

DENTAL HISTORY: Has child been seen by a dentist? ❑ No ❑ Yes If so, how often _____ Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child 's immunization records to your appointment.

Has your child had: ❑ chickenpox ❑ measles ❑ mumps ❑ rubella ❑ meningitis ❑ tuberculosis (TB)

EXPOSURES/HABITS : Any concerns about lead exposure? (old home/plumbing/peeling paint) ❑ No ❑ Yes

Do any household members smoke? ❑ No ❑ Yes

TV —hours per day _____ Computer—hours per day _____ Video Games—hours per day _____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates

_____

_____

_____

Hospitalizations/Operations (with dates): _____

_____

Broken bones or severe sprains _____

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-

FAMILY HISTORY: Please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Psychiatric disorders	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic diseases	

SOCIAL HISTORY:

Birthplace_____ Current (or upcoming) grade:_____

Who lives at home?

Name	Age	Relationship	Highest Education Level

Are the child's parents ❑ married ❑ unmarried ❑ separated ❑ divorced If divorced, when?_____

Parents' occupations: Mother _____ Father _____

Child care situation ❑ parents ❑ others (specify who and hours per day) _____

_____

Concerns about your child: ❑ Alcohol use ❑ Tobacco ❑ Sexual Activity ❑ Aggressive Behavior

Is violence at home a concern? ❑ No ❑ Yes Are there guns in the home? ❑ No ❑ Yes

SCHOOL HISTORY:

Did/does your child attend preschool? ❑ No ❑ Yes Current grade_____ Name of school_____

Any concerns about school performance? _____

Any concerns about relationships with: Teachers ❑ No ❑ Yes _____

Students ❑ No ❑ Yes _____

If over 4 years old does your child have a best friend? ❑ No ❑ Yes

Sports / exercise: Type_____ How often?_____ How long (minutes) _____

REVIEW OF ORGAN SYSTEMS: If child has more than one symptom on a line, circle the relevant one(s).

Constitutional / Endocrine
- ❑ Fevers/chills/excessive sweating
- ❑ Unexplained weight loss / gain

Eyes
- ❑ Squinting/"crossed" eyes/ asymmetric gaze

Ears / Nose / Throat
- ❑ Unusually loud voice/hard of hearing
- ❑ Mouth breathing/snoring
- ❑ Bad breath
- ❑ Frequent runny nose
- ❑ Problems with teeth/gums

Respiratory
- ❑ Cough/wheeze

Gastrointestinal
- ❑ Nausea/vomiting/diarrhea
- ❑ Constipation
- ❑ Blood in bowel movement

Cardiovascular
- ❑ Tires easily with exertion
- ❑ Shortness of breath
- ❑ Fainting

Genitourinary
- ❑ Bedwetting
- ❑ Pain with urination
- ❑ Discharge: penis or vagina

Neurological
- ❑ Headaches
- ❑ Weakness
- ❑ Clumsiness

Muscular / Skeletal
- ❑ Muscle/joint pain

Allergy
- ❑ Hayfever/itchy eyes

Skin
- ❑ Rashes
- ❑ Unusual moles

Psychiatric / Emotional
- ❑ Speech Problems
- ❑ Anxiety/stress
- ❑ Problems with sleep/ nightmares
- ❑ Depression
- ❑ Nail biting/thumbsucking
- ❑ Bad temper/breath holding/ jealousy

Blood / Lymph
- ❑ Unexplained lumps
- ❑ Easy bruising/bleeding

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:
Required by government mandate [although you may refuse]:
Language:
Race:
Ethnicity:
Marital Status:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Employer information

Employer:
Address:
Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information

Insurance Plan Name:
Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

Secondary Insurance Information

Insurance Plan Name:
Last Name:
First Name.:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:
Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for S PARK-DAVIS HEALTHCARE PC DBA COMPREHENSIVE INTEGRATIVE HEALTH CARE

Signed_____ Date:_____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

Signed_____ Date:_____

- I authorize S PARK-DAVIS HEALTHCARE PC DBA COMPREHENSIVE INTEGRATIVE HEALTH CARE to release medical information required to process my claim

Signed_____ Date:_____

- I have read and understand the Financial Policy for S PARK-DAVIS HEALTHCARE PC DBA COMPREHENSIVE INTEGRATIVE HEALTH CARE

Signed_____ Date:_____

- I authorize S PARK-DAVIS HEALTHCARE PC DBA COMPREHENSIVE INTEGRATIVE HEALTH CARE to obtain/have access to my medication history

Signed_____ Date:_____

- I authorize my provider's office to contact me by mobile phone text or voice

Signed_____ Date:_____

- I authorize S PARK-DAVIS HEALTHCARE PC DBA COMPREHENSIVE INTEGRATIVE HEALTH CARE to release all protected health information to Name:_____, Relationship_____. I have read all disclosers about my rights to release health information under regulation in title 42 Code of Federal Regulation, Part 2, and information defined byMCLA 333.5131. I understand that my protected health information disclosed under this authorization may be subject to disclosure by the individual named above and its privacy will no longer be protected by law.

Signed_____ Date:_____

Patient Information and Office Policies

Comprehensive Integrative Health Care (CIHC)
Internal Medicine, Pediatrics and Family Practice
248-926-0009
Dr. Sung Park-Davis & Dr. Heather Koza

Welcome to Our Practice!

Thank you for choosing CIHC as your primary care providers. We are committed to providing you with quality healthcare. In an effort to familiarize you with the office, below are the office and financial policies. Please read it and sign the last page.

1. **Phones** – Telephones will be answered during business hours, which are generally Monday through Friday 9:00-5:00. If there are any changes to the business hours they will be posted by the front doors of both offices. The offices are closed during holidays and during emergencies.

2. **Off Hours Emergencies** – Our office has full-time coverage, which includes an answering service for after-hours emergency calls. If a problem arises during a time when the office is closed, simply call the office number and the physician on-call will be contacted. Your call will be returned in a timely manner. Please be courteous and note that this service is for emergencies only and that prescription refills are not considered emergencies and will **NOT** be done after hours. If you feel that you are experiencing a life-threatening emergency we ask that you go promptly to an Urgent Care or Emergency Department for immediate evaluation.

3. **Prescriptions** – Refill requests will be handled by this practice within 72 business hours after your request. If it is approved by the physician, the pharmacy will be notified. Please note that certain prescriptions require follow-up visits and tests prior to re-prescribing. You will be notified within the 72 hours and asked to schedule an appointment. Refills will not be called in after hours or on weekends, so please allow time for this and call **BEFORE** you run out of your prescriptions.

4. **Phone Consultations** - There may be a phone consultation charge at a rate of $25.00 per 10 minute increments, which will be billed directly to you, NOT your insurance company for a phone consultation with the physician, initiated by you, or a returned call to you by the doctor. This charge will be your responsibility.

5. **Referrals** – Referrals to other physicians or diagnostic facilities can take up to ONE week for our office to process. Referrals will not be done after hours or on weekends. You are required to notify us at least one week in advance of an appointment if it requires a referral. Failure to do so may result in your referral being denied by your insurance company and, therefore, making you responsible for any and all changes incurred at the specialists office, or the inability to perform the tests.

6. **Test Results** – You will be notified of any results of laboratory or diagnostic testing initiated through our practice as soon as they are available (usually within two weeks from the test date, some specialty laboratory testing can take up to 4 weeks from the test date). All results must be reviewed by a physician. You will receive a call from our office with the results or a request for a follow up visit with the physician, depending upon the results. Office staff cannot interpret any results for patients. If you would like a copy of the results you can get one at the offices or they can be faxed to you. The office will not mail out prescriptions or lab results. If you are still waiting for call from our office after two weeks, please call our office to verify results.

7. **Records Release** – It takes our office at least 10 business days to process records requests. Records are processed by an outside document company, which will bill you separately for these services. At this time they charge $25 per record. CIHC has no financial affiliation with this company, so their policy may change without notice.

8. **Forms Completion** – Our office charges a minimum of $5.00 for the completion of forms, and this amount may be more, depending upon how many pages or how complex the forms are to complete. These charges will be your responsibility and will be billed directly to you, not the insurance company. Physical forms will be completed as a courtesy during the visit if the patient provides the form at the time of the visit. If a physical form is processed after the visit it will incur the $5.00 minimum charge.

9. **Insurance and Payment Policy**

Proof of Insurance: We ask that you present your insurance card to us at every visit. If you fail to provide us with the correct insurance information at each visit, you may be responsible for payment for all services provided.

Primary Care Physician: If your insurance company requires you to pick a Primary Care Physician (PCP), Dr. Koza or Dr. Park-Davis must be the PCP listed on your insurance card. If one of the physicians in not listed, the insurance may not pay, and you will be responsible for the entire bill. As long as either physician is your PCP, either doctor may attend to your health care needs.

Participation in Insurance Plans: If you are not insured by a plan we are contracted with, payment in full is expected at the time of service. If you are insured by a plan we are contracted with, but do not have an up-to-date insurance card, or one of the physicians are not a provider for your individual plan, payment in full for each visit is required until we can verify your coverage. If you have any doubts, please ask at the front desk.

Your Responsibility with Your Insurance Company: Your health contract is between you and your insurance company. Knowing your insurance benefits is **YOUR** responsibility. Any questions or complaints regarding your coverage should be directed to your insurance carrier.

Patient Information and Office Policies

CIHC

Co-Payments: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law.

Non-Covered Services: Please be aware that some or all of the services you receive may be non-covered or not considered necessary by your insurer. It is your responsibility to know what your plan covers. If your plan does not cover any service rendered, you must pay for these services in full.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. If non-payment by the insurance company occurs due to your non-compliance in these issues, the balance on the services will be directly submitted to you.

Account Balances: Statements are sent out on a monthly basis. If payment is not made within the due date of the statement, a late fee of $25 may be applied each month it goes unpaid. If you are experiencing financial difficulty and cannot pay the balance in full, please contact our office to arrange a payment plan.

Unpaid Balances: Unless you have already contacted our offices and are on a payment plan with us, any balance over 90 days will be referred to a collection agency and you and your immediate family members may be discharged from this practice.

Missed Appointments: Your account will be subject to a no-show charge of $25 for missed appointments not cancelled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

NSF and other Bank Fees: Your account will be charged a $25 fee in addition to all expenses incurred by us for any non-sufficient checks, checks written on closed accounts, or any other fee we incur as a result of a check you write to us. If your account is not paid as a result of these expenses, your account will be subject to the policies for delinquency and collections.

I have read and understand the office policies and agree to abide by their guidelines:

_____ _____

Print Patient's Name **Birth Date**

_____ _____

Signature of Patient or Responsible Party **Date**

S. PARK-DAVIS HEALTHCARE • 30880 BECK RD, NOVI MI 48377-1000

Patient/Provider Agreement Form for a Patient Centered Medical Home

Dear [redacted] welcome and thank you for choosing our practice for your health care needs. We invite you to join our practice as a Patient Centered Medical Home. As our name implies we wish to integrate your entire health care needs, information, experience, and planning into one practice. We are committed to providing you with the best medical care based on your health needs. Our hope is that we can form a partnership to keep yourself and your family as healthy as possible, no matter what your current state of health. Your commitment to our patient-centered medical home practice will provide you with an expanded type of care. We will work with both you and other health care providers as a team to take care of you. You will also have improved access to us through our web portal as well as continued phone support.

As your primary care providers, we will

- Learn about you, your family, life situation, and health goals and preferences. We will remember these and your health history every time you seek care and suggest treatments that make sense for you.
- Take care of any short-term illness, long-term chronic disease, and your all-around well-being.
- Keep you up-to-date on all your vaccines and preventive screening tests.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.
- Be available to you after hours for your urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings. We will respond promptly to you – and your calls – in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.

We trust you, as our patient, to:

- Know that you are a full partner with us in your care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you're using, and questions you may have.
- Let us know when you see other health care providers so we can help coordinate the best care for you.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your health condition: ask questions about your care and tell us when you don't understand something.
- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Call if you do not receive your test results within two weeks.
- Contact us after hours only if your issue cannot wait until the next work day.
- If possible, contact us before going to the ER so someone who knows your medical history can care for you.
- Agree that all health care providers in my care team will receive all information related to your health care.
- Agree to inform other health care providers and facilities that we are your primary care providers and to ensure that they know to send all relevant information such as discharge summaries, relevant laboratory tests, etc.

[redacted] _____ _____

Patient name Signature of Patient or Guardian Date

Office address and hours:

- 30800 Beck Rd.
- Novi, MI 48374
- (248)-926-0009 fax: (248)-926-8972
- M-F: 9am-5pm
- Closed major national holidays

Emergency Rooms in our area:

Providence Park Hospital
47601 Grand River
Novi, MI 48374
(248) 465-4210
open 24 hrs a day, 7 days a week

Lakes Urgent Care
2300 Haggerty Rd, suite 1010
West Bloomfield Twnshp, MI 48323
(248) 926-9111
M-F:8am-10pm; Saturday, Sunday and holidays:9am-6pm

Off Hour Emergencies: Our office has full time coverage, which includes an answering service for after-hours emergency calls. If a problem arises during a time when the office is closed, simply call one of the office numbers listed above and the physician on-call will be contacted. Your call will be returned in a timely manner. Please be courteous and note that this service is for emergencies only and that prescription refills are not considered an emergency and will **NOT** be done after hours. If you feel that you are experiencing a potentially life-threatening emergency we urge you to go promptly to an Urgent Care or Emergency Room for immediate evaluation.