Mason Pediatrics Demographic and Registration form:

Patient Name: ______________________________ DOB: ____________

Address: ____

City: ______________________ State: __________ Zip code: ______________

Sex: __________ SSN: ________________ Race: ____________________

Ethnicity: ____________________ Religion: ______________________

Child home ph#: ____________

Guarantor or Responsible Party's Name: ______________________ DOB: ____________

Relationship to patient: __________________ Guarantors SSN: ____________________

Address: ____

City: ______________ State: ____________________ Zipcode: ___________

Cell phone#: ____________________ Home#: ______________________

Email address for appointment reminders and portal access (if over 12 it needs to be the child's email or the parents WITH the child's permission only)

____

Other parents name: __________________ DOB: ____________________

Relationship: ____________________ SSN: ____________________________

Phone Number: ____

Insurance Company: ______________________________

Policy/Subscriber Number: ____

Group #: ____

Policy Holder Name: __________________________________ DOB: ___________

Phone Number: ______________________

Emergency Contact (other than listed above) ________________________

Relationship to patient: ________________________ Phone: __________________

Insurance information: Please present insurance card(s) for scanning, In order to submit a claim for payment for services covered under your policy, we must have authorization to release medical information to your insurance company and to our billing office. Please read and sign below.

See next page

I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Mason Pediatrics billing company to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to Mason Pediatrics. I certify that I am financially responsible for all services not paid by my insurance. This authorization is valid indefinitely until revoked by written request by myself for Mason Pediatrics.

Signature: ____ Date: ____________________

Updates: ______________________________________ Date: _______________

Updates: ______________________________________ Date: _______________

Initial History Questionnaire

FORM COMPLETED BY DATE COMPLETED

Name

ID NUMBER

BIRTH DATE AGE ☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. ______

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?
______

Birth History ■ Don't know birth history

Birth weight ______ Was the baby born at term? ______ OR ______ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain ______

Was a NICU stay required? ☐ Yes ☐ No Explain ______

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What ______ When ______

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?
______

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? ______

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain ______

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain ______

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain ______

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain ______

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain ______

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain ______

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain ______

Biological Family History DK = don't know

Have any family members had the following?

Condition					
Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Asthma	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tuberculosis	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Anemia	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Dental decay	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

(Biological Family History continued on back side

Initial History Questionnaire

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Kidney disease	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Obesity	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Drug abuse	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Developmental disability	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who ______	Comments ______
Tobacco use	☐ Yes	☐ No	☐ DK	Who ______	Comments ______

Additional family history ______

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When ______
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain ______
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain ______
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain ______
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain ______
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain ______
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain ______
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain ______
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain ______
HIV	☐ Yes	☐ No	☐ DK	Explain ______
Organ transplant	☐ Yes	☐ No	☐ DK	Explain ______
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain ______
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain ______
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain ______
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain ______
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain ______
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain ______
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain ______
Cancer	☐ Yes	☐ No	☐ DK	Explain ______
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain ______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain ______
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain ______
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain ______
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain ______
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain ______
Obesity	☐ Yes	☐ No	☐ DK	Explain ______
Diabetes	☐ Yes	☐ No	☐ DK	Explain ______
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain ______
High blood pressure	☐ Yes	☐ No	☐ DK	Explain ______
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain ______
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain ______
Tobacco use	☐ Yes	☐ No	☐ DK	Explain ______
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain ______
Developmental delay	☐ Yes	☐ No	☐ DK	Explain ______
Dental decay	☐ Yes	☐ No	☐ DK	Explain ______
History of family violence	☐ Yes	☐ No	☐ DK	Explain ______
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain ______
Pregnancy	☐ Yes	☐ No	☐ DK	Explain ______
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain ______

Has had first period ☐ Yes ☐ No Age of first period ______

Any other significant problem ______

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Mason Pediatrics
200 Temple Street, Mason MI, 48854

Jaime L. Viers, CPNP-PC
P: (517) 978-7337

Anne E. Suess, M.D.

Amanda L. Lynn, CPNP-PC
F: (517) 978-5437

Vaccine Policy

Patient Name (Printed): ____

Patient's Date of birth: ____________________________

By signing this form, I understand and will adhere to Mason Pediatrics Vaccine Policy. I will vaccinate my child according to the CDC's recommended vaccination schedule, including annual flu shot and HPV when age appropriate, unless otherwise contraindicated by a Provider.

Parent Name (Printed): ____

Parent Signature: ____

Date Signed: ____________________________________

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Consent to Treat

Patient's Name: ______________________________ DOB: ____________________

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician including the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to preform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Parent Name (Printed): ____

Parent Signature: ____

Date: ________________________

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Acknowledgment Signature

Patient Name (Printed): ______________________________

Patient's Date of Birth: ______________________

I have been given copies of the Financial Policy, HIPAA Notice and Patient Doctor Partnership (PCMH brochure) for Mason Pediatrics.

I also give my permission for Mason Pediatrics to have access to my RX history.

Parent/Guardian's Name (Printed): ______________________________

Parent/Guardian's Signature: ______________________________

Date Signed: ______________________

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Mason Pediatrics Financial Policy

Welcome to Mason Pediatrics. Thank you for bringing your child here for their health care needs! Our office is committed to providing you with the highest quality care at a fair and reasonable cost.

Please know that we are required by our insurance contracts to collect all copays, coinsurance and deductible amounts for services rendered. We understand healthcare can be expensive and most plans have deductibles, coinsurance and/or copayments that are solely patient responsibility and may be due at the time of your visit. Our office is willing to work with our families to help manage the high cost of healthcare including creative payment options, but this needs to be done prior to treatment being rendered. This means that unless the office manager has approved otherwise the accompanying parent, grandparent, guardian, or babysitter will be responsible for payment at the time of service. We accept cash, check, Visa, Discover or Mastercard.

Change of insurance/change of address: Please notify the office as soon as possible of all insurance and address changes. If the guarantor does not notify the office within 15 days of any changes the guarantor is responsible for all charges not paid because of change in insurance coverage.

If you write a personal check and your financial institution returns the check without payment you will be charged a $30 fee for the return check.

In the case of a divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all of part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Change/cancel appointment: We require 24-hour notice or change or cancel your appointment. If you miss a regularly scheduled appointment without notice, a reminder about our attendance policy will be verbally reviewed and a $50 fee will be charged. If your insurance does not allow cancelation fees to be charged to a patient, then you could be discharged from the practice. Additionally, failure to attend multiple scheduled appointments-- with or without notice-- may result in discharge for the practice.

Patient's Name (Printed): ______________________________

Patient's Date of Birth: ____________________

Parent's Name (Printed): ______________________________

Parent's Signature: ______________________________

Date Signed: ____________________

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CONSENT FOR NON-PARENT TO BRING MINOR CHILD TO APPOINTMENT

Name of Patient (Printed): ____

Patient's Date of Birth: ______________________________

I am the parent or guardian the above named patient. I have the legal right to consent for medical treatment for this child, who is a current patient of Mason Pediatrics.

I authorize the following person(s), who are 18 or older to bring the child to his or her medical appointment and to consent to medical care which is deemed necessary by the physician and medical providers at Mason Pediatrics at the time of the appointment. I understand that this delegation includes receiving health information about the minor necessary to make immediately necessary health care decisions.

	Name of Authorized Person:	Relationship to patient:	Date authorization to expire
1.	____________________	__________________	__________________
2.	____________________	__________________	__________________
3.	____________________	__________________	__________________
4.	____________________	__________________	__________________

Please initial below if you are consenting for the child to receive CDC recommended vaccines during appointments where the parent/guardian is not present.

_____ Vaccines (CDC recommended only)

This consent is valid until revoked in writing by me, the parent or legal guardian.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I am giving permission for a third party to bring the minor patient for treatment and allow the third party to authorize any treatment necessary.
- I will be responsible for the cost associated with the patient's care at Mason Pediatrics.

Parent/Guardian Name (Printed): ____

Parent/Guardian Signature: ____

Date Signed: ______________________

<u>MASON PEDIATRICS HIPAA NOTICE</u>

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO IT. PLEASE REVIEW CAREFULLY. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE OFFICE.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services your children receive at this office. We need this record to provide high quality care and comply with legal requirements. This notice applies to all the records of the care generated by this office whether made by your child's physician or one of the office employees. This notice describes your rights and certain obligations we have about the use and disclosure of this information.

Law requires this office:

1. To make sure the medical information that identifies you is kept private.
2. To give you this notice of our legal duties and privacy practices with respect to medical information.
3. To follow the terms of the notice that is currently in effect.

HOW THIS OFFICE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following describes the different ways that your medical information may be used or disclosed by this office. Not every possible use or disclosure is specifically mentioned. However, all the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

1. **<u>For Treatment</u>**- We will use medical information about your child to provide medical treatment and services. We may disclose medical information about your child to doctors, nurses, technicians and other office personnel who are involved in providing their medical treatment.
2. **<u>For Payment</u>**- We may use and disclose medical information so that treatment and our services your children receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so that your health plan will pay us or reimburse you.
3. **<u>Coroners and Medical Examiners</u>**- We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Right to inspect and copy: You have the right to inspect and get a copy of your medical information except for any psychotherapy notes.

- To inspect and get a copy of your medical information, you must submit your request in writing to the office manager. If you request a copy of the information, we may charge a fee for copying, mailing and supplies.
- We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such reviews, please contact the office manager.
- **Right to amend**: If you feel the medical information, we have about your child is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as this office keeps the information.
    - To request an amendment, your request must be made in writing and submitted to the physician. In addition, you must provide a reason that supports your request.
    - We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

        - Was not created by us
        - Is not part of the medical information kept by this office
        - Is not part of the information which you would be permitted to inspect or copy
        - Is accurate and complete
- **Rights to an Accounting of Disclosures**: You have the right to request an "accounting of disclosures". This is a list of disclosures this office has made of your medical information.
    - To request this accounting of disclosures, you must submit your request in writing to the office manager. Your request must state a time period, which may not be longer than six (6) years.
- **Rights to Request Restrictions**: You have the right to request a restriction or limitation on the use of disclosure we make of your medical information. To make restrictions, your request must be in writing and submitted to the office manager.
    - We are not required to agree to your request for a restriction. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment.
- **Right to a Paper Copy of This Notice**: You have the right to a paper copy of this notice, even if you have agreed to receive this notification electronically. To obtain a copy, please contact the office manager.

REVISIONS TO THIS NOTICE

We reserve the right to revise this notice. Any revised notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised notice in the office. Any revised copy will contain, on the first page, in the top right corner the effective date. In addition, each time you visit the office we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with this office or with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact our office manager at 517-978-7337. All complaints must be submitted in writing.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT

OTHER USES OF MEDICAL INFORMATION

- Other uses and disclosures of your children's medical information not covered in this Notice of Privacy Practices will be made only with your authorization. If you provide us with such an authorization in writing to use or disclose medical information, you make revoke the authorization at any time in writing. If you revoke, we will no longer use or disclose medical information for the reasons covered by your written authorization.