

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.

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: _____

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

Authorization to Disclose Protected Health Information

Patients 18+

Patient's Name (Printed): _____

Patient's Date of birth: _____

I authorize Mason Pediatrics to share my protected health information with the following individual(s) listed below:

Name of Authorized Person:	Relationship to Patient:	Date Authorization to Expire
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

If no expiration date listed this authorization will expire on patient's 22nd birthday or until this authorization is revoked in writing.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- My refusal to sign this authorization will not affect my ability to obtain treatment.

Patient's 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 perform 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 or 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 cancellation 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: _____

MASON PEDIATRICS HIPAA NOTICE

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. **For Treatment**- 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. **For Payment**- 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. **Coroners and Medical Examiners**- 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.