Pleasant Pediatrics New Patient Information

Date: _____

Patient Name: _____ Male/Female
Last First Middle

Patients Social Security#: _____ Age _____ Date of Birth _____

Address: _____
Street Number and Name City State Zip Code

Legal Guardian Phone Number _____ Relation to Parent: _____

Legal Guardian Phone Number _____ Relation to Parent: _____

Which above number is your *preferred* number for contact? _____

Email Address: _____

Race: American Indian/ Native Hawaiian/ Black / White/ Asian/ Refuse/ Other: _____

Ethnicity: Hispanic or Latino/ Not Hispanic or Latino/ Refuse

Language: English/ Spanish/ Other: _____

WHO HAS LEGAL CUSTODY OF THE CHILD? Mother Father Both *Foster *Other

*If Foster or Other marked- Name: _____ Relationship to Child: _____

Divorced Parents Only: A copy of your divorce decree is required for your child's chart that states the following:

Which parent has physical custody, one or both, which parent is financially responsible for medical care, whose insurance is primary, and whose insurance is secondary.

Patient(s) or Guardian(s) Guarantor Information

Parent/ Guardian Name: _____ DOB: _____

Relationship to patient: Mother/ Father/ Foster Parent/ Other: _____

Address: _____

Parent/ Guardian Name: _____ DOB: _____

Relationship to patient: Mother/ Father/ Foster Parent/ Other: _____

Address: _____

Insurance Information

Primary Ins: _____ Member ID: _____

Subscriber Name: _____ DOB: _____ SSN: _____

Employer: _____ Relationship to Patient: _____

Secondary Ins: _____ Member ID: _____

Subscriber Ins: _____ DOB: _____ SSN: _____

Employer: _____ Relationship to Patient: _____

Consent for Treatment for a Minor

Name: _____Phone:_____

Address: _____Relationship to Pt: _____

I, _____ being the parent/ legal guardian of (name of child):_____

DOB: _____, give my consent and authorize the administration and performance of all treatment and diagnostic procedures, which in the judgement of Pleasant Pediatrics licensed physicians and physician assistants are considered necessary. The minor named in this consent form may receive all medical care provided according to generally and currently accepted standards of pediatric medical care.

In the absence of the legal guardian the following people are authorized to bring this minor for medical treatment and have access to his/her medical information. (You may name relatives, friends, grandparents, stepparents, non-custodian parent, day care provider, foster parent or others.)

Name: _____Relationship_____

Name: _____Relationship_____

Name: _____Relationship_____

If no other person is authorized please circle: NONE

Please initial the following:

_____If a minor is brought by any other person not recorded above, Pleasant Pediatrics will make reasonable attempts to contact me for verbal consent to treat. I will keep Pleasant Pediatrics notified of any change of my telephone number.

_____If the custody or guardianship of this minor has changed I will furnish Pleasant Pediatrics with legal form that are required to be included in the minor's medical record to explain the change in guardianship. This will alleviate any confusion that may occur over who may not consent to minors treatment.

_____I have the right to revoke or change this consent to treat in writing.

Parent/Guardian Print Name: _____

Signature: _____ Date: _____

EMERGENCY CONTACT: _____Relationship: _____

Phone Number: _____

If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.
This Consent is effective until withdrawn in writing by the child's parent or guardian or until the child turns 18.

Pleasant Pediatrics participates in the following insurance programs:

COMMERCIAL

-Blue Cross Blue Shield (ALL)
-Blue Care Network
-MultiPlan
-ASR Corp
-McLaren Health Plan
-Aetna
-United Health Care/ Golden Rule/ UMR
-CIGNA PPO
-Trustmark
- Tricare
- Key Benefit Administrators
- US Health and Life
- HealthPlus
- Meritain
- Physician Health Plan (PHP)
- Priority Health HMO/PPO

MEDICAID

- Medicaid
- Meridian Health Plan
- Molina
- McLaren
- Blue Cross Complete
-Priority Health
-United Healthcare

Pleasant Pediatrics participates with a variety of health care plans including many Medicaid plans, BCBS and Children's Special Health Care to name a few. Please talk to our biller to be certain if we par with your plan. As a courtesy to our patients Pleasant Pediatrics submits claims to all carriers, regardless of our participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day services are rendered. Co-pays must be paid before visit at check-in window.

I understand that my insurance policy is a contact between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time service are rendered. I agree to be financially responsible for all costs incurred by my dependent child in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by the office, whether conducted in this office or elsewhere, which are not otherwise paid by my insurance.

I hereby authorize Pleasant Pediatrics or its designees to bill and release to my insurance company and/or third payer(s) and or external review agency(s) such information contained in my child's patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history, illness or diagnostic and therapeutic information.

**SPORT PHYSICALS ARE NOT COVERED BY ANY INSURANCE* They Cost $25.00*

Signature (Legal Parent/ Guardian):_____Date:_____

Welcome and thank you for choosing Pleasant Pediatrics. We are committed to providing your children with the best medical care based on their health needs. Our hope is that we can form a partnership to keep them as healthy as possible, no matter what their 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 your child/children.

As your primary care provider (PCP), I will:

- Take care of any short-term illness, long-term chronic condition, and all-around well-being.
- Keep you up to date on all their vaccines, well-child visits, and other prevention screening tests.
- Connect you with other members of your care team (specialist) and coordinate your care with them as their health needs change.
- Notify you of test results in a timely manner
- Communicate clearly with you so you will understand any conditions and all the options
- Listen to you questions and feelings, I will respond promptly to you in a way you understand
- Help you make the decisions of your child's care.
- Provide information on community resources.

We trust you, as our patient, to:

- Know that you and your family are a full partner with us in your children's care.
- Let us know when you see other health care providers so we can help coordinate the best care.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your child's health, ask questions about their care, and tell us if you don't understand.
- Learn about their condition(s) and what you can do to keep them as healthy as possible.
- Follow the plan that we have agreed is the best for your child's health.
- Give the prescribed medications as directed.
- All health care providers in your care team will receive all information related to your child's health care.
- Learn about your health insurance coverage and contact your insurance provider if you have any questions about benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for your family.
- Ask us about resources you or your family may need.

Dr. Msibi and the care team of Pleasant Pediatrics look forward to working with your family as your child's primary care provider in your patient-centered medical home.

Bhekumusa Msibi

Provider Signature	Print Provider Name	Date

Parent/ Guardian Signature	Printed name	Date

Patient Printed Name	Date of Birth	Date

Childs Name: _____ DOB: _____

Name/Location of Childs Pharmacy: _____

Are the patient's immunizations up to date (circle one): YES NO UNKNOWN

When was the patient's last well-child exam or physical: _____

FAMILY HISTORY:

Please indicate if your child has a family history (parents, siblings, maternal/paternal grandparents) of any of the following: **Please specify maternal/paternal relation

Diagnosis	Family Member	Diagnosis	Family Member
□ ADD/ADHD		□ Hearing disability	
□ Alcohol/Drug Abuse		□ High cholesterol	
□ Allergies		□ High blood pressure	
□ Asthma		□ HIV/AIDS	
□ Birth defects		□ Learning disability	
□ Blood disorders		□ Mental illness	
□ Cancer, type		□ Migraines	
□ Heart disease (heart attack, bypass, stents)		□ Scoliosis	
□ Deafness/Hearing problems		□ Seizure disorder	
□ Depression		□ Speech problems	
□ Developmental delay		□ TB/Lung disease	
□ Diabetes		□ Stroke	
□ Genetic disorder		□ Thyroid disease	
□ Hepatitis/Liver disease		□ Other	

MEDICATIONS:

Medication	Prescribing provider	Dose How many times a day

MEDICATION or FOOD ALLERGIES: □ No □ Yes; if yes, to what medication(s)/Food(s) what was the reaction:

_____

Birth/Hospitalizations/Surgeries/Allergies

Birth Weight: _____ Length: _____ Delivery: Vaginal C-Section

Hepatitis B given at the Hospital? YES NO Number of Weeks Gestation: _____

Was the patient born prematurely? YES NO If Yes, how early? _____

Did the patient have Cyanosis or Jaundice after birth? _____

Male Patients only: Circumcision? YES NO How many days did the baby stay in the hospital? _____

Hospitalizations: _____ Date: _____

Surgeries: _____ Date: _____

Injuries: _____ Date: _____

Before the Patient was born, did the mom have any complications during pregnancy? (See below)

Gestational Diabetes YES NO High Blood Pressure/Preeclampsia YES NO

Urinary Tract Infection YES NO Alcohol/ Drug Use, if yes, specify: _____

Sexually Transmitted infection(s), if yes, specify: _____

Other complications Prenatal or Postnatal: _____

Family Information:

Child Sibling :(please note if step or half): _____ Age: _____

Child Sibling :(please note if step or half) _____ Age: _____

Child Sibling :(please note if step or half) _____ Age: _____

Child Sibling :(please note if step or half) _____ Age: _____

Personal Medical History:

Please check if **your child** has had any of the following medical problems:

□ ADD/ADHD	□ Chicken pox	□ Headaches	□ Liver disease/Hepatitis
□ Allergies	□ Concussion	□ Hearing problems	□ Recurrent ear infections
□ Anemia	□ Diabetes	□ Heart murmur	□ Reflux/GERD
□ Asthma	□ Eczema	□ Congenital heart disease	□ Seizures
□ Bleeding disorder	□ Fracture	□ High blood pressure	□ Urinary Tract Infections
□ Bronchiolitis	□ Handicaps/Disabilities	□ Kidney disease	□ Vision problems

Other: _____

Authorization for Payment and Financial Responsibility (Please read and sign):

I agree to provide my insurance card at each visit and pay my co-pay/deductible. Co-payments, co-insurance, deductibles, and previous balances are due at the time of service by the parent accompanying the child. I understand that fees for services rendered are my financial responsibility. I understand that unpaid claims not paid by my insurance company within 30 days of service will be transferred to the patient's responsibility and will be due upon receipt of the statement. I also understand that balances for items that my insurance company deems as "non-covered services" or "not medically necessary" are also my financial responsibility. Considering services rendered, I agree to pay all charges incurred for my account as the patient and/or responsible party. If I default in the obligation of payment to my provider, I understand that my account(s) can be placed with a collection agency or attorney for collection. I further agree to pay reasonable attorney fees, collection, and court costs if my account(s) is placed for legal or third-party collection action. A 30% fee will be added to all accounts placed with a collection agency. I understand that if my account is transferred to an outside collection agency, your child/children will be dismissed from the practice until the balance is paid in full.

Pleasant Pediatrics charges $35.00 for a returned check. We require a 24-hour cancellation notice to avoid any charges. A $30 missed appointment fee may be charged for missed appointments or not canceled more than 24 hours before the scheduled appointment time. If there are 3 no-show visits within 1 year. Your child/children maybe terminated from the practice. **Exceptions:** *We understand that emergencies and unforeseen circumstances can arise. Exceptions to the no-show fee may be made on a case-by-case basis at the discretion of Pleasant Pediatrics*

All other services that require for you to go elsewhere such as x-rays, MRI's, CT's, etc., are not included in your fee. You will be billed separately for these services from the practicing location

Authorization to Release Medical Information and Consent to Treatment:

I authorize the release of any medical records by HIPAA guidelines via fax, e-mail, and/or the United Postal Service. Including the diagnosis, treatment, or examination rendered to my child during the treatment period to process insurance claims or to satisfy the requirements of managed care organizations that I am a member. I assign all payments for the medical services rendered to my child to the physician or physician's group. I authorize Pleasant Pediatrics to leave or send appointment reminder messages on voicemail, text, or email. I also authorize Pleasant Pediatrics to utilize any e-mail address I provide them as a form of communication. I understand that if I request any change in this information, I am responsible for notifying this office in writing of such a request. I consent to my child's treatment by the Pleasant Pediatrics physicians. These policies supersede and replace any prior verbal or written published policies.

Acknowledgment of Receipt of the Notice of Privacy Practices:

I acknowledge that I have been offered/received the Notice of Privacy Practices from Pleasant Pediatrics. This notice describes how this office may use and disclose my protected health information. I understand that I can obtain additional copies on the website at www.pleasanthealthcare.com at any time or request that a copy be provided to me at any visit.

Normal Lab & Test Results Authorization:

I authorize Pleasant Pediatrics to leave a message on my voicemail/answering machine that my child's test results are normal. I understand that the actual test results will not be left on the message, just that they are normal. If you elect not to authorize this, please notify the Nurse to note it on your child's chart. I understand that by signing below, I, as the parent/guardian authorize and agree to the above terms.

Patient/Childs Name: _____

Signature of parent/guardian: _____ Date: _____

Medical Records Request Policy

Purpose: To ensure that patients and their authorized representatives can access their medical records in a timely and efficient manner while maintaining the confidentiality and integrity of the records.

Scope: This policy applies to all patients and authorized representatives requesting copies of medical records from Pleasant Pediatrics.

Policy Statement: Pleasant Pediatrics is committed to providing patients with access to their medical records in accordance with the Medical Records Access Act and applicable state and federal laws.

Request Process:

1. **Written Request:** Patients or their authorized representatives must submit a written request for medical records. The request should include the patient's name, date of birth, and the specific records being requested.
2. **Verification:** Requests must be verified to ensure the requester is the patient or an authorized representative. This may include providing a valid photo ID and a signed authorization form if applicable.
3. **Fees:** A fee may be charged for copying and providing medical records. The fee structure is as follows:
    - **Initial Fee:** $20.00 per request
    - **Paper Copies:** $1.00 per page for the first 20 pages, $0.50 per page for pages 21-50, and $0.20 per page for pages 51 and over
    - **Non-Paper Records:** The actual cost of preparing a duplicate if the records are in a form other than paper
    - **Postage or Shipping Costs:** Any postage or shipping costs incurred by the health care provider
    - **Retrieval Costs:** Any actual costs incurred in retrieving records that are 7 years old or older and not maintained on-site
4. **Response Time:** Requests will be processed within 30 calendar days. If there are delays, the requester will be notified of the delay and the reason for it.
5. **Denial of Requests:** Requests may be denied in certain limited circumstances, such as if the records contain information that is not subject to disclosure under applicable laws. If a request is denied, the requester will be informed of the reason and their right to request a review of the denial.
6. **Confidentiality:** All requests for medical records will be handled with strict confidentiality. Records will only be provided to the patient or an authorized representative.

Patient/Childs Name: _____

Parent/Guardian Signature: _____ Date: _____

Medication Refills

If your child takes medication regularly, we urge you to keep track of how much medication he/she has left and how many refills are left on the prescription. It is also important to know when they need a visit with the provider in order to get a refill.

You may request a refill by: Calling our office at 989-772-1500 and pressing 2 to leave a detailed message with the Medical Assistants. Please note that you may not receive a call back from our office the same day for non-emergency calls.

Please allow 1-3 days for ALL prescription refills

Great Lakes
PHYSICIANS ORGANIZATION

Social Determinants of Health Questionnaire

Name: Birthdate: County: Date:

Unmet social needs can negatively affect a person's health and wellbeing. There are programs available to help, but they aren't reaching everyone who may need them. Do you need help with any of these items?

Food	
1. Within the past year, did you worry that your food would run out before you got money to buy more?	Yes No
2. Within the past year, did the food you bought just not last, and you didn't have money to get more?	Yes No
Housing & Utilities	
3. Do you have housing?	Yes No
4. Are you worried about losing your housing?	Yes No
5. Within the past year, have you or the family members you live with been unable to get utilities (heat, electricity) when it was really needed?	Yes No
Transportation	
6. Within the past year, has lack of transportation kept you from medical appointments, getting your medications, non-medical meetings or appointments, work or from getting the things that you need?	Yes No
7. Do you have trouble finding or paying for transportation?	Yes No
Interpersonal Safety	
8. Do you feel physically and emotionally safe where you currently live?	Yes No
9. Within the past year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?	Yes No
10. Within the past year, have you been humiliated or emotionally abused in other ways by your partner?	Yes No
Employment & Income	
11. Do you have a steady source of income?	Yes No
Clothing & Household	
12. Do you have enough household supplies? For example, clothing, bedding, hygiene products, infant products, or cleaning products?	Yes No
Childcare	
13. Are you concerned that you won't have reliable childcare to go to work, school, or important appointments?	Yes No
Education	
14. Do you think more education or training, like getting a GED, going to college, or learning a trade would be helpful for you?	Yes No
Resource Support	
15. Are any of your needs urgent? For example, I don't have enough food for tonight, I don't have a place to sleep tonight, I'm afraid I will get hurt if I go home today.	Yes No
16. Would you like to receive assistance with any of these needs?	Yes No