FAMILY HISTORY

CHILD/CHILDREN'S NAME: _____

FAMILY HISTORY (THINK IN TERMS OF THE CHILD'S SIBLINGS, PARENTS, GRANDPARENTS, AUNTS, UNCLES AND FIRST COUSINS):

ANY ALLERGIES, "HAY FEVER", ASTHMA OR ECZEMA? YES/NO

WHO? _____

ANY HEART ATTACKS, STROKES, OR HIGH CHOLESTEROL? YES/NO

WHO? _____ AT WHAT AGE?_____

ANY DIABETES (SUGAR)? YES/NO

WHO?_____

ANY EPILEPSY (SEIZURES)? YES/NO

WHO?_____

ANY CANCER? YES/NO

WHO?_____

ANY BLEEDING DISORDERS? YES/NO

WHO? _____

ANY ANEMIA OR SICKLE CELL? YES/NO

WHO?_____

ANYTHING ELSE YOU THINK WE SHOULD KNOW ABOUT?

_____

THANK YOU FOR YOUR TIME. THIS INFORMATION WILL BE BENEFICIAL IN PROVIDING THE BEST POSSIBLE CARE FOR YOUR CHILD.

Child Health Associates, P.C. Financial policy
(Effective December 10, 2009)

Our goal is to provide and maintain a good physician-patient relationship. We are committed to delivering prompt, accessible high quality pediatric care to our patients. You are responsible for providing us accurate and up to date personal information. **It is your responsibility to pay for our services as they are rendered. CHILD HEALTH ASSOCIATES IS UNABLE TO PROVIDE FINANCING FOR SERVICES PROVIDED.** This policy is designed to make our financial relationship clear to our patients. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your child's behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT FOR THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit. Newborns must be added to your insurance policy as soon as possible.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. Co-payments are due at the time of service. You should be prepared to make payment for these when in the office. Failure to pay a required co-payment will incur a $20 charge.
5. If our physicians do not participate in your insurance plan or you do not have health insurance, payment in full is due at the time of service.
6. Patient balances (balances after insurance processing or charges not covered by insurance) are due immediately.
7. Any account 60 days past due will incur a $20 service charge. Accounts 90 days past due will be sent to a collection agency and further elective medical care will be denied.
8. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
9. There is a 24-hour cancellation policy. A $25 charge will be assessed for appointments not cancelled by the day prior to your child's appointment.
10. A $30 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
11. There is a $25 charge per family to copy or transfer records.
12. After-hours phone calls will be answered by our CHA physicians free of charge until 10pm most nights. After 10pm calls will be answered by our experienced pediatric R.N.'s for a fee of $10 per call charged to your account.
13. Advance notice is needed for all non-emergent referrals. Referrals generally will take between one and two weeks to complete. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
14. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
15. Not all services provided by our office are covered by every plan. Any service determined not to be covered by your plan will be your responsibility.

I have read and understand this financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in these documents.

Patient Name (s) _____

_____ _____

Responsible party member's name Relationship

_____ _____

Responsible party member's signature Date

CHILD HEALTH ASSOCIATES, P.C.

With my consent, Child Health Associates (CHA) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to CHA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CHA Privacy Officer at 1800 W. Big Beaver, Suite #200, Troy, MI 48084.

With my consent, CHA may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, CHA may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that CHA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CHA's uses and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, CHA may decline to provide treatment for me.

_____ _____

Signature of Parent Date

_____

Print Name of Parent

Patient Name	DOB	Patient Name	DOB
Patient Name	DOB	Patient Name	DOB
Patient Name	DOB	Patient Name	DOB

I acknowledge that I have had the opportunity to review Child Health Associates, P.C.'s Notice of Privacy Practices.

Child Health Associates reserves the right to revise its Notice of Privacy Practices at anytime.

_____ _____

Signature of Parent/Guardian Date

INSURANCE INFO SHEET

PLEASE BRING INSURANCE CARD TO THE FRONT DESK WITH THIS FORM

Subscriber_____

Social Security Number _____ DOB ____/____/____

Employer _____

List all children covered under current insurance policy (name and date of birth)

_____ DOB ____/____/____

_____ DOB ____/____/____

_____ DOB ____/____/____

_____ DOB ____/____/____

_____ DOB ____/____/____

_____ DOB ____/____/____

Office use only

Effective date_____

Copay_____

Todays date/initials_____

Pcp_____

Insurance phone # _____

PATIENT INFORMATION SHEET

CHILD'S NAME:_____

DOES YOUR CHILD TAKE MEDICATIONS ROUTINELY FOR ANY MEDICAL PROBLEM? PLEASE INCLUDE OVER-THE-COUNTER AND TOPICAL (CREAMS OR OINTMENTS) MEDICINES.

_____

_____

ANY HISTORY OF CHRONIC MEDICAL PROBLEMS (ASTHMA, ALLERGY, ETC.)?

_____

_____

IS YOUR CHILD ALLERGIC TO ANY MEDICINES? IF SO, WHAT MEDICATIONS?

_____

_____

ANY ADVERSE REACTIONS TO VACCINES IN THE PAST?

YES _____ NO _____

HAS YOUR CHILD EVER BEEN ADMITTED TO THE HOSPITAL (OTHER THAN EMERGENCY ROOM VISITS)?

_____

_____

HAS YOUR CHILD EVER HAD SURGERY? WHAT? WHEN?

_____

_____

CHILD HEALTH ASSOCIATES, P.C.

I _____(name of parent/guardian)give permission for Child Health Associates, P.C. to provide all necessary medical care for my child/children

PLEASE LIST ALL CHILD/CHILDREN **LEGAL NAMES**:

M__F__ FIRST_____ MI__ LAST_____ DOB _____/_____/_____ PT#_____

M__F__ FIRST_____ MI__ LAST_____ DOB _____/_____/_____ PT#_____

M__F__ FIRST_____ MI__ LAST_____ DOB _____/_____/_____ PT#_____

M__F__ FIRST_____ MI__ LAST_____ DOB _____/_____/_____ PT#_____

M__F__ FIRST_____ MI__ LAST_____ DOB _____/_____/_____ PT#_____

M__F__ FIRST_____ MI__ LAST_____ DOB _____/_____/_____ PT#_____

ADDRESS OF WHERE THE CHILD/CHILDREN RESIDE:

Home Address_____City _____ State_____ Zip_____

WITH WHOM DOES THE CHILDREN RESIDE_____

PRIMARY PHONE NUMBER_____ ALTERNATE PHONE_____

E-MAIL ADDRESS(we will only use this to communicate practice information with you)_____

PREFERRED PHARMACY NAME & LOCATION_____

HOW DID YOU HEAR ABOUT OUR PRACTICE (NEW PATIENT ONLY)_____

BILLING ADDRESS (IF DIFFERENT) ADDRESS_____CITY_____

STATE_____ ZIP_____ PHONE NUMBER _____ ALT NUMBER_____

FATHER AND/OR GUARDIAN

FIRST_____MI____ LAST_____ DOB ____/_____/____

OCCUPATION_____ BUS PHONE_____ SS_____

EMPLOYER_____ ADDRESS_____

MOTHER AND/ OR GUARDIAN

FIRST_____MI____ LAST_____ DOB ____/_____/____

OCCUPATION_____ BUS PHONE_____ SS_____

EMPLOYER_____ ADDRESS_____

EMERGENCY MEDICAL RELEASE/CONSENT

I, _____ give my permission for (list below) to seek medical care for my child/children through office visits or telephone advice**.(Someone other than the parent or guardian)**

NAME_____RELATIONSHIP_____ PHONE_____

NAME_____RELATIONSHIP_____ PHONE_____

NAME_____RELATIONSHIP_____ PHONE_____

NAME_____RELATIONSHIP_____ PHONE_____

DATE_____ SIGNATURE_____