Rockford Pediatrics

120 Marcell Dr. NE, Suite C
Rockford, MI 49341
Phone: (616) 259-6100
Fax: (616) 259-5730

Authorization for Release of Medical Records to Rockford Pediatrics

Patient's Name:_____ Date of Birth:____/____/____ Date of Request:_____

Address:_____ Day Time Phone: (____)_____
(Street, city, state, zip code)

Please list where Rockford Pediatrics is to request medical records FROM:

Facility/Office:_____ Fax Number: _____

Address:_____ Phone Number:_____

City/State:_____

Dates of Service:_____ **Reason for request**:_____

The following information is to be disclosed TO Rockford Pediatrics: (Please send ONLY the information listed below.)

List of records to be sent: (Circle all that apply)

Problem List	Immunization Record	Medication List	Labs/Specialist Reports
Growth Chart	Drug Allergy History	Last Well Visit	ADHD History (if applicable)

Please send ONLY THE REQUESTED INFORMATION via fax to Rockford Pediatrics:
Fax Number: (616)259-5730

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing, and I understand that the revocation will not apply to information already released based on this authorization.
Other Rights: a) I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization. I do not need to sign this form to assure treatment. b) I understand that I may inspect or obtain a copy of this information to be used or disclosed.
Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I do not specify an expiration date, event or condition, this authorization will expire six months from the date signed.

By signing this form, I understand and accept full responsibility for the medical records I am requesting. I relinquish Rockford Pediatrics of any and all accountabilities concerning these medical records.

_____ _____
Signature of patient or legal representative Date

_____
If signed by legal representative, relationship to patient

Rockford Pediatrics

Access our patient portal through our website

www.RockfordPediatrics.com

REGISTRATION FORM

Today's date:	Pediatrician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Date of Birth: Age:	Sex: ❑ M ❑ F
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / White		Preferred Language:	
Street address:			What kind of reminder notifications: ☐ Text (____)_____ ☐ E-mail _____ ☐ Phone (____)_____	
City:	State:	Zip:	Home phone: ( )	

Status of Parents: Married ☐ Separated ☐ Divorced ☐ Single ☐ Who does the child reside with? ❑ Mother ❑ Father ❑ Both

If divorced, who has custody? documentation Any restrictions for non-custodial parent? *if so, must provide legal

How did you hear about us? (please check one box): ❑ Internet/Website ❑ Facebook ❑ Mailer ❑ Rec. by Hospital or OB/GYN

❑ Family ❑ Friend _____ ❑ Close to home/work ❑ Insurance Coverage ❑ Other _____

SIBLING INFORMATION

Sibling's last name:	First:	Middle:	Date of Birth:	Sex: ❑ M ❑ F
Sibling's last name:	First:	Middle:	Date of Birth:	Sex: ❑ M ❑ F
Sibling's last name:	First:	Middle:	Date of Birth:	Sex: ❑ M ❑ F

CONTACT INFORMATION

Mother's/Guardian's Last Name: Middle:	First:	Date of Birth:	SS#
Address (if different than above):			
E-Mail:		Mother's Cell Phone:	
Father's/Guardian's Last Name: Middle:	First:	Date of Birth:	SS#
E-mail:		Father's Cell Phone:	

INSURANCE

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance: Subscriber's Last Name:	First:	MI:	DOB:
Insurance Carrier:	Subscriber ID:	Group #:	
Secondary Insurance: Subscriber's Last Name:	First:	MI:	DOB:
Insurance Carrier:	Subscriber ID:	Group #:	
Place of Employment:			

I authorize payment of benefits by the insured directly to Rockford Pediatrics. I also request payment of benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services within 30 days unless a payment is negotiated in advance. I authorize Rockford Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

_____ _____

Patient/Guardian signature Date

AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATION

I understand according to the State of Michigan, Department of Health Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from my family member that a HIV and Hepatitis-B (HBV) blood test will be performed.

_____ _____

Patient/Guardian signature Date

Emergency Contacts (Other than parents)

Last Name:	First:	Relation:	Home Phone: Cell Phone:
Last Name:	First:	Relation:	Home Phone: Cell Phone:

Is it ok to leave a detailed message including medical information on your voicemail? YES ____ NO ____ List Phone #_____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to (other than parent/guardian):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care/Treatment Level of Information _____
- ☐ Billing Information
- ☐ Pick Up PHI (such as prescriptions, billing statements, labs, etc.)
- ☐ Other (Specify in detail – appointments: such as date of service, type of service, level of detail to be released, etc.)

_____

_____

_____

This authorization shall be in force and effective and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the practice's Privacy Contact at: Rockford Pediatrics, 120 Marcell Dr. NE, Suite C, Rockford, MI 49341. I understand that a revocation is not effective to the extent that my physician had relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient/Guardian signature Date

Rockford Pediatrics

Child's name: _____

DOB: _____

Patient History Questionnaire

Birth History

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

Delivery: ☐ Vaginal ☐ Cesarean If C/S, why? _____

Were there any prenatal or neonatal complications?

☐ Yes ☐ No If yes, explain _____

Was a NICU stay required? ☐ Yes ☐ No If yes, explain _____

During pregnancy, did mother use tobacco ☐ Yes ☐ No, Drink alcohol ☐ Yes ☐ No, Drugs or medications ☐ Yes ☐ No If yes, 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 illness or medical condition? ☐ Yes ☐ No ☐ DK

Explain _____

Has your child had any surgeries? ☐ Yes ☐ No ☐ DK Explain _____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK _____

Explain _____

Is your child allergic to any medicine or drugs? ☐ Yes ☐ No ☐ DK _____

Explain _____

Biological Family History (DK = don't know)

Have any family members had the following?

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)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High Cholesterol	☐ 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)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Liver Disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney Disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-Wetting (after 10 years)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or seizures	☐ 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 had,

Chickenpox ☐Yes ☐No ☐DK When _____

Frequent ear infections ☐Yes ☐No ☐DK Explain _____

Hearing loss ☐Yes ☐No ☐DK Explain _____

Nasal allergies ☐Yes ☐No ☐DK Explain _____

Food or seasonal allergies ☐Yes ☐No ☐DK Explain _____

Problems with eyes/vision ☐Yes ☐No ☐DK Explain _____

Asthma, bronchitis, or pneumonia ☐Yes ☐No ☐DK Explain _____

Heart problem or 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 _____

Bone marrow transplant ☐Yes ☐No ☐DK Explain _____

Chemotherapy ☐Yes ☐No ☐DK Explain _____

Frequent abdominal pain ☐Yes ☐No ☐DK Explain _____

Constipation ☐Yes ☐No ☐DK Explain _____

Urinary tract infections ☐Yes ☐No ☐DK Explain _____

Cataracts/retinoblastoma ☐Yes ☐No ☐DK Explain _____

Metabolic/genetic disorder ☐Yes ☐No ☐DK Explain _____

Cancer/malignancy ☐Yes ☐No ☐DK Explain _____

Kidney disease ☐Yes ☐No ☐DK Explain _____

Bedwetting (after 8 years old) ☐Yes ☐No ☐DK Explain _____

Sleep problems/snoring ☐Yes ☐No ☐DK Explain _____

Skin problems (eczema/acne) ☐Yes ☐No ☐DK Explain _____

Frequent headaches/migraines ☐Yes ☐No ☐DK Explain _____

Seizures/neurologic problems ☐Yes ☐No ☐DK Explain _____

Obesity ☐Yes ☐No ☐DK Explain _____

Diabetes ☐Yes ☐No ☐DK Explain _____

Thyroid/endocrine problems ☐Yes ☐No ☐DK Explain _____

High blood pressure ☐Yes ☐No ☐DK Explain _____

Serious fractures/concussions ☐Yes ☐No ☐DK Explain _____

Alcohol or drug use ☐Yes ☐No ☐DK Explain _____

Tobacco use ☐Yes ☐No ☐DK Explain _____

ADHD/anxiety/depression ☐Yes ☐No ☐DK Explain _____

Developmental delay ☐Yes ☐No ☐DK Explain _____

Significant dental decay ☐Yes ☐No ☐DK Explain _____

History of family violence ☐Yes ☐No ☐DK Explain _____

Sexually transmitted disease ☐Yes ☐No ☐DK Explain _____

(Girls) Pregnancy ☐Yes ☐No ☐DK Explain _____

(Girls) Problems with periods ☐Yes ☐No ☐DK Explain _____

Age of first period _____

Other significant problems _____

_____

Rockford Pediatrics

Policies Agreement

Payment Policy

Thank you for choosing us as your pediatric practice. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most major insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services:** Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **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. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Returned Check Policy:** The return of a check issued to Rockford Pediatrics will result in a $50 returned check fee being placed on the patient's account, no matter the reason.

9. **Missed appointments:** Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

10. **Self-pay:** Payment in full is due at time of service. We will give a 25% discount to self-pay patients.

Payment Policy

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Cancellation/No Show Policy

No Show Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company**.

Same Day Appointments
Sometimes a same day sick appointment will be made and your child improves over the course of the day. Simply notify the office if you need to cancel your appointment and a no-show charge will *not* occur.

Scheduled Appointments
We understand that delays can happen however we must try to keep the other patients and doctors on time. **If a patient arrives 15 minutes past their scheduled time, we may have to reschedule the appointment.**

_____ _____

Signature of patient or responsible party Date

Immunization Policy

Because we care about your child's health, Rockford Pediatrics adheres strictly to the immunization guidelines of the American Academy of Pediatrics and the Center for Disease Control. We *do not* alter the immunization schedule based on individual requests as there is no evidence that altered schedules are safe or confer the proper immunity against disease. We request that patients, at a minimum, maintain the required vaccinations required for school.

I understand that I will be provided VIS sheets to review with all immunizations administered and will be given an opportunity to ask questions. Based on that understanding, I hereby **CONSENT** to receive all ***required*** immunizations provided by Rockford Pediatrics, PC. If I refuse a ***recommended*** vaccine, I understand that I will be asked to sign a refusal waiver form.

_____ _____

Signature of patient or responsible party Date

Rockford Pediatrics

Acknowledgement of Receipt of Notice of Privacy Practices

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature of Parent or Guardian

_____

Signature of Patient if over 18 years old

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____