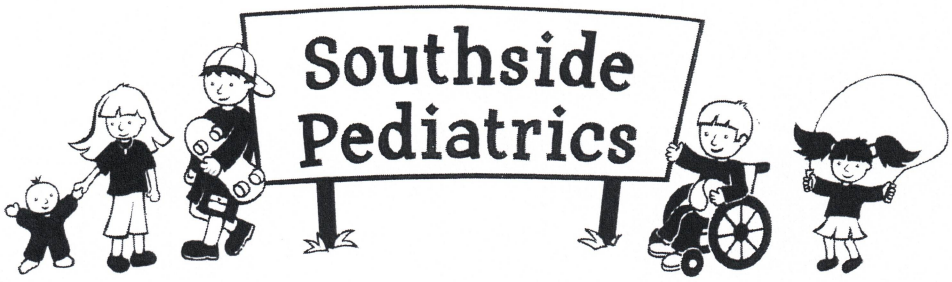


Caring for the Community One Child at a Time

WELCOME TO SOUTHSIDE PEDIATRICS

Patient Name: _____

Date of Birth: _____

Do you have a preference to a physician?

_____

What Insurance do you carry?

_____

How soon do you need an appointment?

_____

What type of appointment?

_____

Southside Pediatrics

Caring for the Community One Child at a Time

Patient Demographics

Person Completing Form: _____ Relationship: _____ Date: _____

PLEASE PRINT

Your Child's Personal Information

Child's Full Name_____ Previous Name: _____
First Name Middle Name Last Name

Date of Birth: _____ Sex: _____ Birth Order: _____

Race: _____ Ethnicity: _____ Language: _____ Translator Needed: Yes / No

City of Birth: _____ Hospital Name: _____

Address where Child Resides:

Street: _____City: _____ State: _____ Zip: _____

Ph. to receive text messages: _____ Ph. to receive for calls: _____

Preferred Pharmacy: _____ City/Street of Pharmacy: _____

Biological/Legal Parent Information

(Step Parent/Foster Parent/Guardian on Next Page)

	Parent	**Parent**
Full Name (First, Middle, Last)	_____	_____
Date of Birth	_____	_____
SSN	_____	_____
Address	_____	_____
City/State/Zip	_____	_____
Home Phone	_____	_____
Cell Phone	_____	_____
Occupation	_____	_____

Parent's Current Marital Status: Married Separated Divorced Unmarried Widowed

PLEASE PRINT

Medical Insurance

PLEASE GIVE A COPY OF YOUR MOST RECENT INSURANCE CARD to the Receptionist

	Primary	Secondary
Insurance Co	_____	_____
Policy Holder Name	_____	_____
Date of Birth	_____	_____
Social Security #	_____	_____
Group Number	_____	_____
Policy/Member ID #	_____	_____
Copay $$$	_____	_____

Be sure to report any changes in Address, Marital Status and Insurance coverage to your primary and secondary insurance. Michigan Insurance Law is regulated by the "Birth Day Rule". Which means: the member whose birthday comes first in the year is primary. Unless there is a divorce settlement which mandates who is to carry the primary insurance.

Patient Portal User Agreement

(1) Please provide a secure email address. The patient portal can only be accessed with a valid email address. Your username and password will be emailed to the email you have provided and you will receive a text message to the cell phone you have provided.

(2) When you first sign in, you will be required to consent to the practice privacy agreement and set up security questions. Please do not share this information.

(3) Be sure to keep your username and password in a secure location. You will have 7 failed attempts to enter your username/password until your password will timeout and it will need to be reset. Your password can only be reset during regular business hours. The after-hours and weekend on-call provider **does not** have the capability to reset passwords.

(4) If you wish to link your children for easy access through Healow please call the office, we will assist in this process.

(5) **Do Not** use the patient portal for requesting same day appointments, please call the office directly to make same day appointment requests.

(6) Please call the office directly to talk with a nurse for all Urgent and Emergent concerns. The patient portal is not for addressing Urgent Health Concerns or Emergency Health situations.

_____ Date _____

Please Sign

Email Address:

(Please write "Decline" above if not wishing to sign up for the Patient Portal)

PLEASE PRINT

Step Parent/Foster Parent/Guardian Information (Please Provide Letter of Guardianship)

	Step/Foster/Guardian Parent	Step/Foster/Guardian Parent
Full Name (First, Middle, Last)	_____	_____
Date of Birth	_____	_____
Address	_____	_____
City/State/Zip	_____	_____
Home Phone	_____	_____
Cell Phone	_____	_____
Occupation	_____	_____

Emergency Contact (Other than Parents)

Name _____

Address _____

City/State/Zip _____

Home Phone _____

Cell Phone _____

Relationship to Patient _____

Siblings

Name: _____ Date of Birth _____ Relationship _____

Name: _____ Date of Birth _____ Relationship _____

Name: _____ Date of Birth _____ Relationship _____

Name: _____ Date of Birth _____ Relationship _____

Name: _____ Date of Birth _____ Relationship _____

Name: _____ Date of Birth _____ Relationship _____

PLEASE PRINT

OFFICE POLICY OVERVIEW – PLEASE READ CAREFULLY before Signing

The providers and staff of Southside Pediatrics are honored to be a part of your child's future. As your **Medical Home Provider,** we look forward to building a relationship with you, your child and your family. So that we can better serve the needs of your child please be sure to keep us up-to-date with any changes in: Health Condition, Contact Information, and Insurance Status.

In accordance with federal and state protected health information and privacy laws, as well as state medical retention laws, Southside Pediatrics is committed to maintaining your child's medical record in a secured environment. Your child's medical record will be maintained in a written and electronic form at this location or in an alternate off-site storage location retained by Southside Pediatrics PC. We will request that you clearly identify those family members who you wish to have medical information disclosed to, other than the biological parents of the child.

If you are unable to accompany your child to his/her appointment and need to send someone in your place, Southside Pediatrics requests that you provide the office with either a written permission slip acknowledging the name of the person bringing your child and that you give them permission to make medical decisions in your absence. If this is not possible, please call us prior to the appointment time and give us verbal permission.

We understand that unforeseen circumstances/emergencies occur that may affect your ability to keep your appointment. We ask that you notify the office prior to your appointment time, as soon as possible. *Multiple missed appointments are subject to Discharge from the practice.* So please call us as soon as you can, this will give us an opportunity to reschedule your appointment and provide an appointment time for another child who needs to be seen.

Most insurance plans do not pay all medical services, even those services that might be helpful to the patient. When the service is not covered by your insurance policy or there is a co-pay, deductible or co-insurance, you will be responsible for the balance. Co-Pays are due at the time of service unless other financial arrangements have been made with the office. Unpaid, overdue balances are subject to collection proceeding so please contact the office if you are having financial difficulties. Keeping your Coordination of Benefits updated with your insurance company is the parent's responsibility.

Vaccine Administration Office Policy: parents choosing to not vaccinate their child will be required to document their choice by signing Southside Pediatrics approved *"Refusal to Consent to Vaccinate"* form. If the parent/guardian/patient is unwilling to sign the refusal form, the providers of Southside Pediatrics will be forced to separate their relationship with the family. While you are seeking a new primary care provider, Southside Pediatrics will extend 30 days of emergency services only. A copy of your child's medical record will be forwarded to your new primary care within 30 days after receiving a signed HIPPA compliant medical records request form.

Parental Acknowledgement

The information I have provided to Southside Pediatrics is accurate and truthful. I have read and understand the policies set forth by Southside Pediatrics. I recognize and accept full responsibility for payment of all services not covered by insurance and rendered by Southside Pediatrics. I authorize the release of any information necessary to the insurance company to process medical claims and request that any payment of medical benefits be made directly to Southside Pediatrics. I understand my financial responsibilities regarding unpaid balances by the insurance company. Overdue patient balances left unpaid are subject to collections designated by Southside Pediatrics. Patient accounts sent to collections will result in a discharge from the practice.

Please Print Your Name here: _____

Please Sign and date here: _____

Consent for Treatment

I authorize Southside Pediatrics, through its appropriate personnel, to perform the appropriate assessment and treatment procedures upon my child/legal dependent, as the provider deems medically necessary.

_____

Patient's Name and Date of Birth

_____

Signature of parent or legal guardian **Today's Date**

Patient Consent for Use and Disclosure Of Protected Health Information

Patient's Name: _____ Date of Birth: _____

With my consent, Southside Pediatrics may use and disclose **P**rotected **H**ealth **I**nformation (PHI) about my child to carry out **T**reatment, **P**ayment and healthcare **O**perations (TPO). Please refer to Southside Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review Notice of Privacy Practices prior to signing this consent. Southside Pediatrics reserves the right to revise its Notice of Privacy Practices at any time. A current copy of the Notice is available for me to review at the office location and available at the office web site: www.southsidecares4kids.com and a revised Notice of Privacy Practices may be obtained by forwarding a written request to Southside Pediatrics located at 300 Meadow Run Drive, Hastings MI 49058 Attn: Medical Records.

With my consent, employees of Southside Pediatrics may: call me and leave voicemail messages at my home number provided at the time of my child's registration with Southside Pediatrics, call/leave messages on my cell phone which I provided at the time of registration, I approve the employees of Southside Pediatrics to text message the cell number listed in the patient profile or on any other designated cell phone. I approve the use of voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance/payment items and any type of call pertaining to my child's clinical care, prescriptions and laboratory results. I also acknowledge that my enrollment in the Southside Pediatrics patient portal is consent to have TPO published to a secured web site for the purpose of secure patient communication. I will abide by the rules and regulations published at the patient portal. ***It is the responsibility of the parent/guardian to keep the office updated with any changes in home phone, cell phone, home address and email address.***

_____ _____ _____

Home Phone Number Cell Phone Number Email address

With my consent, Southside Pediatrics may mail to my home or other designated location, 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 Southside Pediatrics restrict how it uses or discloses my child's PHI to carry out TPO. However, the practice in 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 Southside Pediatrics use and disclosure of my child's 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, Southside Pediatrics may decline to provide treatment to my child.

ACKNOWLEDGEMENT

I acknowledge receipt of the *Southside Pediatrics Notice of Privacy Practice* and give permission to the use and disclosure of PHI and TPO.

_____

Signature of Parent/Legal Guardian Date

_____

Please Print

CONSENT TO TREAT/SHARE MEDICAL INFORMATION

ONLY a Biological Parent or Legal Guardian may complete this form

I, ____, being the (circle one) parent or legal guardian(s) of: ______________________________________ (child's name) DOB: ______________ authorize the following caregivers indicated below to seek care and obtain/consent to:

Routine Medical Care and Treatment ***Emergency Medical Care and Treatment***

Hospitalization ***Immunizations/ Lab and Radiology Testing***

As deemed necessary by a license medical healthcare professional of Southside Pediatrics.

I the undersigned, parent/guardian, consent to the access of my child's protected medical health information in the case of my inability to communicate directly with the office. *I understand that I may revoke or change this consent at any time*. I understand that it is the responsibility of the parent or guardian to maintain this list of names. ***Any updates or changes require a new consent form be completed and signed by the biological parent/ legal guardian ONLY.*** I understand that the biological mother and father are always permitted to have access to my child's protected health information unless the parental rights of either the father or mother have been legally terminated by law.

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend Other: ______________________________

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend Other: ______________________________

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend Other: ______________________________

Name____
Relationship:
O Grandmother O Grandfather O Aunt O Uncle O Guardian
O Stepfather O Stepmother O Babysitter O Daycare Provider
O Family Friend Other: ______________________________

This will be effective for 12 months or revoked by a parent or legal guardian

____ Date: ____________________

Please Sign and Date

For the privacy and security of our patients, this form will be routinely updated at the request of the parent/guardian or as needed by the providers and staff of Southside Pediatrics.

Southside Pediatrics

Caring for the Community One Child at a Time

"A Partnership with Your Physician to Create a Lasting Relationship"

Health care visits for children can be more than just getting shots, having ears examined or treating the physical symptoms of an illness. Each visit is an opportunity for families and their healthcare provider to partner and promote quality health care for the child but also to support the family's needs in their journey to raising their child. The foundation of family centered care is the partnership between families and their healthcare provider. The staff of Southside Pediatrics is looking forward to building a healthy long-term relationship with you and your family.

"Let's get started"

Patient Full Name: _____ ***DOB:*** _____ ***Date:*** _____

As your doctor, our goal as *"Family-Centered Care"*:

- Supporting the family as the constant in the child's life
- Provide information about health and wellness appropriate to the child/youth developmental stage
- Explain diseases, treatment and results in an easy-to-understand way
- Respect your privacy – the medical information will not be shared unless you give us permission
- Have a doctor on-call 24 hours a day, 7 days a week
- Support your family if your child is admitted into the hospital
- We will provide newborn hospital services locally and care coordination if your child must be admitted to a hospital outside our service area
- Work together as partners to make health care decisions
- Refer our patients to trusted experts when needed
- Provide a dedicated ***"Care Team"*** to service your child's needs in the most efficient way
- Assess and accurately document the developmental status of your child.
- Respect you and your child as partners in helping your child grow

A *"Medical Home"* means we trust you to:

- Provide us with all the information you have regarding your child's health and illnesses.
- Work together in the best interest of the child and the family
- Provide us with the most up-to-date information regarding care your child receives outside this office
- Share with us your needs and concerns as your child grows
- Keep scheduled visits or reschedule visits in advance whenever possible
- Call your doctor first with problems, unless it is a medical emergency
- Administer all of the medicine as prescribed and follow the doctor's advice
- Learn about your insurance so you know what and how it provides coverage
- Pay your share of the visit fee when your child is seen in the office
- Respect us as individuals with skills and expertise in helping your child grow

I have read the above information and agree with its content and terms:

_____

Please sign Provider Signature & Date

Medical History Questionnaire

Date	
Patient Name	

Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):	

CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (Food, Meds or Seasonal)	❑ No	❑ Yes
Acid reflux/heartburn	❑ No	❑ Yes
Anemia	❑ No	❑ Yes
Asthma/Wheezing	❑ No	❑ Yes
Asthma Action Plan	❑ No	❑ Yes
Bladder Infections / Kidney Disease	❑ No	❑ Yes
Bleeding Disorders/Hemophilia	❑ No	❑ Yes
Bone or Joint Injuries	❑ No	❑ Yes
Cancer	❑ No	❑ Yes
Chicken Pox (Year)	❑ No	❑ Yes
Dental Problems	❑ No	❑ Yes
Depression/Suicidal Thoughts	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes
Eating Disorders (Bulimia / Anorexia)	❑ No	❑ Yes
Emotional Abuse/Sexual Abuse	❑ No	❑ Yes
Emotional/Behavioral/Psychiatric Problems	❑ No	❑ Yes
Frequent Ear Infections	❑ No	❑ Yes
Head Injury	❑ No	❑ Yes
Hearing Problems	❑ No	❑ Yes
Heart Defects/Disease	❑ No	❑ Yes
Hernia	❑ No	❑ Yes
High Blood Pressure	❑ No	❑ Yes
Language Delay / Speech Problems	❑ No	❑ Yes
Lead Poisoning	❑ No	❑ Yes
Learning Disabilities (Including ADD / ADHD)	❑ No	❑ Yes
Liver Disease/Hepatitis	❑ No	❑ Yes
Migraine Headaches	❑ No	❑ Yes
Mononucleosis	❑ No	❑ Yes
Obesity/Overweight	❑ No	❑ Yes
Physical Disabilities	❑ No	❑ Yes
Pneumonia	❑ No	❑ Yes
RSV	❑ No	❑ Yes
Seizures/Epilepsy	❑ No	❑ Yes
Sexually Transmitted Infections	❑ No	❑ Yes
Sinusitis	❑ No	❑ Yes
Skin Problems/Eczema/Hives	❑ No	❑ Yes
Specialty Doctors … Has Your Child Seen?	❑ No	❑ Yes
Who?		
TB/Lung Disease	❑ No	❑ Yes
Tonsillitis	❑ No	❑ Yes
Vision Problems	❑ No	❑ Yes
Wetting (Day / Night)	❑ No	❑ Yes

Other Concerns:

Current Medication(s): List:

Reviewed by: Date:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List)	❑ No	❑ Yes	Who?
Asthma/Wheezing	❑ No	❑ Yes	Who?
TB/Lung Disease	❑ No	❑ Yes	Who?
Cystic Fibrosis	❑ No	❑ Yes	Who?
HIV/AIDS	❑ No	❑ Yes	Who?
Heart Disease	❑ No	❑ Yes	Who?
Sudden Cardiac Death	❑ No	❑ Yes	Who?
High Blood Pressure/Stroke	❑ No	❑ Yes	Who?
High Cholesterol	❑ No	❑ Yes	Who?
Blood Disorders			
Anemia	❑ No	❑ Yes	Who?
Clotting Disorders	❑ No	❑ Yes	Who?
Hemophilia	❑ No	❑ Yes	Who?
Sickle Cell	❑ No	❑ Yes	Who?
Thalassemia	❑ No	❑ Yes	Who?
Diabetes	❑ No	❑ Yes	Who?
Seizures	❑ No	❑ Yes	Who?
Mental Illness	❑ No	❑ Yes	Who?
Depression/Anxiety/Bipolar	❑ No	❑ Yes	Who?
Other	❑ No	❑ Yes	Who?
Cancer	❑ No	❑ Yes	Who?
Birth Defects	❑ No	❑ Yes	Who?
Hearing Loss	❑ No	❑ Yes	Who?
Speech Problems	❑ No	❑ Yes	Who?
Kidney Disease	❑ No	❑ Yes	Who?
Alcohol/Drug Abuse	❑ No	❑ Yes	Who?
Hepatitis/Liver Disease	❑ No	❑ Yes	Who?
Thyroid Disease	❑ No	❑ Yes	Who?
Learning Problems (Including ADD/ADHD)	❑ No	❑ Yes	Who?
Attention Deficit Disorder	❑ No	❑ Yes	Who?
Mental Retardation	❑ No	❑ Yes	Who?
Family Violence	❑ No	❑ Yes	Who?

Other Concerns:

Has any family member ever had an unexplained, unexpected death before age 50?
❑ No ❑ Yes (If yes, describe on back)

Reviewed by: Date:

continued

Medical History Questionnaire

<continued

PREGNANCY AND BIRTH HISTORY

Adopted	❑ No	❑ Yes
Prenatal care	❑ No	❑ Yes
Illnesses during pregnancy	❑ No	❑ Yes
Medications during pregnancy	❑ No	❑ Yes
Alcohol/drug abuse	❑ No	❑ Yes
Tobacco use	❑ No	❑ Yes
Problems at birth	❑ No	❑ Yes
Baby		
Jaundice	❑ No	❑ Yes
Heart Murmur	❑ No	❑ Yes
Infection	❑ No	❑ Yes
Breathing Problems	❑ No	❑ Yes
Birth Defects	❑ No	❑ Yes

Other:

Name of Hospital:

Full-Term Delivery: ❑ No ❑ Yes

Type of delivery: ❑ Vaginal ❑ C-section ❑ VBAC

Birth Weight:

Newborn Hearing Screen Passed? ❑ No ❑ Yes

Did baby receive Hep B vaccine ❑ No ❑ Yes

If Born Premature, how early?

FEEDING AND DIGESTION

Breast fed ❑ Formula ❑

Severe colic in first 3 months	❑ No	❑ Yes
Feeding problems	❑ No	❑ Yes
Takes vitamins	❑ No	❑ Yes
Constipation problems	❑ No	❑ Yes
Food allergies/issues	❑ No	❑ Yes

PSYCHOSOCIAL HISTORY

Who lives in household:

❑ Rent ❑ Own ❑ Shelter

Who cares for child:

Is child in daycare: ❑ No ❑ Yes

Type: ❑ Center

❑ Private home

Date of Birth:

Mother:

Father:

Parents divorced/separated: ❑ No ❑ Yes

Parents working:

Mother: ❑ No ❑ Yes

Father: ❑ No ❑ Yes

Parents use tobacco:

Mother: ❑ No ❑ Yes

Father: ❑ No ❑ Yes

Child use tobacco (12 years +) ❑ No ❑ Yes

Child Sleep Problems ❑ No ❑ Yes

Foster Care:

Dates: _____ _____

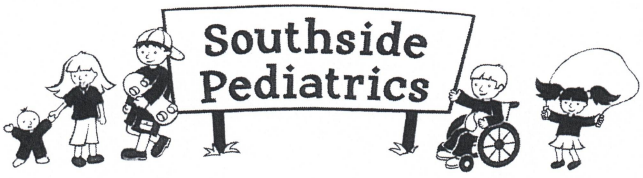
Other Languages:

MEDICAL HISTORY

Broken bones	❑ No	❑ Yes
Serious accidents	❑ No	❑ Yes
Operations	❑ No	❑ Yes
Hospitalizations	❑ No	❑ Yes

Explain:

Additional Information:



Caring for the Community One Child at a Time

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Address: _____

City _____ State_____ Zip _____

Phone _____

Parent(s)/ Guardian(s) _____

Record Release

I authorize my child's records to be sent *FROM*:

Facility Name _____

Facility Address _____

Facility Phone Number _____ Facility Fax Number _____

I authorize my child's records to be sent *TO*:

Southside Pediatrics
300 Meadow Run Dr Hasting MI 49058
P: 269-818-1020 F: 269-818-1266

Information Requested

____ **Completed Records**
____ Care Plan Only
____ Pathology Reports
____ Hospital Reports
___ History & Physical Only
___ Lab Reports Only
___ Treatment Records Only
___ Medication Records Only
___ Progress Notes Only
___ Radiology Reports Only
___ Operative Reports Only
___ Other

For the Date(s) of Service _____

The purpose/reason for this release of information is as follows:

	Transfer of Medical Record		Coordination of Care
	Insurance Claim		Litigation
	School Release		Referral
	Personal- As requested		

By signing this form, I authorize the disclosure of protected health information about my child.

1) ***I understand that the health Record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS) and or human immunodeficiency virus (HIV).***
    a. ***If I do not want these to be released, I will initial here: _____***
        i. ***Please do not release the following Records:***
        _____

2) ***I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing. This authorization shall be in forced and effective until _____ (Date or Event), at which time this authorization expires.***

3) ***I understand that information used to disclose pursuant to this authorization may be disclosed by recipient and may no longer be protected by federal or state law.***

I have read the above foregoing Authorization for Release of Medical Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

This authorization will expire (120) days from the date of my signature, unless I specify otherwise.

X_____ Date _____
Signature of Patient/ Parent/ Guardian or Authorized Representative

_____
Basis of legal authority to act for patient