PORT CITY
PEDIATRICS

A Patient Centered Medical Home

A PATIENT CENTERED MEDICAL HOME is called a "Home" because we'd like this to be the first place you think of for all of your medical needs. Our GOAL is to make it easy and comfortable to get the care you need in a way that works best for you.

Having a MEDICAL HOME means that we ask you to:

- Provide us with all of the information you have regarding your health and illnesses.
- Tell us about your needs and concerns.
- Respect us as unique individuals and as partners in your health care.
- Be involved in your medical decision making.
- Allow us to educate you about wellness and disease prevention.
- Educate yourself about the requirements of your insurance company and what services are covered.
- Follow our medical advice and treatments. If you are unable to do so, let us know why so that we can suggest other options.
- Contact us during emergencies so that we can direct you to the right care.
- Provide us with feed back so that we are able to improve our services.

As we build your MEDICAL HOME, our goal is to:

- Support you in your healthcare goals and desires.
- Respect you as an individual.
- Respect your privacy. Your medical information will not be shared with anyone unless you give us permission or it is allowed by law.
- Provide the best treatment and advice, based on current medical evidence. We respect your right to the information that we provide.
- Manage acute illness, chronic disease and give advise to help you stay healthy.
- Give you timely access to care. A medical decision- maker is available through our office 24 hours a day.
- Use computers and other technology to offer new and improved ways to provide exceptional care to you.
- Be a medical team that makes you feel welcome and comfortable.

When the process is complete, the MEDICAL HOME will feature:

- A personal physician who leads your team; treating you as a whole person.
- Use of advanced electronic tools to help us provide more efficient care and communication.
- User-friendly ways to get appointments that are convenient for you; acting as a "HUB" to arrange all of your outside care.
- Actively getting feedback from you on your satisfaction with the MEDICAL HOME.

Port City Pediatrics
Annual Patient Demographics

A separate form must be completed for each sibling. Please complete all fields pertaining to the patient.

Patient Information

Patient's Full Name: _____
Last First Middle

Date of Birth: ___/___/___ ☐ Male ☐ Female Child's SSN: _____

Address: _____
Street Number and Name City State ZIP Code

Legal Guardian Phone Number: ___-___-___ Relationship to Patient: _____

Legal Guardian Phone Number: ___-___-___ Relationship to Patient: _____

Which above phone number is your **preferred number for contact**? ___-___-___

What is your **preferred method of contact**? ☐ Email ☐ Mail ☐ Text ☐ Voicemail

Email Address: _____

Emergency Contact Name (Someone other than parent/guardian): _____

Relation to Patient: _____ Phone Number: ___-___-___

WHO HAS GUARDIANSHIP OF THE CHILD? ☐ Mother ☐ Father ☐ Both ☐ *Foster ☐ *Other

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

Mother's Name: _____ D.O.B.: ___/___/___ Employer: _____

Address: _____
Street Number and Name City State ZIP Code

Father's Name: _____ D.O.B.: ___/___/___ Employer: _____

Address: _____
Street Number and Name City State ZIP Code

Insurance Information

Who carries the primary insurance? _____ **SSN of Carrier:** ___-___-___

Address of policy holder, if different than child's: _____

Relationship to child: _____ Name of insurance: _____

Who Carries the secondary insurance? _____ **SSN of Carrier:** ___-___-___

Address of policy holder, if different than child's: _____

Relationship to child: _____ Name of insurance: _____

PARENTAL STATUS: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

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

Please bring this documentation to your scheduled appointment

Are there stepparents involved? Yes ☐ No ☐

Name: _____ D.O.B: ___/___/___

Name: _____ D.O.B: ___/___/___

Port City Pediatrics

[illegible]

- With my consent, Port City Pediatrics may use and disclose Protected Health Information (PHI) about me to carry out Treatment Payment and healthcare Operations (TPO). Please refer to Port City Pediatrics' 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 displayed in the Waiting Room (or ask the receptionist for a paper copy) prior to signing this consent. Port City Pediatrics 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 Port City Pediatrics Privacy Officer at 1455 Farr Road, Norton Shores, MI 49444.

- With my consent, Port City Pediatrics may call my home or other designated locations and leave a message via voicemail, text, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

- With my consent, Port City Pediatrics 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 as long as they are marked Personal and Confidential,

- With my consent, Port City Pediatrics may e-mail my appointment reminder cards and patient statements. Port City Pediatrics may also electronically send TPO to my insurance company and other providers involved in my case. I have the right to request that Port City Pediatrics restrict how it uses or discloses my PHI to carry out TPO.

- With my consent, Port City Pediatrics may call out my child's name in the Waiting Room when it is my child's turn to be seen by the doctor in the Examining Room.

By signing this form, I am consenting to Port City Pediatrics' use 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, Port City Pediatrics may decline to provide treatment to me or my child. I have read the notice of Privacy Practices displayed in the Waiting Room and, therefore, I am giving my consent.

______________________________   ____/____/____   ____/____/____

Patient's Name   **D.O.B.**   **Today's Date**

______________________________   ______________________________

Print Name of Patient or Legal Guardian   **Signature of Patient or Legal Guardian**

Financial Authorization

During each visit you must disclose and provide proof of all active insurance at appointment check-in to ensure all active insurance is billed for each visit. I authorize payment of medical benefits to **Richard Golz, M.D. and/or Elizabeth Pallante, M.D. and/or Karl Nicles, M.D. and/or Allison Fox, M.D. and/or Paul Alban, M.D. and/or Dustin Miller, M.D. and/or Jessica Pedersen, M.D.** for services rendered. I authorize the release of all information necessary to process claims and secure payment. My signature requests that payment be made, and I authorize the release of medical information necessary to pay the claim. In Champus cases, the physician agrees to accept the chart determination of the Champus carrier as the full charge and patient is responsible for the deductible, co-insurance, and non-covered services. A photocopy of this assignment is to be considered as valid as the original. I further understand that I am responsible for **disclosing ALL ACTIVE INSURANCE(s) during each visit.** I further understand I am financially responsible for **ALL CHARGES WHETHER OR NOT PAID** by my insurance and guarantee prompt payment until the patient account is paid in full. Failure to make payments will result in the account being sent to collections and possible dismissal from the practice.

By signing below, I acknowledge that I have read, understand, and agree to the provisions and specified terms said above regarding the Financial Authorization.

______________________________   ____/____/____

Signature of Patient or Legal Guardian   **Todav's Date**

____

Email Address

PORT CITY
PEDIATRICS

Port City Pediatrics

Authorization & Release of Medical Information

Authorization for parental consent IN THE ABSENCE OF THE PARENT/GUARDIAN for well exams, sick visits, and immunizations.

Name of Child: _____

In the event that I,_____ am unable to bring my child in for well exams, sick visits and or,
(Please print Parent/Legal Guardian's Name)
immunization visits. I give permission to the following people to bring my child in for a well exam or sick visit. These people may also sign for my child to receive his/her immunizations.

(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)

Parental consent for MEDICAL INFORMATION RELEASE

I,_____, being parent or legal guardian of below-named minor, do hereby give
(Please print Parent/Guardian's name)
my permission to the following person(s) 18yrs and older, to give or receive medical information on my child, _____.
(Child's full name)

(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)
(Name of person bringing in child)	(Phone Number)	(Relation to child)

By signing below, you are acknowledging all the above information is correct to the best of your knowledge.

(Please print Parent/Guardian's Name)	(Signature of Parent/Guardian)	(Todays Date)

Port City Pediatrics

No-Call No-Show Policy

Patients Printed Name: _____ D.O.B.: _____

It is important that we provide the best treatment to all our patients. Our physicians feel that missing an appointment could be detrimental to a child's health and not calling ahead of time to cancel also deprives other children of appointment times.

Therefore, it is the policy of Port City Pediatrics that **all appointments are canceled prior to the start of the appointment time. If the appointment is not canceled and the patient fails to show up for the appointment, this is considered noncompliance and our physicians reserve the right to dismiss the patient and family from Port City Pediatrics.**

Notifications regarding this matter will be mailed as a letter to the patient as they occur. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, I acknowledge that I have read, understand, and agree to the provisions and specified terms said above regarding the No-Call No-Show Policy.

_____ _____

Signature of Parent/Legal Guardian **Date**

Port City Pediatrics, PLC

Consent To Bill

Testing, Hearing, & Vision Screening

Patients Printed Name: _____ DOB:_____

There are tests and screenings that **can** be performed at Port City Pediatrics that may **not** be covered by insurance. **If I elect to have patient tested** and insurance does not cover, each test or screening has a fee for which I will be billed directly for. Those tests and screenings are as follows:

Tests/Charge:

Covid-19: $50

Flu A/B: $50

RSV: $40

Strep A: $35

Screenings/Charge:

Hearing: $5

Vision: $5

By signing below, I acknowledge that I have read, understand, and agree to the provisions and specified terms said above regarding the Consent to Bill Policy. I understand and agree that the Guarantor is responsible for the payment of such fees, and attest that I am the parent and/or guardian of the patient named above.

_____ _____

Signature of Patient/Legal Guardian **Date**

Port City Pediatrics

Michigan Department of Health & Human Service's State Innovation Model Questionnaire

We are complying with the Michigan Department of Health and Human Services' State Innovation Model. Please circle the appropriate answer to the following questions **from your family's viewpoint**. If the question does not apply to your child, i.e., job/ source of income, please answer from your family's point of view. Thank you for your participation.

DATE OF VISIT:_____/_____/_____

PATIENT'S NAME:_____ DATE OF BIRTH:_____/_____/_____

Domain	Question	Response		
Health Care	In the past month, did poor physical or mental health keep you from doing your usual activities, like work, school, or a hobby?	☐ Yes	☐ No	☐ N/A
	In the past year, was there a time when you needed to see a doctor but could not because it cost too much?			
Food	Do you ever eat less than you feel you should because there is not enough food?	☐ Yes	☐ No	☐ N/A
Employment & Income	Do you have a job or other steady source of income?	☐ Yes	☐ No	☐ N/A
Housing &Shelter	Are you worried that in the next few months, you may not have safe housing that you own, rent, or share?	☐ Yes	☐ No	☐ N/A
Utilities	In the past year, have you had a hard time paying your utility company bills?	☐ Yes	☐ No	☐ N/A
Education	Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?	☐ Yes	☐ No	☐ N/A
Transportation	Do you have a dependable way to get to get to work or school and your appointments?	☐ Yes	☐ No	☐ N/A
Clothing & Household	Do you have enough household supplies? For example, clothing, shoes, blankets, mat resses, diapers, toothpaste, and shampoo?	☐ Yes	☐ No	☐ N/A
Childcare	Does getting childcare make it hard for you to work, go to school or study?	☐ Yes	☐ No	☐ N/A
Eldercare	Does getting eldercare make it hard for you to work, go to school or study?	☐ Yes	☐ No	☐ N/A
Personal and Environmental Safety	Do you feel safe in your current home environment or surroundings	☐ Yes	☐ No	☐ N/A
General	Would you like to receive assistance with any of these needs?	☐ Yes	☐ No	☐ N/A
	Are any of your needs urgent?	☐ Yes	☐ No	☐ N/A