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.
    - *Immunization Compliance: It is our expectation that patients follow the immunization schedule as recommended by their doctor. Choosing not to follow doctor-guided medical recommendations regarding immunizations may result in dismissal from the practice, as it impacts the patient–doctor relationship. If you are unable to comply with the schedule, please inform your doctor.*
- 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 PLC

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 understand that I am responsible for contacting patients current insurance company to confirm coverage for all immunizations and services rendered. I authorize payment of medical benefits to **and/or Paul Alban, M.D., and/or Lauren Donley, D.O., and/or Alison Fox, M.D., and/or Richard Golz, M.D., and/or Dustin Miller, M.D., and/or Karl Nicles, M.D., and/or Jessica Pedersen, M.D.** for all immunizations and 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.

Print Name of Patient: _____ Date of Birth:_____/_____/_____

Email Address: _____

Signature of Patient of Legal Guardian: _____ Today's Date:_____/_____/_____

Port City Pediatrics PLC

No-Call No-Show Policy

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

At Port City Pediatrics, we are committed to providing the highest level of care to all of our patients. As ***we operate strictly by appointment,*** it is essential that we manage our schedule to ensure timely and efficient care for everyone. Please note the following:

- *We do not accept walk-in appointments.*
- *We do not perform walk-in testing or other services.*

Our physicians believe that missing an appointment can have a negative impact on a child's health, and that failure to cancel an appointment in advance limits access to care for other children who may need it. Therefore, it is our policy that all appointments must be canceled prior to the scheduled time. Failure to cancel an appointment and not showing up will be considered noncompliance with our policies. In such cases, our physicians reserve the right to dismiss the patient and family from Port City Pediatrics. If this occurs, a letter will be mailed to the family outlining the situation.

Please note, we do not allow patients to switch doctors within our practice for any reason.

Thank you for your cooperation and understanding as we work to provide the best possible care for all of our patients.

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined in this 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:	Screenings/Charge:
Covid-19: $50	**Hearing**: $5
Flu A/B: $50	**Vision**: $5
RSV: $40	
Strep A: $35	
Gene Testing: $15	

CHECK & SIGN ONLY ONE BOX BELOW

☐ **CONSENT:** By checking this box and 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**

☐ **DECLINE:** By checking this box and signing below, I acknowledge that I have read and understand the provisions and specified terms said above regarding the Consent to Bill Policy however, I decline to consent to testing or screening charges. I understand and agree that I do not want Port City Pediatrics to perform any of the testing and screening noted above and I do not consent to billing for charges named above.

_____ _____

Signature of Patient/Legal Guardian **Date**

Port City Pediatrics PLC

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 PLC

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 Patient or 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/Legal 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 Legal Guardian's Name)	(Signature of Legal Guardian)	(Todays Date)

Port City Pediatrics PLC

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 work or school and your appointments?	☐ Yes	☐ No	☐ N/A
Clothing & Household	Do you have enough household supplies? For example, clothing, shoes, blankets, mattresses, 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 & 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