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Internal Medicine and Pediatrics of Bloomfield, PC

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Pediatric Registration Information

Last Name______________________________ First Name_________________________ MI_____

Date of Birth_____/_____/_____ Age______

Address___________________________________City______________ State_____ Zip___________

Cell Phone (______)________________ Home Phone (_______)____________________

Work Phone (______)___________________ext._____ Email ______________________________
Please circle which number is best for us to reach you: **Cell** **Home** **Work**

Emergency Contact:______________________ Relationship____________ Phone ______________
Can we discuss your medical/financial information with anyone? **Yes** or **NO**
If so, who?___________________________ Relationship____________ Phone _____________

Local Pharmacy Name____________________ Address ________________Phone_____________

Mail Order Pharmacy______________________Address_________________Phone_____________

Please circle which race best represents you: **White /African-American/Asian/Other:**_____________________
Please circle which ethnicity best represents you: **Hispanic/Latino** **Other:**____________________________
What Language is spoken in home: ____
Marital Status: **Single** **Married** **Divorced** **Widowed** **Separated**

Insurance Information

Primary Insurance:____

Subscriber Name:__________________________________DOB__________

Patient relationship to subscriber: **Self** **Spouse** **Parent** **Child** **Other**____________________

Secondary Insurance:____

Primary Insurance:____

Subscriber Name:__________________________________ DOB__________
Patient relationship to subscriber: **Self** **Spouse** **Parent** **Child** **Other**__________

Referral Source – How did you learn about our practice?
Newspaper **Phonebook** **Brochure** **Radio** **Other**______

Physician Referral____
Name

Friend or Family Member____
Name

Authorization for release of medical records and assignment of benefits

I hereby authorize the release of medical information necessary to process insurance claim forms. In addition, I request claims be submitted on my behalf and payment for services rendered be directly made to Internal Medicine and Pediatrics of Bloomfield, PC. I understand that I am financially responsible for amounts applied to insurance policy deductibles and co-payments not covered by my insurance company.

Patient Signature/Guardian Signature______________________________ Date______________

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Internal Medicine and Pediatrics of Bloomfield, PC

This is an agreement between Internal Medicine and Pediatrics of Bloomfield, PC, located at 1109 W. Long Lake Road, Bloomfield Hills, MI 48302 and ______________________________ located at ______________________________.

Name Address

In this agreement the words "you", "your", and "yours" means the patient. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refers to Internal Medicine and Pediatrics of Bloomfield, PC.

By executing this agreement, you agree to pay for all services that are received as well as the following and subject to all of the terms and conditions set forth herein.

Co-payments: Any co-payments required by an insurance company must be paid at the time of service as required by your insurance company, we cannot waive these fees.

Deductibles: Patients who have a high deductible insurance policy will be required to pay a portion of the office visit at the time of service. You will be responsible for the difference of the fee collected on the day of service and the amount billed to your insurance company.

Premium Fee: An afterhours fee of $30 will be charged to your account for visits after 5pm Monday thru Friday and on the weekends.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charges, if any, and any payments or credits applied to your account during the month.

Statement Fee: A billing fee of $10 will be imposed on each statement that is sent to Patient due to Patient's non-payment on the date of service. After the third consecutive statement with no Patient response, we will no longer be able to see you in our office, and you will be sent to collections. A $25 fee will be attached to each additional statement sent for unpaid balances.

Payment: I assign and authorize payment from my insurance company directly to Internal Medicine and Pediatrics of Bloomfield, for any and all services rendered. I agree to pay, at the time of service or on an interim basis (agreed upon by Internal Medicine and Pediatrics), all charges not covered by my insurance company. I understand that it is my primary responsibility to pay Internal Medicine and Pediatrics of Bloomfield, PC all charges for services rendered irrespective of any disputes or disagreements between me and my insurance company.

Payment Options: You may choose to pay by cash or credit card on the day that treatment is rendered. No checks are accepted at the time of service.

Charges to Account: No charges to your account at any time. All visits would then need to be paid at the time of service, in full.

Past Due Accounts: If your account becomes past due, we will take any legal steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. There will also be a 30% additional cost added to your balance. If we have to refer collection of the balance to a lawyer, you agree to pay all actual attorney fees which we incur plus all court costs and other charges. In case of suit, you agree that such venue shall be the courts in Oakland County, Michigan.

Missed Appointments: Patients with two consecutive missed appointments may be discharged from the practice. Patients who do not keep their appointment will be charged a cancellation fee of $25. If this fee is not paid before the next visit, patient will not be seen until this is taken care of. Patients who do not cancel 24 hours prior and no show for their wellness appointment will be charged $50 and will be applied to their balance

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, it is due at the time of service rendered. It is the insurance company that makes the final determinations of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company or denial of claim.

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Non-Contracted Insurance: Your insurance policy is a contract between you and your insurance company. If we are NOT a party to this contract, we will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you have received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parents' responsibility to collect from the other parent.

Transfer of Records: You will need to make a written request and pay a $50 fee to pick up a copy of your records. If you are requesting your records to be transferred from another doctor or organization to us, you must authorize us to receive all relevant information, including your payment history.

Master Medical: If you have master medical, you will be required to pay all of your office visit fees at the time of service. We will bill BCBS as a courtesy in order for you to be reimbursed by the carrier.

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions herein and the agreement will be in full force and effect.

Patient Name: ______________________ Responsible Party: __________ (if not the patient)
Patient Signature: ______________________ Date: ______________________

Address:
1109 W. Long Lake Rd.
Bloomfield Hills, MI 48302

Contact:
Phone: 248-723-2400
Fax: 248-723-5785

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GENERAL CONSENT TO TREATMENT

Patient's Name: ______________________________ **Date of Birth**________________

1. **Consent:** I request and authorize medical or surgical treatment deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include diagnostic, radiology and laboratory procedures, blood transfusions, anesthesia, therapeutic procedures, drugs, and medical, nursing and hospital care.
2. **Release of Information**: I, as a patient of Internal Medicine and Pediatrics of Bloomfield, am aware and clearly understand that in the course of providing care, providers will share patient information with other providers who are involved in the patient's care, as appropriate. I authorize Internal Medicine and Pediatrics of Bloomfield to release pertinent information and/or copies of medical records for treatment, payment or health care operations purposes. I understand such information may include Human Immunodeficiency Virus (HIV), AIDS Related Complex (ARC), Acquired Immunodeficiency Syndrome (AIDS), Hepatitis, substance abuse, psychiatric/psychological services records, and social work records, if any. See Notice of Privacy Practices for further information.
3. **Human Immunodeficiency Virus (HIV) and Hepatitis B (HBV) Testing**: I understand and agree that, in accordance with State Law, and HIV or HPV test may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of my test will be treated confidentially.
4. **Testing and Disposal of Specimens and Tissues:** I authorize William Beaumont Hospital to retain, preserve, or use for research, scientific or teaching purposes or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.
5. **No Guarantees:** I am aware that the practice of medicine and surgery are not an exact science and I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment which I have hereby authorized.

I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.

_______________ ____

Date *Signature of patient/parent (if patient is a minor)/legal guardian/patient advocate/closest relative (if patient is unable to consent)*

______________________________ ______________________________

Signature of Witness *Please indicate relationship*

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Internal Medicine & Pediatrics of Bloomfield, PC

Pediatric History Form

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Name:______________________ Date of Birth:__________________

FAMILY MEDICAL HISTORY

Have any members of your family (parents, brothers, sisters, grandparents, aunts, uncles) ever had:

	YES	NO
High Blood Pressure		
Heart Trouble		
Diabetes		
Arthritis		
Tuberculosis		

	YES	NO
Cancer		
Asthma		
Mental Disorders		

Other ______________________

____

Birth and Development:

Term (# of weeks):__________ Delivery (Vaginal or C-section):__________ Birth Weight:__________

Condition at Birth______________________

Condition 1st week:______________________

Feeding:______________________ Cyanosis:______________

Convulsions:______________________ Jaundice:______________

Sat Up:____________ Stood:____________ Walked:______________

Short Sentences:__________ First Teeth:__________

Potty Training:________ Bladder:____________ Bowels:______________

Has your child ever had:

	YES	NO
Acid Reflux		
Anemia		
Asthma		
Behavior Problem		
Bleeding Disorder		
Chicken Pox		
Concussion		
Diabetes		
Ear Infections		
Headaches		
Heart Disease		
Heart Murmur		
Hepatitis		
Kidney Disease		
Pneumonia		
Rheumatic Fever		
Scarlet Fever		
Seasonal Allergies		
Seizure Disorder		
Sickle Cell		
Skin Irritation		
Thyroid Disease		
Urinary Tract Infection		

Past Surgeries: ______________________

____

____

Current Medications: ______________________

____

____

____

Medication Allergies: ______________________

____

Social History

Household Members: ______________________

(including pets) ______________________

____

____

____

____

____

Cigarette Use YES NO Years Smoked __________

Packs Per Day __________

Alcohol Use YES NO Drinks Per Day __________

Drug Use YES NO Date Last Used__________

Type of Drug ______________________

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How To Get Lab and Imaging Test Results

1. Signing for the patient portal is easy.

An email will be sent to your email address with a link.

(If you deleted/lost the email, please ask the front desk to resend it.)

Sign up for patient portal **ONLY** through the email we send you titled **"Follow My Health."**
You must sign up by **clicking on this email from a computer, tablet or, smartphone.**
Do not register from our website.
Follow the steps to register from the patient portal. You can create an account with the FMH secure log in, or login through an existing account like Google or Yahoo. With an existing account it may be easier to remember your password.
Signing up with FMH secure login: Password should be at least 8 characters in length, and include at least one numeric and one special character, such as !@#$%^&*-(
Write down your password in a secure spot.
The first time you log into the app, you will be prompted to enter your 4 digit invitation code to verify that it is you. It will be 1234.

2. Download app for your phone for easy access to the patient portal.

In your app store search: **"Follow My Health"** and download and open and login.
The app name appears exactly as FollowMyHealth® Mobile

3. Once registered, check your labs online: https://www.followmyhealth.com/

Or access from our website: www.medpedsdoc.com – click the patient portal tab on the left.

4. Lab results protocol:

All lab results will be released to the Patient Portal once reviewed by the physician, typically within 1-3 business days.If not on the patient portal, labs are released via mail 7 days after the blood draw. Only urgent abnormal labs are resulted by telephone.
We strongly encourage all patients to register for the patient portal.

5. The patient portal is not monitored as an inbox. Do not reply to messages or send questions through this way. The patient portal is used for outgoing messages only, although it does allow them to go through. For medical questions please call our office (248) 723-2400, or for medical emergencies call 911 or go to the ER.

Thank you for taking responsibility for your health.
The healthiest people are active and knowledgeable about their medical care!

I understand and agree to the above policies: ____________________Date: ______

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