|  |
| --- |
| **Patient’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****D.O.B. \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Sex: □ M □F Primary Phone Number: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **RACE** □ American Indian or Alaska Native □Asian □ White □ Africa American □ Native Hawaiian □ Other □ Refused to disclose.**ETHNICITY** □ Hispanic or Latino □ Not Hispanic or Latino □ Refused to disclose  |
| **Mailing Address**  | **City** | **State** | **Zip** |
| **Email for Patient Portal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Mother’s Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** **Cell Phone: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **Father’s Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_** **Cell Phone: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |

**TODAY’S DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| PRIMARY INSURANCE  |  **SECONDARY INSURANCE**  |
| **Insurance Company Name** | **Insurance Company Name** |
| **Address****Phone #:**  | **Address****Phone #:** |
|  **Identification Number Group Number** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  **Identification Number Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Insured Name Insured Date of Birth** | **Insured Name Insured Date of Birth** |
| **Patient’s relationship to insured: Insured’s Social Security Number****□Self □Spouse □Dependent \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Patient’s relationship to insured: Insured’s Social Security Number:****□Self □Spouse □Dependent \_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pharmacy Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**EMERGENCY CONTACT AND AUTHORIZATION FOR NON-PARENT/GUARDIAN TO**

**ACCOMPANY PATIENT, SPEAK TO DOCTOR/STAFF, GIVE AUTHORIZATION TO TREAT, MEDICATE, VACCINATE, AND MAKE GENERAL HEALTH DECISIONS REQUESTED** **BY TH DOCTOR. THE PERSONS LISTED BELOW WILL NEED TO PRESENT A PHOTO IDENTIFICATION AT TIME OF SERVICE**

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship to patient** | **Cell Phone**  |
| **Name** | **Relationship to patient** | **Cell Phone**  |
| **Name** | **Relationship to patient** | **Cell Phone**  |

**Greater Beaumont Pediatrics and Family Medicine Consent Form**

**Assignment and Release of Financial and Medical Records**

I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release all information contained in my financial and medical records to my insurance company, health plan, or any other person or entity that is responsible for paying or processing for payment any portion of my bill. I understand that I am totally responsible for payment of all fees and services rendered. I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient or Authorized Person’s Signature Date

**PATIENT’S NAME: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TODAY’S DATE: \_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

**Financial Obligation**

I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and I fully understand that I am fully responsible for payment of all fees and services rendered, regardless of insurance coverage or other responsibilities and ultimately responsible for payment in full if my insurance company does not pay in a timely manner.

#### Divorce/Custody/Adoption Case Policy

The parent or guardian who brings the patient into our office will be held financially responsible, regardless of the provisions in the divorce decree, or who has custody, or who has the insurance. To provide the best medical care, we ask that you do not discuss your account balance or financial aspects with the physician(s) or medical staff. Please discuss any account information with the front desk. If parent or guardian exclusions are stated in any court order, you must provide the order for documentation for the patient’s safety. A court order is required for the patient’s chart for all adoptions and guardian assignments outside of the biological parents.

**Annual Wellness/Physical Policy**

* All patients are required to have an annual well exam regardless of the need for vaccines. Any patient that fails to have annual physical TWO consecutive years will be considered NOT COMPLIANT and might not be able to schedule any appointment with this practice.
* If a patient has any symptoms or treatment other than wellness, the annual check-up could be rescheduled for a later date and the copay (if applicable) will be applied.

**Vaccination Policy**

The providers at this facility follow the required and recommended vaccines according to the schedule published by the centers for disease control (CDC) and the American Academy of Pediatrics (AAP). I acknowledge and consent to the above policy unless otherwise indicated.

**No Show Policy**

Patients must give us advance notice if they need to reschedule their appointments. A “No Show” of $25 could be applied to missed appointments that are not canceled 24 hours in advance. If any family member exceeds more than **3” No Shows”,** the family may be subjected to dismissal from the practice effective 30 days past the last no show appointment.

## Consent For Treatment

I hereby authorize the providers, nurses, medical assistants, and staff to conduct examinations, administer treatment and medications as they deem necessary and advisable. I consent to the use and disclosure of my/the patient’s protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care procedures consistent with Dr. Ramona Ataya-Dakour Notice of Privacy Practices. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

## Authorization for Release of Information

1. Can we leave results to internal and external office testing or referrals in voicemail? □ Yes □ No

# Advanced Practice Nurse Consent for Treatment

This facility has on staff an advanced practice nurse to assist in the delivery of medical care.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

**PATIENT’S NAME: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TODAY’S DATE: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

# Advanced Practice Nurse Consent for Treatment

This facility has on staff an advanced practice nurse to assist in the delivery of medical care.

An advanced practice nurse is not a doctor. An advanced practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advanced practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advanced practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advanced practice nurse for my health care needs.

I understand that at any time I can refuse to see the advanced practice nurse and request to see a physician.

**Permission for Telehealth Visits**

Telehealth is a way to visit with health care providers, such as your doctor or nurse practitioner.

* You can talk to your provider from any place, including your home.
* Your provider may decide you still need an office visit.
* Your provider will tell you if someone else from their office can hear or see you.
* We use telehealth technology that is designed to protect your privacy.
* If you use the internet for telehealth, use a network that is private and secure.
* There is a small chance that someone could use technology to hear or see your telehealth visit.
* You can stop using telehealth anytime, even during a telehealth visit.
* You can still get an office visit if you no longer want a telehealth visit.
* A telehealth visit will cost the same as an office visit.

 If you decide you do not want to use telehealth again, please call 409-832-1225. By signing this document, you agree that:

* We talked about the information in this document.
* We answered all your questions.

I have read each of the statements above and authorize, understand, and agree to each statement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

 Patient or Authorized Person’s Signature Date

|  |  |  |
| --- | --- | --- |
| **Patient's Information** | **Child's Medical History** | **Mother** |
| **Patient's Name:** | **Prenatal care provider:** |
| **D.O.B:**  | **Trimester prenatal care began: —1 —2 — 3** |
| **Place of Birth:** | **Number of living children —** |
| **Birth Weight: lb oz** | **Mother's age at birth —** |
| **Birth Length: inches** | **Vitamins**  | **— YES — NO** |
|  **Biological Adopted Stepchild Guardian** | **Iron**  | **— YES — NO** |
| **Hours of labor:**  | **New Born Hearing Test (in hospital)**  | **Number of years between previous pregnancy and this child:**  |
| **Delivery: \_\_\_\_\_\_\_\_\_\_\_\_ weeks** | **\_\_ Normal**  | **\_\_ Abnormal**  |
|  **1. Newborn Blood Screening**  | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Hepatitis** | **— YES — NO** | **Maternal Complications** |
|  **2. Newborn Blood Screening**  | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Immunization Current** | **— YES — NO** |
| **Nursery** | **Dental Care Current** | **— YES — NO** |
| **Type of delivery:** | **Trauma/Injury** | **— YES — NO** |
| **Vaginal Caesarean** | **Hospitalization** | **— YES — NO** |
| **Age at Discharge: \_\_\_\_\_\_\_\_\_\_\_days** | **Medications** | **— YES — NO** | **Vaginal bleeding**  | **— YES — NO** |
| **Complications: Breech Multiple birth Other** | **Anemia** | **— YES — NO** | **Anemia/Blood disorder**  | **— YES — NO** |
| **BIRTH** | **Early Childhood Caries** | **— YES — NO** | **Hypertension**  | **— YES — NO** |
| **Difficulty with initial breathing**  | **— YES — NO** | **Ear Infections** | **— YES — NO** | **RH Negative**  | **— YES — NO** |
| **Heart Murmur**  | **— YES — NO** | **Bladder/Kidney Inf.** | **— YES — NO** | **Diabetes**  | **— YES — NO** |
| **Infection**  | **— YES — NO** | **Strep Throat** | **— YES — NO** | **Premature labor**  | **— YES — NO** |
| **Transfusion**  | **— YES — NO** | **Pneumonia** | **— YES — NO** | **Injury/Surgery**  | **— YES — NO** |
| **Seizures**  | **— YES — NO** | **Developmental Delay** | **— YES — NO** | **Flu like illness**  | **— YES — NO** |
| **Jaundice req. treatment**  | **— YES — NO** | **Vision/Hearing Problem** | **— YES — NO** | **Alcohol**  | **— YES — NO** |
| **Referral Made**  | **— YES — NO** | **Seizures** | **— YES — NO** | **Street Drugs**  | **— YES — NO** |
| **Muscle/Bone disease**  | **— YES — NO** | **Toxin/Lead Exposure** | **— YES — NO** | **Kidney Problems**  | **— YES — NO** |
| **Childhood Hearing Impairment**  | **— YES — NO** | **Allergies** | **— YES — NO** | **STDs**  | **— YES — NO** |
| **Inherited/Genetic Diseases**  | **— YES — NO** | **Asthma** | **— YES — NO** | **Hepatitis (A, B, C)**  | **— YES — NO** |
| **Major birth defects**  | **— YES — NO** | **Eczema** | **— YES — NO** | **Exposure to TB**  | **— YES — NO** |
| **Tuberculosis**  | **— YES — NO** | **Substance Abuse** | **— YES — NO** | **Dental Disease**  | **— YES — NO** |
| **Psychiatric Disorders**  | **— YES — NO** | **Alcohol** | **— YES — NO** | **OTC Meds**  | **— YES — NO** |
| **Physical/emotional/sexual abuse**  | **— YES — NO** | **Drugs** | **— YES — NO** | **Prescription MEDs**  | **— YES — NO** |
| **Domestic violence**  | **— YES — NO** | **Tobacco** | **— YES — NO** | **Tobacco**  | **— YES — NO** |
| **Other**  | **— YES — NO** | **Other** | **— YES — NO** | **Caffeine**  | **— YES — NO** |