DOWNRIVER PEDIATRICS
23050 WEST RD SUITE 110
BROWNSTOWN MI 48183

PATIENT INFORMATION

Date: _____

Child 1: _____ **DOB:** _____ **Gender:** _____

Child 2: _____ **DOB:** _____ **Gender:** _____

Child 3: _____ **DOB:** _____ **Gender:** _____

Child 4: _____ **DOB:** _____ **Gender:** _____

Address: _____

Street *City* *State* *Zip*

PARENT/GUARDIAN INFORMATION

Parent/Guardian: _____ **DOB:** _____ **Gender:** _____

Relationship to patient: _____

Address the same as patient? ☐

Address: _____

Street *City* *State* *Zip*

Phone: _____ **Social Sec #:** _____ **Marital Status:** _____

Employer: _____ **Occupation:** _____

Parent/Guardian: _____ **DOB:** _____ **Gender:** _____

Relationship to patient: _____

Address the same as patient? ☐

Address: _____

Street *City* *State* *Zip*

Phone: _____ **Social Sec #:** _____ **Marital Status:** _____

Employer: _____ **Occupation:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder's Name: _____ **DOB:** _____ **Relationship to patient:** _____

Insurance Name: _____ **Insurance ID Number** _____

SECONDARY INSURANCE

Policy Holder's Name: _____ **DOB:** _____ **Relationship to patient:** _____

Insurance Name: _____ **Insurance ID Number** _____

DOWNRIVER PEDIATRIC ASSOCIATES, P.C.

23050 WEST ROAD SUITE 110 BROWNSTOWN MI 48183-1468

PHONE 734-671-9800 FAX 734-671-7690

WHEN YOUR CHILD NEEDS TO SEE A DOCTOR, BUT YOU CAN NOT BE THERE

IF YOU CANNOT BRING YOUR CHILD TO THE DOCTOR FOR AN APPOINTMENT, YOU CAN SEND THEM WITH ANOTHER PERSON WHO IS ATLEAST 18 YRS OLD AND HAS YOUR PERMISSION TO ALLOW TREATMENT OR MAKE DECISIONS. AN EXAMPLE WOULD BE IF YOUR CHILD HAS A CROUPY COUGH AND A FEVER, THE DOCTOR MAY WANT TO RUN SOME LAB WORK OR DO A CHEST X-RAY. IN THIS CASE THE PERSON WHO COMES TO THE OFFICE WOULD HAVE TO GIVE PERMISSION FOR THE PROPER TEST TO BE DONE.

BY LAW, THE DOCTOR CANNOT TREAT YOUR CHILD, EXCEPT FOR A LIFE THREATENING SITUATION, WITHOUT THE BIOLOGIC PARENT OR A GUARDIAN WITH PROPER PAPERS. PLEASE LIST ANY STEP-PARENTS ON THIS FORM ALSO BECAUSE THEY ALSO DO NOT HAVE ANY LEGAL RIGHTS TO MAKE DECISIONS ABOUT YOUR CHILDS CARE. ADOPTIONS OR LEGAL GUARDIANSHIPS NEED TO HAVE THE PROPER LEGAL DOCUMENTATION TO BE PLACED ON FILE IN OUR OFFICE.

PATIENT NAME: LAST FIRST DATE OF BIRTH

THE UNDERSIGNED GRANTS TO THE INDIVIDUALS LISTED BELOW THE LIMITED POWER OF ATTORNEY TO ACT FOR ME, IN MY ABSENCE, FOR THE APPROVAL OF MEDICAL CARE, DIAGNOSIS AND TREATMENT. THIS INCLUDES, BUT NOT LIMITED TO:

* HEALTH MAINTENANCE VISITS (ROUTINE PHYSICALS, IMMUNIZATIONS AND IN OFFICE LABS)
* ACUTE ILLNESS (OFFICE CARE AND TREATMENT)
* VERBAL COMMUNICATION (ADVISE AND TREATMENT RECOMMENDATIONS)

1. _____
NAME OF RESPONSIBLE ADULT RELATIONSHIP PHONE NUMBER

2. _____
NAME OF RESPONSIBLE ADULT RELATIONSHIP PHONE NUBMER

3. _____
NAME OF RESPONSIBLE ADULT RELATIONSHIP PHONE NUMBER

_____
SIGNATURE OF PARENT OR LEGAL GUARDIAN REATIONSHIP TO PATIENT DATE

DOWNRIVER PEDIATRIC ASSOCIATES P.C.

CANCEL/NO-SHOW POLICY

We are committed to prompt service and will work very hard, barring emergencies, to stay on time. This policy has been established to improve appointment availability and access to care for our patients.

Parents are asked to call and cancel an appointment by 5 pm the night before for appointments scheduled before 10am, or to call by 9 am the day of the appointment for appointments scheduled after 10am. After these times you will be marked as a Late Cancellation. There will be a fee for late cancellation. A courtesy call to us should be made regardless of the time of the appointment. If we do not receive notice from the parent, the visit will be considered a No-Show. Please keep in mind that missing or cancelling appointments at the last minute leaves other patients being unable to be seen.

If you No show for a double 20 minute appointment (longer appointments for two children) you will no longer be able to schedule double 20 minute appointments.

New patients that No-Show for their first scheduled new patient appointment will not be allowed to be a patient at our practice.

Note: If you arrive late for your appointment, we will ask you to reschedule. Time management in a physician office is often a frustration to patients, staff and providers. We realize this and ask for your help and understanding. There will be a fee for late no shows.

There is a fee for a no show appointment. Patients who consistently fail to present themselves for scheduled appointments will be considered a chronic no-show. Three no-shows within a 365 day period will result in dismissal of the family from Downriver Pediatric Associates, P.C.

Parent Signature: _____ Date: _____

NAMES OF CHILDREN SEEN IN THIS OFFICE:

_____ _____

_____ _____

_____ _____

10/01/2014

Downriver Pediatrics
23050 West Rd Suite 110
Brownstown, MI 48183

Vaccine Policy

At Downriver Pediatrics, we respect parents' rights to make informed decisions regarding their child's healthcare, including the choice to decline recommended immunizations. However, as a practice, we strongly support the childhood vaccination schedule endorsed by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP), as it is based on sound scientific evidence and designed to protect children from serious and preventable diseases.

Our physicians will discuss the importance, safety, and effectiveness of vaccines at each well-child visit. We encourage open dialogue and are committed to addressing all questions and concerns with respect and transparency.

If, by your child's 2-month well visit, you have decided not to begin the recommended immunization schedule, we will respectfully ask that you transfer care to another healthcare provider whose philosophy aligns more closely with your own. This policy is in place to ensure we can provide the safest environment possible for all our patients, especially those who are medically vulnerable.

Modified Scheduling: Downriver Pediatrics may honor parent requests to offer immunizations on a non-standard schedule (i.e., fewer immunizations at one time), following discussion with a medical provider. However, parents will be asked to (i) acknowledge and sign that this altered schedule is counter to expert guidance and may place their child at risk for serious illness or event death, and (ii) release Downriver Pediatrics from all associated liability.

Thank you for your understanding and for partnering with us in your child's health. Your signature below states understanding of this policy.

Signature: _____ **Date:** _____

Downriver Pediatric Associates P.C
23050 West Road Suite 110 Brownstown MI 48183
Phone: 734-671-9800 Fax: 734-671-7690

Dionisia A. Sy M.D., F.A.A.P.
Melissa Wylie D.O.
Andrew Dettore D.O.

Insurance Agreement Form

Your insurance company may reimburse you for fees you have paid to this office for services rendered. Having insurance is not a substitute for payment. Many insurances have fixed allowances or percentages based on your contract with them, not with our office. PAYMENT IS DUE AT THE TIME OF SERVICE WHICH INCLUEDS ALL CO-PAYS AND ANY BALANCE ON THE ACCOUNT WILL HAVE TO BE PAID IN FULL OR THE APPOINTMENT WILL BE RESCHEDULED. We will assist you in receiving insurance reimbursement, but you are responsible for any co-pays, deductible, co-insurance, and any other balances not paid for by your insurance company.

I realize that it is my responsibility to keep the office informed and updated on all insurance changes.

I hereby authorize my insurance benefits to be paid to Downriver Pediatric Associates, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature _____

Date _____

Children Seen in Office:

_____ _____

_____ _____

_____ _____

Downriver Pediatric Associates PC

23050 West Rd Suite 110

Brownstown, MI 48183

Notice of Privacy Practices

Name of Patient (print): _____

Date of Birth: _____

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices (upon request) for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative:

_____

Relationship to patient:

_____

Date: _____ Time: _____