Cascade Pediatrics

Access our Patient Portal & Facebook through our website
www.cascadepediatrics.com

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's Last name: First: MI:		Date of Birth: Age:	Sex: M or F
Preferred Name: Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White	Preferred Language:	
Address City State Zip		Reminder Call: CALL or TEXT (**please select one)** Primary Phone: Secondary Phone:	
With whom does the child reside?		Physician:	

SIBLING INFORMATION

Patient's Last name: First: MI:		Date of Birth: Age:	Sex: M or F
Preferred Name: Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White	Preferred Language:	
With whom does the child reside?		Physician:	
Patient's Last name: First: MI:		Date of Birth: Age:	Sex: M or F
Preferred Name: Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White	Preferred Language:	
With whom does the child reside?		Physician:	
Patient's Last name: First: MI:		Date of Birth: Age:	Sex: M or F
Preferred Name: Preferred Pronouns:		Gender Identity:	Orientation:
Ethnicity: Hispanic / Non-Hispanic / Unknown	Race: American Indian / Asian / Black / Hawaiian / White	Preferred Language:	
With whom does the child reside?		Physician:	

CONTACT INFORMATION

Parent # 1 Last Name: First: MI:		Date of Birth:	Employer:
Address (if different than above):			
Home Phone:	Cell Phone:	Work Phone:	
E-Mail:			
Parent # 2 Last Name: First: MI:		Date of Birth:	Employer:
Address (if different than above):			
Home Phone:	Cell Phone:	Work Phone	
E-Mail:			

OVER →

Emergency Contact: (Other than parents)

Last Name:	First:	Relation:	Home Phone: Cell Phone:
Last Name:	First:	Relation:	Home Phone: Cell Phone:

Are there any legal restrictions that would restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? YES or NO

***If yes, please explain and provide a copy of any legal paperwork that supports this restriction: _____

INSURANCE

(Please give your insurance card to the receptionist.)

Primary Insurance: Subscriber's Last Name:	First:	MI:	Date of Birth:
Insurance Carrier:	Subscriber ID:		Group #:
Secondary Insurance: Subscriber's Last Name:	First:	MI:	Date of Birth:
Insurance Carrier:	Subscriber ID:		Group #:

I authorize payment of medical benefits by the insured directly to Cascade Pediatrics. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services within 30 days unless a payment plan is negotiated in advance. I authorize Cascade Pediatrics to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Patient/Guardian signature Date

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a cutaneous, mucous membrane or open wound exposure to blood or other body fluids from my family member that a HIV and Hepatitis-B (HBV) blood test will be performed.

Patient/Guardian signature Date

AUTHORIZATION FOR SPECIFIC CONFIDENTIAL COMMUNICATION

Is it ok to leave a detailed message including medical information on your voicemail? Yes _____ No _____ List Phone #: _____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to (other than *parent/guardian*):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care/Treatment Level of Information: _____
- ☐ Billing Information
- ☐ Pick up PHI (such as prescriptions, billing statements, labs, etc.)
- ☐ Other (Specify in detail – appointments: such as date of service, type of service, level of detail to be released, origin of information, etc.)

_____

_____

_____

This authorization shall be in force and effect and expires in 12 months or until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Cascade Pediatrics 5150 Cascade Rd SE, Suite B, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient/Guardian signature Date

Medical History Questionnaire

Date:_____

Patient Name:_____DOB:_____Sex: M F

CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (List)_____	Y	N
_____		
Asthma/Wheezing	Y	N
Asthma Action Plan	Y	N
Pneumonia	Y	N
Chicken Pox (Year)	Y	N
Frequent Ear Infections	Y	N
Vision Problems	Y	N
Hearing Problems	Y	N
Skin Problems/Eczema/Hives	Y	N
TB/Lung Disease	Y	N
Seizures/Epilepsy	Y	N
High Blood Pressure	Y	N
Bone or Joint Injuries	Y	N
Obesity/Overweight	Y	N
In-Patient Hospital Stay	Y	N
List Reason and Dates_____		
Learning Disabilities	Y	N
Lead Poisoning	Y	N
ER/Urgent Care Visits	Y	N

Heart Defects/Disease	Y	N
Liver Disease/Hepatitis	Y	N
Diabetes	Y	N
Kidney Disease	Y	N
Bladder Infections	Y	N
Physical Disabilities	Y	N
Bleeding Disorders/Hemophilia	Y	N
Sexually Transmitted Infections	Y	N
Emotional/Behavioral Problems	Y	N
Depression/Suicidal Thoughts	Y	N
Surgeries	Y	N
List Type and Dates_____		
Physical Abuse	Y	N
Sexual Abuse	Y	N
Emotional Abuse	Y	N
Eating Disorders	Y	N
Dental Problems	Y	N
Attention Deficit Disorder	Y	N
Vaccines Up To Date	Y	N
Is Child in Daycare	Y	N
Child Ever in Foster Care	Y	N

Who Cares for Child_____

List Current Medications_____

Other

Concerns_____

_____

_____

_____

Physician Signature _____

FAMILY MEDICAL HISTORY

Has mom(M) or dad (D), maternal grandma (MGM), maternal grandpa (MGP), paternal grandma (PGM), paternal grandpa (PGP), maternal aunt (MA), paternal aunt (PA), maternal uncle (MU), paternal uncle (PU), sister (S), or brother (B) had:

Allergies (List)_____	Y	N	WHO?_____	Suicide	Y	N	WHO?_____
_____				Family Violence	Y	N	WHO?_____
Cystic Fibrosis	Y	N	WHO?_____	Depression	Y	N	WHO?_____
Asthma/Wheezing	Y	N	WHO?_____	Alcohol/Drug Abuse	Y	N	WHO?_____
TB/Lung Disease	Y	N	WHO?_____	High Blood Pressure	Y	N	WHO?_____
Clotting Disorders	Y	N	WHO?_____	Heart Disease	Y	N	WHO?_____
Sickle Cell Disease	Y	N	WHO?_____	High Cholesterol	Y	N	WHO?_____
Thalassemia	Y	N	WHO?_____	Sudden Cardiac Death	Y	N	WHO?_____
Protein C, Protein S deficiency	Y	N	WHO?_____	Stroke	Y	N	WHO?_____
Other Blood Disorders	Y	N	WHO?_____	Seizures	Y	N	WHO?_____
HIV/AIDS	Y	N	WHO?_____	Kidney Disease	Y	N	WHO?_____
Anemia	Y	N	WHO?_____	Hepatitis/Liver Disease	Y	N	WHO?_____
Colorectal Cancer	Y	N	WHO?_____	Diabetes	Y	N	WHO?_____
Breast Cancer	Y	N	WHO?_____	Thyroid Disease	Y	N	WHO?_____
Cervical Cancer	Y	N	WHO?_____	Speech Problems	Y	N	WHO?_____
Other Cancers_____	Y	N	WHO?_____	Hearing Loss	Y	N	WHO?_____
Learning Disabilities	Y	N	WHO?_____	Hip Dysplasia	Y	N	WHO?_____
Attention Deficit Disorder	Y	N	WHO?_____	Birth Defects	Y	N	WHO?_____
Mental Illness	Y	N	WHO?_____				

Other Concerns_____

_____

_____

_____

Has any Family member ever had an unexplained, unexpected death before age 50? Y N WHO?_____

Date of Review:_____

Physician Signature _____

PREGNANCY FOR MOTHER

Prenatal Care	Y	N
Illness during Pregnancy	Y	N
Medications during Pregnancy	Y	N
Alcohol/Drug abuse	Y	N
Problems at birth	Y	N
Miscarriage	Y	N
Toxemia	Y	N

Baby Birth History

Adopted	Y	N
Part of Multiple Birth	Y	N

Name of Hospital_____

Baby was delivered at _____weeks gestation

Type of delivery: Vaginal____ C-Section____VBAC____

Birth Weight:_____

Discharge Weight:_____

Respiratory Problems at Birth	Y	N
Heart Problems at Birth	Y	N
Jaundice at Birth	Y	N
Did Baby Receive Hep B Vaccine	Y	N
Passed Hearing Screen	Y	N
Breastfed	Y	N
Formula Fed	Y	N

Other concerns or Questions

_____

_____

_____

_____

SOCIAL HISTORY

Who lives in household:_____

_____

_____

Date of Birth:

Mother:_____

Father_____

Parents divorced/separated:	Y	N
Mother use tobacco :	Y	N
Father uses tobacco	Y	N

Physician Signature _____

Cascade Pediatrics

FINANCIAL POLICY

We would like to thank you for choosing Cascade Pediatrics as your child's medical home. We are committed to providing you with the best care possible. As your child's pediatrician, our relationship is with you and not your insurance company. Therefore, it is necessary for you to know what benefits your insurance plan has for you.

INSURANCE CARDS

It is your responsibility to provide us with your child's current insurance information at each visit.
If your insurance plan requires you to see a designated Primary Care Physician, please make sure we are listed as your child's Primary Care Physician prior to the appointment.

We will submit a claim to your insurance as a courtesy. However, any charges not covered by your insurance plan will be your responsibility.

PAYMENT OPTIONS

For your convenience, we accept cash, checks or credit cards (MasterCard and Visa).

Co-payments are due at the time of service. You are responsible for knowing your co-payment amount.

For patients with no insurance, full payment is required at time of service.

For patients with high deductible plans, payment is required within 30 days of the visit.

Saturday appointments are for urgent medical issues only and an additional $25 fee will be added to all weekend appointments.

MISSED APPOINTMENTS / LATE CANCELLATIONS

If you are unable to make your appointment, please call us at least 24 hours in advance to cancel or reschedule the appointment. A "No Show" fee of $25.00 will be charged for missed appointments or late cancellations.

PATIENT STATEMENTS

Outstanding balances are due within 30 days. If you are unable to pay the balance in full, please contact the billing department to discuss payment arrangements.

A $10.00 statement fee will be added to accounts with balances more than 60 days past due.

A final notice for payment letter will be issued to patients with balances more than 90 days past due. Balances not paid in full after 90 days may be sent to a collection agency.

A $30.00 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

PATIENT FINANCIAL RESPONSIBILITY

I authorize payment of medical benefits by the insured directly to Cascade Pediatrics LLP. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to my family member and for any yearly deductible or co-payment amounts. Furthermore, I understand it is my responsibility to know/understand my insurance plan benefits. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize Cascade Pediatrics LLP to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

I have read and fully understand this financial policy. I also understand that Cascade Pediatrics has the right to amend this policy at any time without prior notice to patients.

Patient Names (list all children): _____ Date: _____

Name of Parent or Guardian: _____ Signature: _____

Cascade Pediatrics

Notice of Privacy Practices **Revised 10/21**

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e. name, address, phone, etc.), that may identify you and relates to your past, present, or future physical or mental health condition and related healthcare services.

Cascade Pediatrics is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law. Regarding use of information for health care law, be aware that our office records and transmits health information, including prescription information, electronically. PHI may be shared with our Business Associates in order to obtain payment for services you received. They may contact you at any telephone number associated with your account, including wireless telephone numbers. They may also contact you by sending text messages or e-mails, using any e-mail address you have provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. Health information is shared and protected electronically through local, state and national health information exchanges (HIE's) and clinically integrated networks (CIN's) and these HIE's and CIN's have strict rules on how this information is accessed.

Your Rights Under The Privacy Rule - Following is a statement of your rights, under the Privacy Rule, in reference to your PHI Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice.

You have the right to authorize other use and disclosure - This means you have the right authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication - This means you have the right to ask us to contact you about medical matters using an alternative method (i.e. email or telephone), and to a destination (i.e. cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice or your own, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. We have the right to charge a reasonable fee for paper as established by professional, state, or federal guidelines.

You have the right to request restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restrictions, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of you PHI for as long as we maintain this information. In certain cases, we may deny your request.
You have the right to request a disclosure of accountability - This means that you may request a listing of disclosures that we have made at your request, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.
If you have questions regarding your privacy rights, or would like a more in depth copy of our privacy policy please feel free to contact our Compliance Officer.

You may file a complaint with us by notifying our Compliance Officer at **(616) 940-3168.** We will not retaliate against you for filing a complaint.

Cascade Pediatrics

AUTHORIZATION FOR TREATMENT & RELEASE OF SPECIFIC CONFIDENTIAL COMMUNICATIONS

Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____

I, _____ as parent or legal guardian of child (children) listed above, authorize the following person (people) to bring my child (children) to Cascade Pediatrics for the following types of visits. *Please include any Step-Parents.

- ❑ Evaluation and Treatment
- ❑ Well Visits
- ❑ Lab Tests
- ❑ Immunizations

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I, _____ as parent or legal guardian of child (children) listed above, authorize Cascade Pediatrics physicians, clinical and administrative staff to disclose the following Protected health information about the child (children) listed above to the following person (people) *Please include any Step-Parents.

- ❑ Medical Care / Treatment: Level of Information: _____
- ❑ Other: (specify in detail) _____ _____
- ❑ Pick up PHI: (Such as prescriptions, billing statements, labs, school forms):
- ❑ Billing Information / Statements

If not previously revoked in writing, this authorization will be in force and effective until its ***expiration in TWELVE (12) months*** from the date of my signature or as otherwise specified here: from: _____ to _____. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Cascade Pediatrics 5150 Cascade Rd SE Suite B Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date _____
Patient / Parent / Guardian Signature Relationship: _____

Cascade Pediatrics

Patient Physician Partnership Agreement

The health and wellness of our patients is our top priority at Cascade Pediatrics. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if I, your physician, along with my staff, and you, my patient, work together. This concept is called the Patient Centered Medical Home. We would like you to think of Cascade Pediatrics as your 'Home' ~ the first place you think of for **all** of your medical and/or healthcare needs.

Our Promise to You

We pledge to do our best to provide you with quality health care that is easy to schedule, safe, patient-centered, collaborative and satisfying to both you the patient, and us, the treating physician team. Our goals are to:

- Provide you with a team led by a physician that has knowledge about you, will provide you the opportunity to talk about your concerns about medical or social health care and who will be responsible for your ongoing care and needs in a timely manner.
- Explain any test, illness, treatment, and possible outcomes for accepting or refusing treatment in a way that is easy to understand. Provide educational materials that will help to make communication and understanding of your care easier.
- Make care needs easier by the use of computers and health information. Discussion between all persons on the physician team, including specialists, will make sure that you get the care that you need, when and where you need it while respecting your privacy. As your provider, we will share your patient information with other providers who are involved in your care, as appropriate. Information sharing may be through provision of written medical information, telephonic communication, or through electronic sharing of information using a health information exchange. (HIE)
- Help in arranging care with other qualified professionals, taking into consideration your personal, medical and life circumstances.

What We Expect of You

- As we pledge to do our best for you, we also expect you to be an active member of your care team. We expect you to:
- Provide your health care team with complete and honest information about your health history, current concerns and health care requests.
- Do your best to follow a healthy lifestyle and be involved in understanding and managing your health care. If you are unable to follow the advice of your health care team, let them know it. Be honest and open in your reasons and let them know what you are able to do.
- **Contact your provider FIRST for all medical issues, other than life-threatening emergencies.** This can prevent unnecessary tests, exams and treatments that may have already been done by the team or one of their professionals. You may access an on-call Cascade Pediatrics physician at any time.
- Keep scheduled appointments. If you must reschedule, do so as soon as possible, prior to 24 hours of the appointment, so that we may offer that time to another patient.
- Notify your health care team of any medical or health care services you receive outside of this office, such as eye exams, dental care, surgeries, flu shots, immunizations, etc. This also includes any care that you may have received at a hospital, emergency room or urgent care facility.
- Contact our office to schedule follow up visits with your primary care provider within 48 hours after discharge if you have received care at a hospital, emergency room or urgent care facility. This allows us to coordinate all of your care and avoid unnecessary tests, exams, and treatments.
- Please ask us if you have questions about other resources available to you outside of this office, such as community agencies and services that might be of benefit to you.

Establishing a partnership between the patient and the health care team, along with family members and patient advocates, allows decisions to be made that are respectful of the physician's knowledge and experience while making sure the patient's wants, needs and personal preferences are met. Cascade Pediatrics, LLP, wants you, our patient, to be supported by the knowledge that you can make decisions and participate in your own care!