Wellness
PEDIATRICS
Where Kids Matter the Most
Wholeheartedly and Wholistically

Patient Registration

FORM COMPLETED BY _____ NAME _____

INITIAL DATE COMPLETED _____ ID NUMBER: _____

DATES UPDATED _____ BIRTH DATE _____ AGE _____ SEX M ◯ F ◯

Patient #1

NAME _____ DATE OF BIRTH _____ SEX M ◯ F ◯

PRIMARY LANGUAGE _____ RACE _____ ETHNICITY _____

Patient #2

NAME _____ DATE OF BIRTH _____ SEX M ◯ F ◯

PRIMARY LANGUAGE _____ RACE _____ ETHNICITY _____

Patient #3

NAME _____ DATE OF BIRTH _____ SEX M ◯ F ◯

PRIMARY LANGUAGE _____ RACE _____ ETHNICITY _____

Patient Registration

Insurance: Primary policy

HOLDER'S NAME | DATE OF BIRTH | SEX M ◯ F ◯

INSURANCE PROVIDER | ID# | GROUP#

Insurance: Secondary policy

HOLDER'S NAME | DATE OF BIRTH | SEX M ◯ F ◯

INSURANCE PROVIDER | ID# | GROUP#

Pharmacy

NAME | CITY | CROSS STREETS

Household

MAILING ADDRESS | PRIMARY PHONE

WHO LIVES IN THE HOUSEHOLD | SECONDARY PHONE

Parent / Legal guardian #1

NAME | BIRTH DATE | SSN

RELATION TO PATIENT | CELL NUMBER | WORK NUMBER

EMAIL | OCCUPATION

PREFERED CONTACT HOME ◯ CELL ◯ WORK ◯ LIVES WITH PATIENT YES ◯ NO ◯

Parent / Legal guardian #2

NAME | BIRTH DATE | SSN

RELATION TO PATIENT | CELL NUMBER | WORK NUMBER

EMAIL | OCCUPATION

PREFERED CONTACT HOME ◯ CELL ◯ WORK ◯ LIVES WITH PATIENT YES ◯ NO ◯

Fill if parents divorced or separated

WHO HAS CUSTODY?

Are there 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 ◯ NO ◯

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

Contract of Financial Responsibility

Please read each paragraph and sign when indicated to acknowledge your understanding and acceptance, if you are a minor (under 18) a legal guardian must accept financial responsibility on your behalf.

1.I agree that I will pay for all services provided to me by Wellness Pediatrics at the date of service unless my services are covered by a contracted insurance.

2.I understand that my insurance company or health plan may require me to pay co-payments, co-insurance, or deductibles. I agree to pay these in full at the time of service.

3.I understand that I am responsible for providing you with all billing information for primary, secondary, and tertiary health plans.

4.I understand that if, upon 60 days after billing and or insurance filing, my contracted insurance has not paid, I will be required to contact them to find out why the claim has not been paid.

5.I understand that if, 60 days after billing, I fail to pay any balance due on my account (unless this balance is still out to contracted insurance), further action may be taken on my account, unless other previous arrangements have been made and approved by Wellness Pediatrics.

6.If my account is sent to collections, I am responsible for all amounts due plus costs of collection, including:

- All collection expenses charged by the collection agency.
- Court costs
- Reasonable attorney's fees
- Any discounts I may have received on my account will be reversed

7.I am aware that there is a $25.00 service fee charged for all returned checks.

8.I am aware there will be a $25.00 charge for missed or no-show office appointments without 24-hour advance notice.

9.I herby authorize the release of information to my insurance company concerning charges and/or treatment provided to me by the physicians of Wellness Pediatrics. I herby assign benefits and I understand that payment is due as services are provided, including my deductible, co-payment, coinsurance, of any balance not paid by my insurance (excluding contractual allowance). I request that payment be made directly to Wellness Pediatrics. I acknowledge that I am responsible for payment is this assignment is not honored.

10.By signing this document, I agree, for Wellness Pediatrics to service my account or collect any amounts I may owe, Wellness Pediatrics and its third-party billing and/ or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text message or emails, using any email address I provide. Methods of contact may include using prerecorded/ artificial voice messages and/ or use of an automatic dialing device, if applicable.

I/we have read this disclosure and authorize express consent that Wellness Pediatrics and its affiliates, and third-party service providers may contact me/ us as described above.

PRINT PATIENT'S NAME

TODAY'S DATE

SIGNATURE OF PATIENT OR PARENT/GUARDIAN OF MINOR

Wellness PEDIATRICS

Where Kids Matter the Most
Wholeheartedly and Wholistically

Affiliated with
Beaumont
William Beaumont Hospital

PRINT _____ _____

Patient name | Patient date of birth

I hereby acknowledge that Wellness Pediatrics has made their Notice of Privacy Practices available to me.

_____ _____

Signature of patient or patient's representative/parent | Date

PRINT _____ _____

Printed name of patient or patient's representative/parent | Date

_____

Relationship to patient

For office use only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

- ◯ An emergency existed & a signature was not possible at the time.
- ◯ The individual refused to sign.
- ◯ A copy was mailed with a request for a signature by return mail.
- ◯ Unable to communicate with the patient for the following reason:
  EXPLAIN _____
- ◯ Other SPECIFY _____

Prepared by _____ Date _____

Signature _____

HIPAA

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact Wellness Pediatrics by mail or phone. Our contact information is listed above.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Wellness Pediatrics
511 Pierce St. Suite-C
Birmingham, MI 48009

HIPAA Notice of Privacy Practices

Revised 01/2022USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS

We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information:

You have the right to inspect and have a copy of your protected health information (fees may apply). Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Patient Requesting Medical Record Copies. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees.

You have the right to request a restriction of your protected health information – You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications – You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

You have the right to request an amendment to your protected health information – You may ask us to correct health information about you that you think is incorrect or incomplete. We may say “no” to your request, but we will tell you why in writing within 60 days.

You have the right to receive an accounting of certain disclosures — You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request.

You have the right to receive notice of a breach - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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Records Release

Transfer of medical records release form

Patient

LAST NAME | FIRST NAME | DATE OF BIRTH

Additional siblings

LAST NAME | FIRST NAME | DATE OF BIRTH

LAST NAME | FIRST NAME | DATE OF BIRTH

Contact

ADDRESS | PHONE

I, the undersigned, hereby authorize _____ located at _____

To provide my medical record information to PRACTICE NAME _____

Contact

ADDRESS _____ PHONE _____ FAX _____

Date(s) of service requested _____

I understand that the entire medical record, including information pertaining to drug or alcohol abuse and psychological or psychiatric treatment, will be provided unless I specify that the following information should not be released: _____

_____

I am requesting the transfer of my child's/ children/s medical records due to:

Relocation ◯ Child's age ◯ Dissatisfaction with physicians / staff ◯ Insurance change ◯

Other ◯ SPECIFY _____

OTHER COMMENTS _____

_____

Signed by Patient ◯ Parent/Legal guardian ◯

I understand that I have a right to receive a copy of this authorization upon request. DATE _____

SIGNATURE _____

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Initial History Questionnaire

FORM COMPLETED BY _____ NAME _____

INITIAL DATE COMPLETED _____ ID NUMBER: _____

DATES UPDATED _____ BIRTH DATE _____ AGE _____ SEX M ◯ F ◯

Initial History Questionnaire

General

Do you consider your child to be in good health? Yes ◯ No ◯ Don't Know ◯ EXPLAIN _____

Does your child have any special health care needs? Yes ◯ No ◯ Don't Know ◯ EXPLAIN _____

Has your child ever been hospitalized? Yes ◯ No ◯ Don't Know ◯ EXPLAIN _____

Is your child allergic to medicine or drugs? Yes ◯ No ◯ Don't Know ◯ EXPLAIN _____

Social History

Please list all those living in the child's home.

NAME	RELATIONSHIP TO CHILD	AGE

Please list other siblings not living in the same home

NAME	AGE	WHERE ARE THEY LIVING

Does the child live with both biological parents? Yes ◯ No ◯

If no, what is the child's current living situation?

Single parent custody ◯ Joint custody ◯ Adoptive family ◯

Other family members ◯ SPECIFY _____ Foster care ◯

How often does the child have visitation with parent(s) not living in the home?

_____

Birth History

HOSPITAL _____ BIRTH WEIGHT _____

Full-term ◯ Preterm ◯ WEEKS _____ Post-term ◯ WEEKS _____

Delivery: Vaginal ◯ Cesarean ◯ REASON _____

Any complications during or after birth?

Yes ◯ No ◯ EXPLAIN _____

Did the baby have to go to the NICU (Neonatal Intensive Care Unit)?

Yes ◯ No ◯ EXPLAIN _____

During the pregnancy, did the mother:

Take prenatal vitamins? Yes ◯ No ◯ Don't know ◯

Smoke or used e-cigarettes? Yes ◯ No ◯ Don't know ◯

Drink alcohol? Yes ◯ No ◯ Don't know ◯

Use marijuana? Yes ◯ No ◯ Don't know ◯

Use illicit drugs? Yes ◯ No ◯ Don't know ◯

Take other medications? Yes ◯ No ◯ Don't know ◯

If yes, please list: _____

Blood type: MOTHER Unknown ◯ BABY Unknown ◯

Mother's lab results:

Hepatitis B	Positive ◯	Negative ◯	Unknown ◯
HIV	Positive ◯	Negative ◯	Unknown ◯
Group B Streptococcus (GBS)	Positive ◯	Negative ◯	Unknown ◯

How was the baby fed? Bottle formula ◯ Bottle breast milk ◯

Breast fed ◯ FOR HOW LONG _____

Did the baby go with their biological mother from hospital after birth?

Yes ◯ No ◯ EXPLAIN _____

Initial History Questionnaire

NAME _____

Past Medical History

Has your child ever had any of the following problems?

Eye problems, cataracts or retinoblastoma:	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Vision impairment or concerns	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Nasal allergies (dust, pets or environmental)	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Frequent ear infections	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Hearing loss or concerns	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Multiple cavities or problems with teeth	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Frequent colds or sore throats	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Asthma, wheezing or breathing problems	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Bronchitis, Bronchiolitis or Pneumonia	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Heart murmur or other heart problems	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
High blood pressure	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Frequent stomach pain	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Constipation needing medical treatment	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Food allergies or intolerance (ie Milk, Gluten)	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Feeding issues or underweight	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Overweight or obesity	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Urinary tract infections	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Bed wetting after 5 years old	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Kidney, ureter or bladder problems	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Serious injuries or fractures	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Bone, joint or muscle problems	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Frequent headaches or dizzyness	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Concussion or head injury	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Convulsions, seizures or neurological issues	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Sleep problems or snoring	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Skin problems, eczema or hives	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Acne	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Thyroid or other endocrine problems	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Diabetes	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Metabolic/genetic disorders	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Anemia or bleeding problems	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Cancer or chemotherapy	Don't Know ◯	No ◯	Yes ◯	DETAILS _____
Bone marrow or organ transplant	Don't Know ◯	No ◯	Yes ◯	DETAILS _____

Initial History Questionnaire

NAME _____

Past Medical History

Has your child ever had any of the following problems? (continued)

Blood transfusion	Don't Know ◯	No ◯	Yes ◯	DETAILS
HIV or AIDS	Don't Know ◯	No ◯	Yes ◯	DETAILS
Chickenpox or zoster (shingles)	Don't Know ◯	No ◯	Yes ◯	DETAILS
Developmental delays (speech or motor)	Don't Know ◯	No ◯	Yes ◯	DETAILS
School problems or learning difficulties	Don't Know ◯	No ◯	Yes ◯	DETAILS
ADHD or behavioral concerns	Don't Know ◯	No ◯	Yes ◯	DETAILS
Anxiety, depression or mood problems	Don't Know ◯	No ◯	Yes ◯	DETAILS
Tobacco, alcohol or drug use	Don't Know ◯	No ◯	Yes ◯	DETAILS
Exposure to family violence	Don't Know ◯	No ◯	Yes ◯	DETAILS
Pregnancy or miscarriage	Don't Know ◯	No ◯	Yes ◯	DETAILS
Sexually transmitted infections	Don't Know ◯	No ◯	Yes ◯	DETAILS
Females: issues with periods	Don't Know ◯	No ◯	Yes ◯	DETAILS

Age of first period _____ Other medical problems (please list) _____

Surgical History

Has your child ever had surgery? No ◯ Yes ◯ If yes, please provide details:

SURGERY / PROCEDURE	DATE PERFORMED / CHILD'S AGE	WHERE COMPLETED	DETAILS

Other surgical / procedural problems (Please list) _____

Initial History Questionnaire

NAME _____

Family History

Have any of your child's parents, grandparents, aunts, uncles, brothers or sisters ever had any of the following conditions?

Anemia or bleeding problems	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Asthma	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Allergies	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Alcohol use problems	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Bed-wetting after age 10	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Cancer before age 55	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Childhood hearing loss	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Dental decay or multiple cavities	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Depression or anxiety	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Developmental disability	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Diabetes	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Heart attack (myocardial infraction)	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Heart disease before age 55	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
High blood pressure	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
High cholesterol	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
HIV or AIDS	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Kidney disease	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Liver disease	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Mental health conditions	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Obesity	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Seizures or epilepsy	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Stroke	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Substance use problems	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Sudden death before age 50	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Thyroid or endocrine disease	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Tobacco use problems	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Tuberculosis	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS
Vision or eye problems	Don't Know ◯	No ◯	Yes ◯	WHO	DETAILS

Other medical problems (Please list) _____

Provider signatures

Provider 1 PRINTED NAME _____ SIGNATURE _____

Provider 2 PRINTED NAME _____ SIGNATURE _____