PAL REGISTRATION FORM

PATIENT INFORMATION:

Patient's Name (First /Middle/Last):_____ Birth Date: _____

Address:_____

(Street) (City) (State) (ZIP)

Home #: ( )_____ Gender: ☐ M ☐ F

Custody Status: ☐Biological parent ☐Adoptive parent ☐Foster parent ☐Other legal guardian _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race: ☐ American Indian ☐Alaskan ☐Asian ☐ Black or African American ☐Native Hawaiian or Islander ☐White

PARENT/GUARDIAN INFORMATION:

Name (First/Middle/Last): _____

DOB: _____

Address: _____

City/State/ZIP: _____

Home #: _____

Cell #: _____

Work #: _____

Email: _____

Employer: _____

Name (First/Middle/Last):_____

DOB: _____

Address: _____

City/State/ZIP: _____

Home #: _____

Cell #: _____

Work #: _____

Email: _____

Employer: _____

INSURANCE INFORMATION:

Please notify the office of any insurance changes at each visit that may affect your account. We will bill your insurance company on your behalf. You are responsible for any remaining balance.

Subscriber (First/Middle/Last):_____

Relationship to Patient: _____

DOB: _____ Group #: _____

Contract/ID #: _____

Insurance Company: _____

Phone #: _____ Co-pay: _____

Subscriber (First/Middle/Last):_____

Relationship to Patient: _____

DOB: _____ Group #: _____

Contract/ID #: _____

Insurance Company: _____

Phone #: _____ Co-pay: _____

EMERGENCY CONTACT (Person to contact in case of an emergency)

Name: _____ Relationship to Patient: _____

Phone Number: (Home) _____ (Cell) _____

Preferred Mode of Contact: ☐ Email ☐Cell Phone ☐Work Phone ☐Home Phone

SIGNATURE OF RESPONSIBLE PARTY ☐Mother ☐Father ☐Guardian

X _____ Date:_____

PATIENT-PHYSICIAN AGREEMENT

PAL has earned the distinction of becoming a Patient Centered Medical Home (PCMH). The PCMH is health care centered on your child, the patient. It is a partnership between your child, you and the doctor. Your physician leads a team of health care professionals in a medical practice committed to improving your child's overall health and to helping you reach your child's health goals. Instead of just being treated for a problem here and there without making a connection between symptoms, the patient-centered medical home focuses on connecting the dots and coordinating care.

Your child's health team will consist of a Pediatrician, specialty physicians, dieticians, and others depending on your child's needs. For example, do you want to better control your child's weight, behavioral issues, diabetes or asthma? Your physician will put the right team in place for your child. If your child needs a specialist for a specific condition, your patient-centered medical home will help you find the right specialist for your child's needs. We will also share medical information to prevent duplicate efforts. Because all tests and treatments done by other doctors will be sent to our office, we will be a centralized home for their medical care. Your child's medical information will be shared with specialists when appropriate.

PARENT/GUARDIAN RESPONSIBILITY:

- Tell us what you know about your child's health and illnesses, and what your child's needs and concerns are.
- Take an active part in planning your child's care and following that plan. Inform us if you are unable to meet the goals defined for your child.
- Tell us what medications your child is taking, give your child the prescribed medications as directed, and ask for refills in a timely manner. Ask for your refills at the time of your child's office visit. Otherwise, give the office staff at least 24 hours notice to complete refills.
- Seek our advice before arranging to see other physicians or other health care professionals. Keep us informed of the recommendations they make.
- Learn about wellness and prevention for your family, as we believe a healthy family produces a healthy child.
- Keep the appointment you have scheduled for your child.
- Know what insurance they have, as well as what it covers. We appreciate and expect co-pays to be paid at the time of service.

PHYSICIAN RESPONSIBILITY:

- Provide safe, quality care to your child.
- Respect your child's and family's privacy. We will not share your medical information without your permission.
- Provide 24 hour access to our health care team.
- Help you plan goals that meet your child's needs, and discuss these goals with you to improve your child's health and help prevent persistent health problems.
- Discuss the most appropriate tests and procedures your child may need. Coordinate your child's care among other health care professionals.
- Tell you about your child's health and illnesses in a way that you can understand, and provide care for a short or long term illness as well as give you advice to help your child stay healthy.
- We promise to be what our motto states "Partners in your child's care."
- To share some of your child's health care information to support population management.

Patient Name: _____Parent/Guardian Name: _____

Signature: _____ Date: _____

E-MAIL POLICY

E-mail shall be used by Pediatric Associates of Livingston to enhance communication with patients and families.

E-mail shall be used in the following ways:

- **Educational Materials:** New practice guidelines, medication recalls, safety information, etc.
- **Office Functions:** Changes in office hours, changes in office staff, new procedures offered, etc.
- **Immunization Information:** Flu clinics, new immunization protocols (such as the addition of a new immunization, a change in the schedule of an existing immunization or a need for a booster).
- **Reminder System:** To remind families of needed appointments or services such as a return visit for a booster immunization or to schedule a well child check-up.

The e-mail messages may be included as part of the medical record.

E-mail shall not be used to send information such as lab or x-ray results or advice on how to handle an illness.

The e-mail system does not include a reply function. If you have questions about an e-mail received, or to schedule an appointment, please call our office.

The e-mail system is protected by strict encryption standards both while the e-mail is stored on our e-mail server and while in transit to and from our server. Our e-mail accounts are password protected and our e-mail server is secured from intrusion by an internet firewall.

By signing this policy you agree to receive e-mail. It is the patient's parent/guardian's responsibility to inform Pediatric Associates of Livingston of any change in the contact e-mail address. Please take steps to ensure that e-mails from Pediatric Associates of Livingston are not received in "junk mail".

Patient's Name:

_____Date:_____

Parent/Guardian's Name:

_____

Parent/Guardian's Signature:

_____

Preferred E-mail Address:

_____

Pediatric Associates of Livingston PLLC ™

Acknowledgement of Notice of Privacy Practices

I acknowledge:

A copy of the provider's *Notice of Privacy Practices* was made available to me at Pediatric Associates of Livingston, PLLC. A copy of the *Notice of Privacy Practices* was made available for me to keep if I so desired.

The *Notice of Privacy Practices* was posted in a clear and prominent location where I could read it.

If I came in for health care services in an emergency situation, I was able to view the *Notice of Privacy Practices* as soon as reasonably possible after the emergency situation.

I received the *Notice of Privacy Practices* no later than the first day I received health care services in person. If I received health care services by telephone/cellular phone or electronically, a copy of the *Notice of Privacy Practices* was mailed or sent to me electronically.

Patient's Name (Please Print) Date of Birth

Signature of Patient or Personal Representative Date

Signature of Workforce Member Date

TEXT MESSAGING POLICY

Text messaging will be used by Pediatric Associates of Livingston to enhance communication with patients and families.

Text messaging shall be used in the following ways:

To ***remind*** families of needed appointments or services such as a return visit for a booster immunization, incomplete lab orders, or to schedule a well child check-up.

The text messages may be included as part of the medical record.

Text messaging shall not be used to send information such as lab or x-ray results or advice on how to handle an illness.

You may <u>not</u> use text messaging to request any medical advice as this system is not monitored on an immediate basis.

By signing this policy you agree to receive text messages. It is the patient's parent/guardian's responsibility to inform Pediatric Associates of Livingston of any change in the contact numbers.

- ☐ Yes, I agree to accept/receive text messages for reminders. I understand that the staff of Pediatric Associates of Livingston, request a return response regarding the text they send. I do understand that I cannot at any time text message the office requesting medical advice. I must call the office for this. **_____ (initials)**
- ☐ No I do not agree to receive text messages from Pediatric Associates of Livingston.

Patient's Name:

_____Date:_____

Parent/Guardian's Name:

_____

Parent/Guardian's Signature:

_____

Cell Phone Number: _____

Pediatric Associates of Livingston, PLLC

Name:_____**DOB:**_____

1. Consent for medical treatment:

I, the above listed parent/guardian, consent to any routine medical, diagnostic, therapeutic or minor surgical procedure that may be recommended by the doctor and performed by, or under the supervision of, the doctor. Specific procedures will be explained to me along with the expected benefits and possible risks prior to any procedure being conducted. I know that I can ask questions at any time and will do so if I have any concerns. I recognize that the practice of medicine and surgery is not an exact science; no one can make promises or assure me about the exact results of any examination, treatment or procedure that my child receives.

Signature: _____**Date:**_____

Parent or Guardian

2. Authorization for Release of Patient Records if unable to sign:

I authorize Pediatric Associates of Livingston, PLLC to release information contained in my patient records to the party responsible for payment of my child's care, including but not limited to the Medicaid/Medicare programs, my insurance carrier, my employer's insurance carrier, and/or any other party, including a family member or other individuals, whom I have indicated will be responsible for payment of my child's care. I intend that this authorization for release of patient information to these parties shall extend to any information including drug, alcohol and drug abuse treatment (protected under the regulations in Code 42 of the Federal Regulations, Part 2), if any; information about mental health services and social services, including communications made by me to a social worker or mental health professional. Further this authorization will include release of information about the diagnosis or testing for HIV (Human Immunodeficiency Virus) AIDS (Acquired Immunodeficiency Syndrome) and ARC (AIDS Related Complex) and records of any other communicable diseases.

Signature: _____**Date:**_____

Parent or Guardian

3. Authorization for payment of Insurance Benefits:

I authorize payment of insurance benefits, including Medicaid/Medicare benefits, to be made directly to Pediatric Associates of Livingston, PLLC. I understand that I am financially responsible to Pediatric Associates of Livingston, PLLC (including physician, nurse practitioner physician assistant) for services not covered or payable by my insurance carrier. I further understand my provider is under no duty or obligation to seek payment from an insurance carrier before requesting full or partial payment from me.

Signature: _____**Date:**_____

Parent or Guardian

4. Full payment is due at the time of service:

Any amount, excluding deductible, required to be paid by or on behalf of your child is due at time of service (i.e., co-payment, injection fee, etc.). If full payment is not made at the time of service, an additional processing fee may be assessed.

Signature: _____**Date:**_____

Parent or Guardian

5. For your information:

In accordance with the Michigan Public Health Code, if a health professional or other office personnel experiences an exposure to your child's blood of other bodily fluids, they may be tested for evidence of HIV. The cost of the test will not be charged to you or your insurance company. The performance and the result of this test are confidential. This information will not be released without your written consent, except to those individuals or organizations that have been given access by law, who are also required to keep your child's records confidential.

Signature: _____**Date:**_____

Pediatric Associates of Livingston PLLC™

Partners in your child's health

Web Portal Agreement

We are excited to announce that PAL is now offering a patient portal. The patient portal will be utilized to provide summary of care and communication of **lab results only.**

When lab results are available, you will receive an email with the login link suggesting that you log into your child's portal. You will find a message in your inbox with the lab results and any directions the physician may have for you. The summary of care contains your child's immunizations, growth measurements, vital signs as well as their medication information. The summary of care will be available within 24 hours of your child's appointment. You may log into the link provided below as you wish to review the summary of care.

PLEASE INITIAL EACH STATEMENT Below:

_____ I understand that no messages for requests for prescription refills will be accepted via the portal.
_____ I understand that no messages for appointments will be accepted via the portal.
_____ I understand that no messages for referrals will be accepted via the portal.
_____ I understand that no messages for prior authorizations will be accepted via the portal.
_____ I understand that no messages for medical advice will be accepted via the portal.

To login to the portal, type the following address into the address bar on your web browser and press enter.
https://www.medicalofficeconnect.com:8444/PatientPortal

The PAL patient login page will appear. We are very excited to offer this new technology to our patients; however, please keep in mind we will only be accepting messages regarding lab results. Please call the office with any other questions you may have.

Please note to protect the privacy of all children placed in foster care, the patient portal will be deactivated. In the event the child is returned to the legal parents, the parents may request the portal be reinstated.

_____ _____
Parent Guardian Signature Date

_____ _____
Patient Name email Address

PORTAL LOGIN INFORMATION - PLEASE KEEP FOR YOUR RECORDS.

Dear Parent,

We are excited to announce that PAL is now offering a patient portal. The patient portal will be utilized to provide summary of care and communication of lab results only.

The summary of care contains your child's immunizations, growth measurements, vital signs as well as their medication information. The summary of care will be available within 24 hours of your child's appointment. You may log into the link provided below as you wish to review the summary of care.

When lab results are available, you will receive an email with the login link suggesting that you log into your child's portal. You will find a message in your inbox with the lab results and any directions the physician may have for you.

Username: patient's first and last name with no capital letters, special characters or spaces.

ie: timmytrainer Password: pal12345
Upon your first login, you will be forced to change your password for security purposes.

PLEASE SEND US A MESSAGE TO ACTIVATE YOUR ACCOUNT!

To login to the portal, type the following address into the address bar on your web browser and press enter.
https://www.medicalofficeconnect.com:8444/PatientPortal

The PAL patient login page will appear.

We are very excited to offer this new technology to our patients; however, please keep in mind we will only be accepting messages regarding lab results. No messages for requests for prescription refills, referrals or appointments will be accepted at this time. Please call the office with any other questions you may have.

Please note to protect the privacy of all children placed in foster care, the patient portal will be deactivated. In the event the child is returned to the legal parents, the parents may request the portal be reinstated.

Sincerely,

Pediatric Associates of Livingston