PAD PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name			Birth Date:	Age:
Street Address		City:	Zip:	Home Phone
Ethnicity (race):	Social Security No:	If student, current grade:	Name of School:	
Sex: F / M	Pharmacy: name/address: Phone Number:		Parent's email address:	

PARENT'S OR LEGAL GUARDIAN'S INFORMATION (if parent is under 18 or insurance is in patient's name)

Name: ____Father ____Step Father ____Guardian		Name: ____Mother ____Step Mother ____Guardian	
Employeer		Employeer:	
Employeer Address:		Employeer Address:	
Businss Phone:	Birth Date:	Business Phone:	Birth Date:
Cell Phone:	Social Securty Nbr:	Cell Phone:	Social Security Nbr:
Driver's License Nbr:		Driver's License Nbr:	

IN CASE OF AN EMERGENCY (Please give contact information of a friend or relative not living at your address)

(1) Name	Relationship to you:	Phone Nbr:
(2) Name	Relationship to you:	Phone Nbr:

INSURANCE INFORMATION

Primary Insurance Company:		Secondary Insurance Company:	
Subscriber Name (as it appears on card)		Subscriber Name (as it appears on card)	
Contract Nbr:	Group Nbr:	Contract Nbr:	Group Nbr:

I hereby authorize Dr. Natacha Umlauf to treat my child and to apply for benefits on my behalf for services covered under my insurance policy, which are rendered by Dr Umlauf. In an eventthatmy insurance carrier denies all or part od my claim, Iam responsible for my outstanding balance, and will remit payment for thr outstanding balance to Dr. Umlauf upon notice that my insurance company denied all or part of my claim. I hereby authorize any payments made bt my Insurance company forservicesrendered by Dr. Umlauf tp be paid directly to Dr. Umlauf. I hereby certify that the information reprted about is accurate.

Signature_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By Signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

Signature_____Date_____

PLEASE TAKE A MINUTE TO ANSWER A FEW QUESTIONS.

Patient Name: _____ DOB: __/__/__

Did you or your child have any problems during pregnancy or delivery? YES OR NO
If yes, please explain: _____

Does your child has any chronic or recurrent disease or were they ever hospitalized? YES OR NO
If yes, please explain: _____

Is your child allergic to any medication? YES OR NO
If yes, please explain: _____

Does your child have any food allergies? YES OR NO
If yes, please explain: _____

Has your child ever had any significant reaction to immunization? YES OR NO
If yes, please explain: _____

Does any close family member have a significant disease? YES OR NO
(Diabetes, Heart Disease(especially younger then 40 years), sudden death (younger then 40 years) SIDS, Thyroid disease, genetic disease, Cystic Fibrosis, Neurofibromatosis, Congenital defects, deafness, blindness, seizures, psychiatric disorders, Kidney, sickle cell, anemia, bleeding disorder, asthma, allergies, etc.)
If yes, please explain: _____

Please list siblings: Name, Sex, and Age:

_____

_____

_____

Please include any additional information in the space provided

_____

_____

_____

Formed filled out by: _____ **Date:** __/__/__

Doctor Review _____ Date _____

Doctor Review _____ Date _____

Doctor Review _____ Date _____

Pediatric Associates of Dearborn – 2331 Monroe Street, Dearborn, MI 48124
Financial Agreement

Date: _____

Dear PAD Patient:

Thank you for choosing **Pediatric Associates of Dearborn ("PAD")** as your Pediatric Primary Care Provider.

The following is our Financial Policy, which will help you understand our billing and payments procedures. Payment for services is due at the time service is rendered. We accept cash, personal checks, debit cards, MasterCard, Visa, Discover and American Express.

PAD will submit an insurance claim on your behalf. PAD will bill your insurance with the understanding that whatever they will not pay; the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE.**

As your Pediatric Primary Care Provider, a PAD Doctor MUST be designated as your Primary Care Physician (PCP). Patients are responsible for deductible balances, co-insurance and non-covered amounts **at the time of service**. Any billed balances are due within 30 days of the statement date.

Remember that billing your insurance does NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. PAD will require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. There will be a $30.00 fee for all returned checks.

Should your account become delinquent and be referred to a collection agency, you will be financially responsible for the costs of collection and/or legal fees.

Please have **ALL INSURANCE CARDS and a PHOTO ID AVAILABLE FOR VERIFICATION AT ALL TIMES**. Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

PAD has a **"$25 NO SHOW FEE"** policy.

1. If a patient cannot attend a scheduled appointment, they must cancel or reschedule the appointment 24 hours prior to the scheduled appointment.
2. For private insurance patients: If a patient does "NOT SHOW" up for a scheduled appointment, they will be charged a $25 No Show fee.
3. For Medicaid insurance patients: If a patient has three (3) "NO SHOWS" for scheduled appointments, they will receive a Letter of Discharge from this office.

I request that payment of authorized Medicaid/or any third party benefits be made to **Pediatric Associates of Dearborn** for any services rendered. I authorize any holder of medical information to be released to the Center of Medicare/Medicaid Services and its agents or any third party payor any information to determine these benefits or the benefits payable for related service.

_____ _____

Print Patient's Name Parent or Guardian Signature

_____ _____

Patient's Date of Birth Signature Date

Pediatric Associates of Dearborn
2331 Monroe st
Dearborn MI 48124
P: (313) 792-0345
F: (313) 792-0346

The Patient - Doctor Partnership

It is a honor and privilege that you choose us to be your child's pediatrician, your child's health and well being will be a top concern of our office, from the first visit as a newborn until he or she enters to college. This office priodes in providing, evidence based high quality, family oriented, patient centered, care, making every visit an opportunity to provide the best service available. This Goal of best of care every visit can only be met with a partnership of Doctor and Patient working together. This concept is called Patient Centered Medical Home.

Patient Responsibilities:

- As a parent, ask questions and share information about your child.
- As an adolescent, ask question and know that your confidentially is guarded by the doctor.
- Schedule timley Well Child Care visits, bring your concerns with child's well-being to be discussed with the Doctor.
- Follow recommended immunizations indicated for your child's age. Bring any concerns to the Doctor's attention.
- Make healthy dietary choices for your child and permit a healthy lifestyle from your age.
- Clear understanding of Diagnosis treatment plan and follow up at the end of every visit.

Doctor Responsibilities:

- Most of all LISTEN to parent or patient concerns and feelings to make an adequate decision about their care.
- Explain Diseases, Treatment, and results in an easy to understand way. Give patient directions about medications and other treatments in easy to understand way.
- -Follow Education and anticipatory Guidance adequate for every well Child Care visit, Discuss Child's Growth, Development, Diet, immunizations, anticipatory guidance indicated in different age groups.
- -Provide care on the best of my abilities based on my understanding of the most current medical methods available.
- Follow Evidence Based treatment and current immunizations recommendations.
- Kep Treatment, discussions and records private.
- When needed send patient only to entrusted experts for treatment.
- End every visit with clear instructions about expectation, treatment and follow up.

Patient Name_____ **Patient D.O.B**_____

Parent Signature_____ **Date**_____

Pediatric Associates of Dearborn

HIPAA COMPLIANCE & eHx CONSENT (REQUIRED)

I hereby give my consent to Pediatric Associates of Dearborn to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the above patient's record.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. It is available on the homepage of our website, www.pediatricdearborn.com and we can provide a copy upon request.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at the front desk.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I give my consent to opt-in the eHx Program, which allows the community of Pediatric Associates of Dearborn to access my information.

Signed: _____

Name: _____

Relationship, if not the patient: _____