CAPITAL AREA PEDIATRICS

3937 Patient Care Dr. Ste. 101
Lansing MI 48911
517.394.6484 Fax: 517.394.7785

PATIENT INFORMATION

Patient's Legal Name: _____DOB:_____ () Male () Female

Home Address: _____City:_____State:____ZIP:_____

Patient Resides with Mother and Father () Yes () No **If no, please list**: _____

Mother's/Stepmother's/Guardian's information (please circle):

Legal Name: _____DOB:_____

Home Address: _____City:_____State:____ ZIP:_____

Home Phone: _____Cell:_____Work:_____Ext:_____

Which phone number is the best number to reach you? ( ) Home ( ) Cell ( ) Work OK to leave a message? () Yes () No

Insurance Company Name:_____() Primary () Secondary

Father's/Stepfather's/Guardian's Information (please circle):

Legal Name: _____DOB:_____

Home Address: _____City:_____State:____ZIP:_____

Home Phone: _____Cell:_____Work:_____Ext:_____

Insurance Company Name :_____() Primary () Secondary

Information on Parent Child Does Not Live With (if applicable):

Legal Name: _____DOB:_____ () Male () Female

Home Address: _____City:_____State:____ZIP:_____

Home Phone: _____Cell:_____Work:_____Ext:_____

Which phone number is the best number to reach you? ( ) Home ( ) Cell ( ) Work OK to leave a message? () Yes () No

Insurance Company Name :_____() Primary () Secondary

Relationship to Child: () Father () Mother () Guardian () Other:_____

Medicaid Insurance Information:

Does the child have Medicaid Insurance? () Yes () No **If yes, Medicaid ID #:_____**

Emergency Contact (other than parents): Name: _____

Phone: _____ Relationship to Child: _____

I certify the above information is true and correct to the best of my knowledge:

Guarantor's signature: _____Date:_____

Guarantors relationship to the Child: () Father () Mother () Guardian () Other :_____

CAPITAL AREA PEDIATRICS HEALTH HISTORY (5 YEARS AND OLDER)

Name	Date of Birth

Pregnancy and Birth History

Did mother have any problems during the pregnancy? ☐No Problems ☐Illness requiring medication ☐Bleeding problem ☐High blood pressure ☐Sugar Diabetes ☐Premature Labor ☐Other _____

Was this child born within 2 weeks of your due date? ☐ Yes ☐ No

Were there any problems in the nursery that required the baby to stay at the hospital after mom was discharge? ☐Yes☐No
If yes please tell us about the problems: _____
_____

Past Medical History

Has your child ever been hospitalized overnight? ☐No ☐Yes Reason_____

Has your child had any surgery? ☐No ☐Yes Types of Surgery_____

Has your child had any serious injury requiring medical attention ☐No ☐Yes Explain_____

Has your child ever been diagnosed as having any of these problems? ☐Allergies ☐Asthma ☐Bladder/kidney infection ☐Chicken pox ☐Recurrent ear infection ☐Eczema ☐Hay fever ☐Heart problems ☐Pneumonia
☐Seizure ☐Recurrent sinusitis ☐Recurrent sore throat ☐Wheezing ☐Other medical problems_____
_____

Allergies/Medications/Immunization

Does your child have any allergy to medications? ☐No ☐Yes If yes explain what medication and what happened when medication was taken:_____

Is your child currently on any medications ☐No ☐Yes List all prescription medications that your child is on:
_____

Does your child receive a fluoride supplement? ☐Yes ☐No

Are your child's immunizations up to date? ☐Yes ☐No ☐I don't know (Please provide us with a copy of your child's immunizations)

Tuberculosis Risk Assessment	**No**	**Yes**
Has your child ever had a positive TB skin test?		
Has any member of this child's family or anyone that this child spends time with had a positive TB skin test or been treated for tuberculosis?		

Development/Educational History

Did you have any concerns about your child's development in the preschool years? ☐Yes ☐No

What grade is your child in at this time?

Does your child receive any special education services? ☐Yes ☐No If yes please explain:_____
_____

Do you or your child's teacher have concern about how your child is doing in school at this time? ☐Yes ☐No If yes please explain:_____

Please list any other information about your child that you would like us to know or any concerns you have at this time:

_____
_____
_____
_____

Parent/Guardian Signature	Date	Reviewed by Provider	Date

Capital Area Pediatrics — Social History Form

Patient Name	Date of Birth
Mother's Name	**Mother's Occupation**

Mother's Education (Check any that apply)

☐ GED ☐ High School Diploma ☐ College graduate ☐ Some college/training ☐ Graduate School ☐ Post Graduate

Father's Name	Father's Occupation

Father's Education (Check any that apply)

☐ GED ☐ High School Diploma ☐ College graduate ☐ Some college/training ☐ Graduate School ☐ Post Graduate

Parent's Current Relationship

☐ Married ☐ Separated ☐ Divorced ☐ Living Together ☐ A couple but not living together ☐ No longer together as a couple

If parents are not living in the same household, what is the custody arrangement?

☐ Lives with mom ☐ Lives with Dad ☐ Joint Custody ☐ Shared custody- weekends ☐ Shared custody-summers

Is the other parent involved?

☐ Father has regular visitation ☐ Mother has regular visitation ☐ Father not involved ☐ Mother not involved

List all people living in child's household

Name	DOB (MM/YY)	Relationship to child	Name	DOB (MM/YY)	Relationship to child

What is the current child care arrangement?

☐ Mother doesn't work outside the home ☐ Father doesn't work outside the home ☐ Parents work different hours

☐ Cared for by a relative ☐ Day Care Home ☐ Day care center ☐ Babysitter/ Nanny ☐ Other:_____

Have there been any recent stresses in the family?

☐ Parental job loss ☐ Parental job change ☐ Family move ☐ Major illness in family member ☐ Death in family

☐ Recent parental separation/divorce ☐ Loss of insurance ☐ Homeless/ Living in a shelter/ friend's house ☐ Other: _____

What is the child's race? Check those that apply

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White ☐ I don't wish to identify my child's race

What ethnicity is your child?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I do not wish to identify my child's ethnicity

What is the Primary Language spoken in your home?

☐ English ☐ Hindi ☐ Spanish ☐ Other_____

What is the source of drinking water at the home where the child lives?

☐ Well water ☐ Bottled water ☐ Bottled water w/ fluoride ☐ Lansing city ☐ Other city:_____

Does anyone who lives in your house smoke?

☐ No one smokes at home ☐ Mother smokes in home ☐ Father smokes in home ☐ Family members smoke in home

☐ Mother smokes outdoors only ☐ Father smokes outdoors only ☐ Family members smoke outdoors only

For children 6 yrs or less to help us assess your child's risk of lead exposure, please check all that apply:

☐ Live in a house Built before 1950 ☐ Live in a house built between 1950 and 1978 ☐ Visits a house built before 1950 regularly ☐ Child has a playmate/ sibling that has been diagnosed w/lead poisoning

Do you live in a house that has undergone major remodeling recently? Yes ☐ No ☐

Parent/Guardian: _____Date:_____

Capital Area Pediatrics — Family History Form

Name Patient: _____ Date of Birth: _____

Does any biologic relative (Parents, Grandparents, Siblings, Aunt/Uncle) have any of the following health problems?

Please circle yes or no for each of the following health problems:		Name the family members that have the problem by listing their relation to the child
Respiratory or Allergies		
Asthma	Yes No	
Allergies	Yes No	
Allergic Rhinitis	Yes No	
Eczema	Yes No	
Other: _____		
Cardiovascular Diseases		
Heart disease in male family member before age 55	Yes No	
Heart disease in female family member before age 65	Yes No	
Sudden Unexpected Death	Yes No	
Heart Attack	Yes No	
Angina	Yes No	
Coronary Artery Disease	Yes No	
Stroke	Yes No	
Blood clots	Yes No	
High Blood Pressure	Yes No	
Arrhythmia	Yes No	
Other:_____		
Mental Health Concerns		
Depression	Yes No	
Attention Deficit Hyperactivity Disorder	Yes No	
Anxiety Disorder	Yes No	
Alcohol/Drug Abuse	Yes No	
Other:_____		
Inherited Disease		
Sickle Cell Trait	Yes No	
Sickle Cell Anemia	Yes No	
Hearing Loss	Yes No	
Birth Defect	Yes No	
Other Inherited Disease:_____ _____		
Miscellaneous		
Cancer	Yes No	
Seizure Disorder	Yes No	
Epilepsy	Yes No	
High Cholesterol	Yes No	
Diabetes	Yes No	
Problems with anesthesia	Yes No	

List any other health problems in your family that are not previously listed:_____
_____

Parent/ Guardian Signature	Date	Reviewed by Provider	Date

Capital Area Pediatrics

3937 Patient Care Drive, Suite 101
Lansing, Michigan 48911
(517) 394-6484 fax (517) 394-7785

Authorization for Disclosure of Protected Health Information

Patient Name_____ Birth Date_____

Address_____ Phone No._____

1. I authorize disclosure of the protected health information (child's name) _____ be made by:

Previous Practice Name: _____

Address _____

Phone _____ **Fax** _____

Information to be disclosed will include, as applicable, unless crossed out:

- Alcohol and drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.
- Information about human immunodeficiency virus-HIV acquired immunodeficiency syndrome-AIDS, and AIDS related complex-ARC, as defined by Department of Community Health rules (1989 Public Act 174)

2. Person or organization authorized to receive information: **Capital Area Pediatrics**
3937 Patient Care Drive, Suite 101
Lansing, MI 48911

3. Specific Type of information to be disclosed.

☐ Entire Record ☐ Immunization Records ☐ Records from visit on_____

☐ Other_____

4. This information may be disclosed for the following purpose:

☐ Continued Care ☐ Personal Use ☐ Attorney Use ☐ Insurance Use

☐ Other_____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment.

6. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by state or federal privacy laws and regulations, the information described above may be disclosed and no longer protected by those laws and regulations

7. I understand that I may revoke this authorization at any time by notifying Capital Area Pediatrics in writing by sending a letter to the attention of the office manager. However, the revocation will not be valid if Capital Area Pediatrics has taken action in reliance on this authorization.

8. This authorization expires 365 days from date of the signature below unless otherwise requested.

_____ _____
Printed name of patient or patient's representative Relationship to child

_____ _____
Signature of patient or patient's representative Date

Capital Area Pediatrics has verified the identification of patient's representative

☐ Person known to staff ☐ driver's license/state identification ☐ other_____

Effective 2017

Financial Policy

1. It is your responsibility to know your child's/children's insurance benefits such as co-pays, co-insurances, deductibles, policy limitations and services that are not a covered benefit. This applies to but is not limited to:

    a. Sick Office Visits and Well Child Visits

    b. In depth medical conditions, vision, hearing and development screenings discussed or performed at a Well Child Visit may require a co-pay.

    c. Immunizations

    d. Procedures such as Wart Removal, Umbilical Cauterization, etc. (a deductible may apply)

    e. Lab Services Performed at Capital Area Pediatrics

    f. Medical/Therapeutic Items Supplied by Capital Area Pediatrics

    g. Procedures, lab services, medical and therapeutic items *are not included* in sick office visits or well child visits

    h. Inpatient Hospital Visits

2. You are responsible for keeping our office informed of any changes to your child's/children's addresses, phone numbers, or insurance(s).

3. When requested you must present your identification and insurance card(s).

4. Co-pays are due at the time of service and should be paid when you check-in. Co-pays not paid at the time of service will be subject to a $5.00 co-pay billing fee. Please keep a record of your payments made to our office.

5. **Important! The parent who accompanies a child for a visit will be financially responsible for any charges incurred. Our office does not bill responsible parties based on court documents.**

6. You are responsible for knowing if our office participates with your insurance. Any out-of-network benefit expenses incurred for services provided by Capital Area Pediatrics will be your responsibility.

7. If your insurance carrier requires a designated Primary Care Physician they must have the correct Capital Area Pediatrics' provider's name on file. This information needs to be on file at the time of service or your visit may have to be rescheduled.

8. **Medicaid is not accepted as a primary insurance. You have 90 days to procure commercial insurance otherwise your child may be considered for discharge.**

9. For established patients with Medicaid or a Medicaid HMO insurance you are responsible for:

    a. Providing our office with the patient's Medicaid identification number.

    b. Keeping our office informed of any changes to the patient's Medicaid plan. We only accept straight Medicaid, PHP and McLaren insurances.

    c. You must keep Medicaid informed of any other insurance(s) your child/children may have and provide us with the same information. This applies to both active and inactive insurances.

10. CSHCS – we do not accept Children Special Health Care Services insurance.

11. Statement balances are to be paid in full, within 30 days from the statement date, unless payment arrangements have been made with our billing office. If your family's account balance remains unpaid, Capital Area Pediatrics reserves the right to turn your account over to a collection agency and/or a small claims court.

We accept Visa/MasterCard, checks, money-orders and cash. Payments can be made by phone, using your Visa/MasterCard or debit card. ***ONLINE BILL PAYMENT IS NOW AVAILABLE THROUGH THE FOLLOWMYHEALTH PATIENT PORTAL***

Fees:

a. Medical Records:

- There is no charge for the copying of paper charts or compact discs, if your child/children are transferring to another practice. Medical records must be mailed directly to that practice. *Excludes: Medical records mailed or taken outside of the continental United States*.
- Medical records mailed or picked-up from Capital Area Pediatrics for other reasons or to be taken outside of the continental United States must be paid in advance and are subject to the following fees:
  - Paper: $25.00 per child
  - Compact Disc: $20.00 per child

b. FMLA Form Fees:

- $15.00 per request (must be prepaid)

c. Returned Check Fees:

- $35.00 per check

d. Sports Physical Forms

- $35.00 per form

e. Other Form Fees:

- Will be charged at the discretion of the provider of service.

Failure to follow any of the above conditions may result in the discharge of your family from Capital Area Pediatrics.

Assignment of Benefits: For all services rendered by Capital Area Pediatrics I hereby authorize my insurance carrier(s) to issue all payment(s) directly them. I understand that I am responsible for any amounts not covered by my insurance carrier(s).

Please provide the name(s) of all your family members seen @ Capital Area Pediatrics:

Name: _____DOB:_____ () Male () Female

Name: _____DOB:_____ () Male () Female

Name: _____DOB:_____ () Male () Female

Name: _____DOB:_____ () Male () Female

Name: _____DOB:_____ () Male () Female

I have read, understand and agree to the Capital Area Pediatrics' Financial Policy for the above family member(s):

Guarantor's Signature: _____ Date: _____

Guarantor's Relationship to the Child: () Father () Mother () Guardian () Other: _____

Capital Area Pediatrics

Written Acknowledgement of
Patient Centered Medical Home Contract
Receipt of Notice of Privacy Practices
Receipt of Appointment Cancellation Policy

I have received a copy of Capital Area Pediatrics Medical Home Contract, Notice of Privacy Practices and Cancellation Policy.

I understand that if my child misses three appointments in a 12 month period, he/she and all other children in the household will no longer be able to receive medical care from Capital Area Pediatrics.

I, _____, acknowledge receipt of these policies on behalf of
Parent or Guardian

my child _____ whose date of birth is_____.
Patients name

Signature_____ Date_____
Parent or Guardian

Relationship to child_____

CAPITAL AREA PEDIATRICS

A Patient Centered Medical Home

3937 Patient Care Drive Suite 101
Lansing MI 48911
Ph: (517) 394-6484 Fax: (517) 394-7785

Mary F. Mora, M.D.
Melissa Morin, D.O.
Amanda Torgeson, D.O.
Arti U. Shah, M.D.
Courtney Hart, M.D.
Katheryn Wheeler-Fulton, N.P.-C

We appreciate the opportunity to provide you with medical services. The information that follows is designed to answer the questions most frequently asked by our patients. We want you to know our policies and methods of practice. **If you have any questions, please ask us.**

Capital Area Pediatrics Is a Patient Centered Medical Home

A **Medical Home** is a trusting partnership between a doctor led health care team and an informed patient. It includes an agreement between the doctor and the patient that acknowledges the role of each in a total health care program.

We trust you, our patient, to:

-Tell us what you know about your child's health and illnesses
-Tell us about your needs and concerns and those of your child
-Take part in planning your child's care
-Follow the care plan that is agreed upon-or let us know why you cannot so that we can try to help, or change the plan
-Tell us what medications your child is taking and ask for a refill when you need one at your office visit
-Let us know when your child sees other doctors and what medication changes are made by another doctor
-Ask other doctors to send us a report about your child's care when you see them
-Seek our advice before you take your child to see other physicians
-We may be able to care for your child and we know about the strengths of various specialists
-Learn about wellness and how to prevent disease
-Learn about your insurance so you know what it covers
-Respect us as individuals and partners in your child's care
-Keep your appointments as scheduled, or call and let us know when you cannot
-Pay your share of the visit fee when you are seen in our office
-Give us feedback so we can improve our services

As a health care team we will continue to:

-Provide your child with a care team who will know you and your family
-Respect you as an individual-we will not make judgments based on race, religion, sex, age, disability, etc.
-Respect your child's privacy-your child's medical information will not be shared with anyone unless you give us permission or it is required by law
-Provide care with a team of people led by your child's physician
-Give the care your child needs when you need it
-Give care that meets your needs and fits with your goals and values and those of your child
-Have a doctor on call 24 hours a day and 7 days a week
-Take care of short illness, long term disease and give advice to help your child stay healthy
-Tell you about your child's health and illnesses in a way you can understand
-To improve your child's care we are using technology--like our electronic medical records and electronic prescribing and we strive to continuously improve our use of technology

You may notice that as a health care team:

-We ask what your goal for your child is, or what you want to do to improve your child's health
-We ask you to help us plan your child's care, and to let us know if you think you can follow the plan
-You will be offered a summary of your visit
-Written copies of care plans may be given in more complex illnesses
-We remind you when tests are due so that your child can receive the best quality care

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above and we will acknowledge our agreement to you. Our goal has been to provide excellent care for you.

It is our desire to continue to improve our services to you!

Practice Hours

Monday 8:00am-7:00pm **Tuesday through Friday 8:00am-5:00pm**

Phone services available:

Monday through Friday 8 am to 12 noon and 1pm to 5 pm. We have an automated system so when you call you will hear a brief message with prompts to direct your call. You may speak with our receptionist to schedule appointments or leave a message regarding triage, refills, and referrals and billing concerns.

*Triage staff is available 8 am-noon and 1 pm – 4:30 pm. Calls are returned on urgency basis as soon as possible. All calls received by 4:30pm will be returned the same day. If you need urgent advice, please let our receptionist assist you.

*Voicemail for refill and referral lines are checked frequently each day. Please allow 24 – 48 hours for refills to be completed.

Our voicemail boxes can be reached 24 hrs/day, 7 days a week. Messages left after 5 pm or on weekends will be reviewed the following business day. Please speak clearly and slowly, spell your child's name and give the date of birth to enable our staff to help you more efficiently.

After hour services:
Monday evening hours are now available from 5 pm – 7 pm. There will be one physician and our nurse practitioner available in our office.

There is a physician available each night, weekend and holiday to assist you with ***urgent*** concerns. You may reach the on-call physician by calling our office number ***(517.394.6484).*** You will be prompted to leave your child's name and date of birth and briefly describe the problem. Please leave a phone number at which you can be reached. Please keep this line open to receive the return call. Our on-call staff will be paged and will return your call –striving to do so within 30 minutes. If you have not heard from us in that time, please call back and leave a second message. We ask that this service be used for matters that cannot wait until regular office hours.

Emergency Care and Urgent Care:
CAP strives to accommodate patients who need more urgent care. Please call us to see if we can see your child or to ask for guidance. If we are unable to see your child or feel that an emergency room or urgent care facility can serve you better, we will guide you to appropriate care.

Insurance Participation:
Your insurance policy is a contract between you and your insurance carrier or HMO. It is your responsibility to know what services are covered and your co-pay amount for physician office visits. CAP participates in many health plans. Your health plan probably covers preventive care such as well child exams and vaccines. CAP reviews health plans with your interests in mind.

* Be prepared to present your insurance card and personal identification card at every office visit.
* The person accompanying the patient is responsible for payment at the time of service. Be prepared to pay any charges not covered by your insurance. This includes deductibles, co-pays or payment for non-covered services.
* Register your NEWBORN on your insurance plan as soon as possible to help us maintain accurate billing-if this is not done within 30 days of birth-you may have to wait until the next open enrollment period with your employer.

If you have questions regarding a bill, please call our office @ 517.394.6484. You may leave a message on the billing office voicemail 24 hrs/day-be sure to leave your name and best phone number at which you can be reached.

Laboratory and Test Results:
Please try to use laboratories and other test facilities we use regularly to ensure better communication. We strive to get test results to patients. Please call if you have not heard from us within a week after test(s) are done.

Welcome To Our Practice!

Capital Area Pediatrics

3937 Patient Care Dr. Ste 101
Lansing MI 48912
Ph: 517.394.6484 Fax:517.394.7785

Missed Appointment Policy
Revised 4/2014

It is the responsibility of the patient's parent/guardian to notify our office if you cannot keep an appointment that has been scheduled. It is our expectation that our office staff will be notified as soon as possible if an appointment needs to be canceled for any reason. **Our staff needs to be notified greater than 4 hours prior to your appointment time to avoid the appointment being counted as a no show.** Our office telephone hours are Monday through Friday 8:00 – 12:00 and 1:00 – 5:00. If you need to call during non office hours you may leave a message on our cancellation line which is option 9 when you call our office letting our staff know you need to cancel your appointment.

You may leave a message 24 hours a day (517.394.6484)

If any member of your family who is receiving care at Capital Area Pediatrics misses a scheduled appointment 3 times in a 12 month period, our staff will no longer be able to provide care for any child in the family.

1st Missed appt: If a scheduled appointment is missed or an appointment is cancelled with less than 4 hours notice, a letter will be sent to the parent/guardian notifying them of our missed appointment policy and documenting the first missed appointment.

2nd Missed appt: If any member of your family misses or cancels another appointment with less than 4 hours notice, within the above noted 12 month period, a second letter will be sent. This letter will again remind you of our missed appointment policy and will document the dates of the appointments that have been missed.

3rd Missed appt: If a third appointment is missed or cancelled with less than 4 hours notice by any member of your family within the above noted 12 month period, a termination letter may be sent. This letter will document all 3 missed appointments. For thirty days after the date of the letter, Capital Area Pediatrics will provide emergency care for your child(ren). Thirty days from the date of the letter your child(ren) *will no longer* be able to receive medical services from Capital Area Pediatrics.

If you feel you have received a letter documenting a missed appointment in error, please contact our office as soon as possible to talk with our office manager. She may be reached at 517.394.6484

Effective 2017

Financial Policy

12. It is your responsibility to know your child's/children's insurance benefits such as co-pays, co-insurances, deductibles, policy limitations and services that are not a covered benefit. This applies to but is not limited to:

    i. Sick Office Visits and Well Child Visits

    j. In depth medical conditions, vision, hearing and development screenings discussed or performed at a Well Child Visit may require a co-pay.

    k. Immunizations

    l. Procedures such as Wart Removal, Umbilical Cauterization, etc. (a deductible may apply)

    m. Lab Services Performed at Capital Area Pediatrics

    n. Medical/Therapeutic Items Supplied by Capital Area Pediatrics

    o. Procedures, lab services, medical and therapeutic items *are not included* in sick office visits or well child visits

    p. Inpatient Hospital Visits

13. You are responsible for keeping our office informed of any changes to your child's/children's addresses, phone numbers, or insurance(s).

14. When requested you must present your identification and insurance card(s).

15. Co-pays are due at the time of service and should be paid when you check-in. Co-pays not paid at the time of service will be subject to a $5.00 co-pay billing fee. Please keep a record of your payments made to our office.

16. **Important! The parent who accompanies a child for a visit will be financially responsible for any charges incurred. Our office does not bill responsible parties based on court documents.**

17. You are responsible for knowing if our office participates with your insurance. Any out-of-network benefit expenses incurred for services provided by Capital Area Pediatrics will be your responsibility.

18. If your insurance carrier requires a designated Primary Care Physician they must have the correct Capital Area Pediatrics' provider's name on file. This information needs to be on file at the time of service or your visit may have to be rescheduled.

19. **Medicaid is not accepted as a primary insurance. You have 90 days to procure commercial insurance otherwise your child may be considered for discharge.**

20. For established patients with Medicaid or a Medicaid HMO insurance you are responsible for:

    d. Providing our office with the patient's Medicaid identification number.

    e. Keeping our office informed of any changes to the patient's Medicaid plan. We only accept straight Medicaid, PHP and McLaren insurances.

    f. You must keep Medicaid informed of any other insurance(s) your child/children may have and provide us with the same information. This applies to both active and inactive insurances.

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We accept Visa/MasterCard, checks, money-orders and cash. Payments can be made by phone, using your Visa/MasterCard or debit card. ***ONLINE BILL PAYMENT IS NOW AVAILABLE THROUGH THE FOLLOWMYHEALTH PATIENT PORTAL***

Fees:

f. Medical Records:

- There is no charge for the copying of paper charts or compact discs, if your child/children are transferring to another practice. Medical records must be mailed directly to that practice. *Excludes: Medical records mailed or taken outside of the continental United States*.
- Medical records mailed or picked-up from Capital Area Pediatrics for other reasons or to be taken outside of the continental United States must be paid in advance and are subject to the following fees:
  - Paper: $25.00 per child
  - Compact Disc: $20.00 per child

g. FMLA Form Fees:

- $15.00 per request (must be prepaid)

h. Returned Check Fees:

- $35.00 per check

i. Sports Physical Forms

- $35.00 per form

j. Other Form Fees:

- Will be charged at the discretion of the provider of service.

Failure to follow any of the above conditions may result in the discharge of your family from Capital Area Pediatrics.

Patient Portal – FollowMyHealth

Capital Area Pediatrics invites you to be a part of our patient portal. It is accessible anywhere, anytime and enables you to take a proactive role in managing your child's/children's health care needs. With FollowMyHealth, you can:

- Request to schedule or change appointments
- Request prescription refills
- Receive test and lab results from your physician
- View medical notes from your physician
- Send non –urgent messages (i.e.-request school notes, etc)
- View balance and make payments
- Receive email/text reminders of upcoming appointments
- Update your address/phone number/insurance information
- Have access using the mobile app

…Plus much more!!

To sign up – email us at **capfollowmyhealth@gmail.com** , contact our office staff or leave message on our 24 hour message line with the following information:

Your email address, full name and date of birth for your each child

Effective Date of this Notice: February 2014

Capital Area Pediatrics

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Capital Area Pediatrics
3937 Patient Care Drive, Suite 101
Lansing, MI 48911
(517) 394-6484

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including, but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat you or assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Heath-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury, or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose the information

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of this request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

a. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
b. Concerning a death we believe has resulted from criminal conduct
c. Regarding criminal conduct at our offices
d. In response to a warrant, summons, court order, subpoena or similar legal process
e. To identify/locate a suspect, material witness, fugitive or missing person
f. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurance that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI
You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484;* specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family member and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request by law, in emergencies, or when the information is necessary to treat you. IN order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484.* Your request must describe in a clear and concise fashion.
(a) the information you wish restricted
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not psychotherapy notes. You must submit your request in writing to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484;* in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484.* You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484.* All requests for an "accounting of disclosures" must state a time period, which

may not be longer that six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484.*

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact *Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484.* All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note - we are required to retain records of your care.

Again if you have any questions regarding this notice or our health information privacy policies or would like another copy of this notice, please contact:
Capital Area Pediatrics; 3937 Patient Care Drive, Suite 101; Lansing, MI, 48911; (517) 394-6484.