PLEASANT HEALTH CARE, P.C. –NEW PATIENT INFORMATION Date: _____

PATIENT NAME: _____ MALE /FEMALE
Last First Middle

PATIENT'S SOCIAL SECURITY #:_____ AGE _____ DATE OF BIRTH (DOB):_____

ADDRESS: _____

CITY/STATE/ZIP: _____ PHONE: _____

RACE: AMERICAN/ INDIAN/ ASIAN /NATIVE HAWAIIAN /BLACK; AFRICAN AMERICAN/ WHITE/ HISPANIC/ OTHER/ REFUSE TO REPORT

ETHNICITY: HISPANIC OR LATINO/ NOT HISPANIC OR LATINO /REFUSE TO REPORT

LANGUAGE: ENGLISH/ INDIAN (INCLUDES HINDI) /SPANISH /CHINESE /OTHER_____

PARENT(s) or GUARDIAN(s) GUARANTOR INFORMATION

PARENT / GUARDIAN NAME: _____ DOB: _____

RELATIONSHIP TO PATIENT: MOTHER /FATHER /GRANDPARENT /FOSTER PARENT/OTHER _____

PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

EMAIL FOR PATIENT PORTAL ACCESS: _____

PARENT / GUARDIAN NAME: _____ DOB: _____

RELATIONSHIP TO PATIENT: MOTHER/ FATHER /GRANDPARENT/ FOSTER PARENT /OTHER _____

PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

INSURANCE INFORMATION

PRIMARY INS: _____ MEMBER ID: _____ GROUP: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN#_____

EMPLOYER: _____ REALTIONSHIP TO PATIENT: _____

SECONDARY INS: _____ MEMBER ID: _____ GROUP: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN#: _____

EMPLOYER: _____ RELATIONSHIP TO PATIENT: _____

IN CASE OF EMERGENCY, PLEASE PROVIDE THE NAME OF A RELATIVE OR FRIEND WE MAY CONTACT **AT A DIFFERENT ADDRESS**:

NAME: _____ PHONE:_____

ADDRESS: _____ RELATIONSHIP TO PT: _____

HOW DID YOU HEAR ABOUT US? INTERNET SEARCH/ PHONE BOOK/ INSURANCE COMPANY/ ADVERTISTMENT/ FRIEND/FAMILY

Pleasant Pediatrics-Insurance Participation List

Pleasant Pediatrics participates with the following insurance programs:

- Blue Cross Blue Shield (ALL)
- Blue Care Network
- MultiPlan
- ASR Corp
- Mclaren Health Plan
- Aetna
- United Health Care/Golden Rule
- CIGNA PPO
- Physicians Health Plan Comm'l HMO/PPO
- Tricare
- Key Benefit Administrators
- US Health and Life
- HealthPlus
- Meritain
- Physician Health Plan (PHP)
- Priority Health HMO/PPO
- Cofinity Network

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- Medicaid (State of Michigan)
- Meridian Health Plan (MI Child)
- PHP (MI Child)
- Molina (MI Child)
- Mclaren (MI Child)

Pleasant Health Care, P.C. participates with a variety of health care plans including many Medicaid plans, BCBS, Cofinity and Children's Special Health Care to name a few. Please talk to our biller to be certain if we par with your plan. As a courtesy to our patients Pleasant Health Care, P.C submits claims to all carriers, regardless of our participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day service's are rendered.

I understand that my insurance policy is a contract between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time service are rendered. I agree to be financially responsible for all costs incurred by my dependent child in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by the office, whether conducted in this office or elsewhere, which are not otherwise paid by my insurance.

I hereby authorize Pleasant Health Care, P.C. or its designees to bill and release to my insurance company and/or third payer(s) and /or external review agency(s) such information contained in my child's patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history, illness or diagnostic and therapeutic information.

Signature (Legal Parent/Guardian):_____ Date:_____

PLEASANT PEDIATRICS CONSENT TO TREAT

Consent for treatment of a minor

I, _____ being the parent or legal guardian of

Name of the child: _____ Date of Birth: _____

give my consent and authorize the administration and performance of all treatment and diagnostic procedures, which in the judgment of Pleasant Pediatrics licensed physicians and physicians assistant are considered necessary. The minor named in this consent form may receive all medical care provided according to **generally and currently accepted standards of pediatric medical care.**

In the absence of the legal guardian the following people are authorized to bring this minor for medical treatment and have access to his/her medical information. (You may name relatives, friends, grandparents, stepparents, non-custodian parent, day care provider, foster parent or others.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

If no other person is authorized please circle **NONE**

Please initial the following:

____If a minor is brought by any other person not recorded above, Pleasant Pediatrics will make reasonable to attempts to contact me for verbal consent to treat. **I will keep Pleasant Pediatrics notified of any change of my telephone number.**

____If the custody or guardianship of this minor has changed I will furnish Pleasant Pediatrics with the legal forms that are required to be included in the minor's medical recorded to explain the change in guardianship. This will alleviate any confusion that may occur over who may or may not consent to minor's treatment. .

____I have the right to revoke or change this consent to treat in writing.

Parent/Legal guardian signature Printed Name Date

_____

PATIENT-PROVIDER PARTNERSHIP AGREEMENT

Welcome and thank you for choosing Pleasant Pediatrics. We are committed to providing your children with the best medical care based on their health needs. Our hope is that we can form a partnership to keep them as healthy as possible, no matter what their current state of health.

Your commitment to our patient-centered medical home practice will provide you with an expanded type of care. We will work with both you and other health care providers as a team to take care of your child/children.

As your primary care provider (PCP), I will:

- Learn about your child, your family, life situation, and health goals and preferences. I will remember these and the health history every time you seek care and suggest treatments that make sense for your family.
- Take care of any short-term illness, long-term chronic condition, and all-around well-being.
- Keep you up to date on all their vaccines, well-child visits, and other prevention screening tests.
- Connect you with other members of your care team (specialists) and coordinate your care with them as their health needs change.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you will understand any conditions and all the options.
- Listen to your questions and feelings. I will respond promptly to you in a way you understand.
- Help you make the decisions of your child's care.
- Provide information on community resources.

We trust you, as our patient, to:

- Know that you and your family are a full partner with us in your children's care.
- Come to each visit with any updates on medications, or remedies you're using, and questions you may have.
- Let us know when you see other health care providers so we can help coordinate the best care.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your child's health, ask questions about their care, and tell us if you don't understand.
- Learn about their condition(s) and what you can do to keep them as healthy as possible.
- Follow the plan that we have agreed is best for your child's health.
- Give the prescribed medications as directed.
- All health care providers in your care team will receive all information related to your child's health care.
- Learn about your health insurance coverage and contact your insurance provider if you have any questions about benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for your family.
- Ask us about resources you or your family may need.

Dr. Msibi and the care team of Pleasant Pediatrics look forward to working with your family as your child's primary care provider in your patient-centered medical home.

Provider Signature | Printed Provider name | Date

Parent/Guardian Signature | Printed Name | Date

Printed Patient Name

Pleasant Health Care, P.C.

Notice of Privacy Practices

This notice describes how medical information about you may be used and how disclosed and how you can get access to this information. Please Review it carefully. The privacy of your medical information is important to us.

Overview

The law requires us to keep your protected health information (PHI) private in accordance with this Privacy Practices (Notice), as long as this notice remains into effect. We are also required to provide you with a paper copy of this notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI.

From time to time, we may revise our privacy practices and terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and out notice may be retroactive. Our notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convince, we have provided the following examples of such potential uses or disclosures:

Treatment. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you. This included disclosure of your PHI to other healthcare providers through electronic exchanges such as patient registries and Health Information Exchanges (HIEs)

Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

Health care Operations. Your PHI may be used or disclosed as part of our internal health care operations. Such health programs, accreditation, certification, licensing or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in the notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose you PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized use or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the individual Rights sections of this notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A

disclosure of your PHI may also be made if we determine it is reasonable necessary or in your best interests for such purposes as allowing a person acting on your behave to receive filled prescriptions, medical supplies, X-Rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgement that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers compensation or similar laws, public health laws court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations, or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence, or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement official to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstance not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI

Military and National Security. We may disclose to military authorities the medical informational of Armed Forces personnel under certain circumstances. When required by law, we may disclose you PHI for intelligence, counterintelligence and other national security activities.

Dr. Msibi records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state and national health information exchanges. This organization participates in the Great Lakes Health Connect (GLHC) information network. GLHC has rules regarding how health information can be accessed through GLHC, and limits on use or disclosures of that information. For more information about GLHC and your rights associated with transmissions of your information through this and other health information exchanges.

Your Individual Rights.

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which you PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and locating responsible parties. For each 12 month period, you have the right to receive one free copy of accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12 month period, we will charge you a reasonable, cost based fee for additional requests. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer. You have the right to request a restriction on your PHI covered Entity uses or disclosures for treatment, payment or health care operations. You have a right to request a limit on disclosures of your PHI to others, such as a patient registries and HIEs and family members or friends who are involved in your care or the payment of your care. Your request must include the PHI you wish to limit whether you want to limit Covered Enmity's use, disclosure, or both and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse). You may request such a restriction using the Contact Information at the end of this notice.

Alternative Communication. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or locations and provided a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend you PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstance, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which you may prepare a rebuttal, a copy of which will be provided to you at cost. Please contact our Privacy Officer with any further questions about amending your medical record.

HIPPA

Complaints

If you believe we have violated your privacy rights, you may complain to us or the secretary of the United States Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer.

We support the right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the United States Department of Health and Human Services

Privacy Officer
Dr. Bhekumusa Msibi, D.O
1970 Ashland Dr.
Mt. Pleasant, MI 48858
989-772-1500

Pleasant Health Care, P.C

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned patient or legally authorized representative ("Agent") of the patient acknowledges that he or she personally received a copy of the Pleasant Health Care, P.C's Notice of Privacy Policies on the date indicated below.

Signature: _____ Date: _____

Patients Name: _____

Information about Agent (attach appropriate documentation):

Agent: _____ Title: _____

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Medication and Pharmacy Consent

The undersigned patient or legally authorized representative ("Agent") of the patient hereby give consent for Pleasant Pediatrics to access the patients past and present medication history. This is necessary for use of electronic prescription writing.

Childs Name: _____ D.O.B _____

Name of Childs Pharmacy: _____

City of Pharmacy: _____

Signature of Guardian: _____

Pediatric Health History

Patient: _____ Date of Birth: ____/____/_____

Name of Person Completing Form: _____

Relationship to Child: Mother/Father/Grandparent/Foster parent/Guardian

Signature: _____

Are the patients immunizations up to date: ☐ Yes ☐ No ☐ Unknown
When was the patient's last well child exam or physical? _____

Medical Conditions: If either the patient of family member has or had any of these conditions, mark an (x) in the box by the condition listed. For family members, indicate their relationship to the patient. (Please specify which side Mom or Dads).. Ex: Grandma on mom's side

Condition	The Patient	Family Member	Relationship to Child (SPECIFY)
Allergies/Hay Fever			
ADD/ADHD			
Asthma			
Cancer (Type)			
Depression			
Diabetes			
Hearing Loss			
Heart Problems			
High Blood Pressure			
High Cholesterol			
Kidney Problems			
Migraine Headaches			
Panic Attacks/Anxiety			
Seizures			
Skin Problems			
Thyroid Problems			
Cystic Fibrosis			
Cerebral Palsy			
Sickle Cell Anemia			
Developmental disabilities			
Muscular Dystrophy			
Other:			
Other:			

Nurse Signature/Date: _____

Provider Signature/Date: _____

Pediatric Health History

Name:_____

BIRTH HISTORY

Birth Weight: _____Length: _____

Hepatitis B given in Hospital? ☐ Yes ☐ No Number of weeks Gestation: _____

Was the patient born prematurely? ☐ Yes ☐ No If Yes, how early? _____

How was the patient born? ☐ Vaginally ☐ By C-Section, if C-Section, why? _____

Did the patient have **Cyanosis** or **Jaundice** after birth? _____

Male Patients only: **Circumcision** ☐ Yes ☐ No

How many days did baby stay in the hospital? _____

Before the Patient was born, did mother have any complications during pregnancy? (see below)

- ☐ Gestational Diabetes ☐ High Blood Pressure/Preeclampsia
- ☐ Urinary Tract Infection ☐ Alcohol /Drug Use , specify _____
- ☐ Sexually Transmitted infection(s), specify _____
- ☐ Other complications Prenatal or Postnatal:_____

Family Information: Mothers Date of Birth: _____Age_____ Fathers Date of Birth: _____Age_____

Child's Siblings: _____ Age _____ Full Sibling ☐ Yes ☐ No

Child's Siblings: _____ Age _____ Full Sibling ☐ Yes ☐ No

Child's Siblings: _____Age _____ Full Sibling ☐ Yes ☐ No

Child's Siblings: _____Age _____ Full Sibling ☐ Yes ☐ No

Child's Siblings: _____ Age _____ Full Sibling ☐ Yes ☐ No

HOSPITALS

Has the patient been re-admitted to the hospital since birth and/or have been seen for any reason? ☐ Yes ☐ No
If YES, please specify substance(s) and reaction(s)

_____

SURGERIES

Has the patient ever had surgery? ☐ Yes ☐ No
Please list any surgeries or procedures your child had had with approximate dates:

_____

ALLERGIES

Is the patient allergic or intolerant to any medications, foods or any environmentals? ☐Yes ☐ No
If YES, please specify substance(s) and reaction(s):_____

OTHER

Exposed to a Communicable Disease? ☐ Yes ☐ No If Yes, Explain: _____
Traveled Outside of U.S? ☐ Yes ☐ No If Yes, where: _____

Nurse Signature/Date: _____

Provider Signature/Date: _____

MEDICATIONS

Please list any medications the patient is using including Over the Counter Medications, Vitamins and Herbal Supplements and Contraception's:

Medication	Dose/Amount	How many times per day

Symptom Check List:

If the patient has had any of the following problems, please mark an (X) in the box by the condition listed.

General: ☐ Fever ☐ Fatigue ☐ Chills ☐Unintended Weight Change (How much -/+ _____) ☐ Other: _____

Head: ☐ Headaches ☐ Dizziness ☐ Injury, specify_____ ☐ Other: _____

Ears: ☐ Ear Pain ☐ Ear Discharge ☐ Change in Hearing ☐ Other: _____

Nose: ☐ Congestion ☐ Sinus Pressure ☐ Sinus Pain ☐ Other: _____

Throat: ☐ Sore Throat ☐ Snoring ☐ Sleep Apnea ☐ Itchy Throat ☐ Other: _____

Eyes: ☐ Changes in Vision ☐ Flashing Lights ☐ Eye Pain ☐ Eye Discharge ☐ Itchy or Irritable ☐ Other: _____

Heart: ☐ Chest Pain/ Pressure ☐ Palpitations/ Racing Heart ☐ Other: _____

Lungs: ☐ Trouble Breathing ☐ Cough ☐ Wheezing ☐ Pneumonia ☐ Bronchitis ☐ Other: _____

Urinary: ☐ Painful Urination ☐ Foul Smell ☐ Incontinence ☐ Frequency Other:_____

Digestive: ☐ Heartburn or Acid Reflux ☐ Abdominal Pain ☐ Vomiting ☐ Nausea ☐ Blood in Stool

☐ Constipation ☐ Diarrhea ☐ Other: _____

Bones & Joints: ☐ Back Pain ☐ Joint Pain ☐ Neck Pain ☐ Muscle Aches ☐ Other: _____

Neurological: ☐ Weakness ☐ Seizures ☐ Numbness ☐ Fainting ☐ Other: _____

Psychological: ☐ Anxious ☐ Panic Attack ☐ Insomnia ☐ Appetite Changes ☐ Self Injury

☐ Uncontrollable Anger or irritability ☐ Other: _____

Skin: ☐ Abnormal Changes ☐ Bruising ☐ Rashes ☐ Hair or Nail Changes ☐ Dryness ☐ Other: _____

Nurse Signature/Date: _____

Provider Signature/Date: _____