Isabella Citizens for Health, Pediatrics Registration: **PLEASE PRINT CLEARLY** Today's Date:

PATIENT INFORMATION

Last name: First: Middle:

Sex: ☐ Male ☐ Female

Marital status: ☐Single ☐ Married ☐ Divorced ☐Widowed ☐Legally Separated

E-mail: Preferred Method of Contact: ☐ Text ☐ Email ☐ Phone

As a Federally Qualified Health Center, we are required by the Federal Government to ask more questions than a typical demographic form. We ask about income because our low-income patients may qualify for discounted services. If you have any questions, please feel free to ask.

Primary Phone:	Secondary Phone:	Work Phone:	Birth date:	SS #

Address:	City:	State:	Zip Code:	PO Box: Apt./Lot #:
Secondary Address:	City :	State:	Zip Code:	PO Box: Apt./Lot #:

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other: ______________________

Race: ☐ Asian ☐ African American/Black ☐White/Caucasian ☐ American Indian/Alaskan Native ☐ Multi-Racial ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Unknown/Refuse to Report

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/non-Latino
- ☐ Decline To Answer

Employment Status: ☐Full Time ☐Part Time ☐Not Employed

Employer:

Student Status: ☐ N/A ☐ Full Time ☐ Part Time

Household Income: _______________ ☐ Decline To Report
Please specify (circle): Weekly/Monthly/Annually
Household Size: __________

Do you live in public housing?	☐Yes	☐ No
Were you homeless within the last 12 months?	☐Yes	☐No
Are you a Veteran?	☐Yes	☐No
Are you a migrant or seasonal agricultural worker?	☐ Yes	☐No

Guarantor/Parent (if not patient):	Relationship to patient:	Birth date:	Social Security #:
Address:	Phone:	Employer:	
Second Parent:	Relationship to patient:	Birth date:	Social Security #:
Address:	Phone:	Employer:	

Primary Insurance Information **(Please be sure to present copy of card(s) to receptionist)**

Name of primary insurance:	Subscriber's name:	Birth date:	Policy Number:	Group Number:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name and birth date:	Policy Number:	Group Number:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone Number:	Alt Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Isabella Citizens for Health or insurance company to release any information required to process my claims.

Patient/Guardian Signature ______________________ Date ______________

Isabella Citizens for Health, Inc.

Patient's Name: ______________________________ **Birth Date:** ______________

I have received the following documents and understand the policies outlined within. I have read the policies in their entirety and fully understand how the information relates to me and my family members. **(Please initial each line.)**

INITIAL:_________ **General Consent for Treatment**

INITIAL:_________ **Patient and Center Rights and Responsibilities**

INITIAL:_________ **Missed Appointment Policy**

INITIAL:_________ **I acknowledge I have been offered or have received the Notice of Privacy Practice of Isabella Citizens for Health, Inc.**

Release to Family and Friends Involved in Health Care

Isabella Citizens for Health has always been committed to the protection of your personal medical information. We realize that in today's society your spouse, individual family members, or close friends may be involved with your care or the payment of your care. In an effort to protect your personal medical information, we need to know the individuals you wish to allow our staff to release or discuss your care or the payment of your care with.

The physicians, nursing staff, and office staff have my permission to release or discuss my personal medical information concerning the following:

CHECK EACH TYPE OF INFORMATION THAT CAN BE RELEASED:

☐ **General Medical Care** ☐ **Billing and Accounts** ☐ **Medications**
☐ **Insurance Information** ☐ **Appointments**

Isabella Citizens for Health may release or discuss my personal medical information, as indicated above, with any of the following individuals in person or by telephone:

1) ______________________________ **Relationship:** ______________________

2) ______________________________ **Relationship:** ______________________

3) ______________________________ **Relationship:** ______________________

4) ______________________________ **Relationship:** ______________________

2790 Health Parkway • Mt Pleasant, MI 48858
(989) 779-5270
Fax: (989) 779-5279

Release to Family and Friends Involved in Health Care continued:

Print Name of Patient | Date

Signature of Patient or Legal Representative | Relationship to Patient

Signature of Witness | Date

Isabella Citizens for Health will not release or discuss your personal medical information with your spouse, individual family members, or close friends, as indicated above, for the following:

- Any information related to sexual abuse, child abuse, other abuse, neglect, or domestic violence.
- Any information that we feel may cause or bring harm to you or someone else.
- Any information related to pregnancy, infertility, sterilization, or other related topics.
- Any information related to sexually transmitted diseases.
- Any information related to Acquired Immunodeficiency Syndrome (AIDS), or human-immunodeficiency virus (HIV)
- Any information related to alcohol or substance testing, treatment, or abuse.

If you desire our staff to release or discuss any of the above items with your spouse, individual family members, or close friends, you must specifically authorize, in writing, for us to do so. Any Isabella Citizens for Health staff member will assist you in doing so. This document shall remain in effect until revised or revoked by the patient or their personal representative.

Isabella Citizens for Health, Inc.

Pediatric Health History Form

Patient Name: ________________________ **DOB:** __/__/____

Age: ____ **Today's Date:** __/__/_____ **Preferred Pharmacy:** ________________________

Sex: ☐ Male ☐ Female Birth Weight: _______ Birth Length: _______ Time of Birth: _________

Birth History: Mother and Child

Number of pregnancies: _______ Number of live births: _______ Full/pre-term weeks: ________

Complications during pregnancy: ☐ Pre-term labor ☐ High Blood pressure ☐ Diabetes

Medications taken during pregnancy (include supplements, inhalers, over the counter medications):

Name	Strength	How often?

☐ Vaginal birth ☐ C-section *if C-Section, was it ☐ Elective or ☐ Emergency?

Newborn Complications: ____

Immunizations given to child at birth: ____

Child's Past Medical History:

☐ Asthma ☐ RSV ☐ Frequent ear/throat infection ☐ADD/ADHD ☐ Thyroid Problem

☐ Birth defect ☐Chicken pox ☐ Heart Problem ☐ Eczema

Other: ____

Child's Past Hospitalization, Surgeries, and Injuries History (please describe and include dates):

____

____

Physicians/Other Providers Who Have Treated the Child:

____ Dates: ______________

____ Dates: ______________

Are you interested in your child receiving Fluoride Varnishment? (Children > 3 Yrs) ☐ Yes ☐ No

Date of last dental exam: _________ Name of Dentist: ________________________

Date of last vision exam: _________ Name of Eye Doctor: ________________________

Child's Medications (include supplements, inhalers, over the counter medications):

Name	Strength	How often?

Does the child have allergies, including medications or foods? ☐ Yes ☐ No If yes, please list below:

____

____

Are your child's immunizations up to date? (or provide current, completed form): ☐ Yes ☐ No
Patient Name:___________________________ **DOB:**____________

Diet History:
Was/is the child breastfed? ☐ Yes ☐ No Formula fed? ☐ Yes ☐ No Ounces per day? ______________
Baby food? ☐ Yes ☐ No Solids? ☐ Yes ☐ No
Did your child have difficultly gaining weight as a baby? ☐ Yes ☐ No

Developmental History:
Age at the following: Rolling Over: ________Sitting alone _______Crawling _______Walking _______
Talking _______Teeth _______Toilet training _______
Comparison to siblings ____
School age children: Does your child have special needs or would they benefit from an individualized education program? ______________________________
Family Medical History:
*****PLEASE SPECIFY FAMILY MEMBER/MATERNAL OR PATERNAL*****

Medical Problem	Yes	No	Relationship
Heart Disease			
Cancer/ Type? _______________			
High Blood Pressure			
Diabetes			
Kidney Disease			
Headaches			
Neurological disorders/seizures			
Mental Illness			
Learning Disabilities			

Other: ____

Social History:
Who lives with the child at home? ____
Does the child go to school? ☐ Yes ☐ No Daycare? ☐ Yes ☐ No
Are there smokers in the home? ☐ Yes ☐ No *If yes, inside or outside? ☐ Inside ☐ Outside
Are there pets in the home? ☐ Yes ☐ No *If yes, describe:_______________________________
Are there guns in the home? ☐ Yes ☐ No ☐ Decline to Report *If yes, are they secured? ☐ Yes ☐ No
Are there smoke detectors in the home? ☐ Yes ☐ No

Other History:
Do you have special concerns about the child you wish to discuss?
____
____

Signature of Parent/Guardian ____________________________________ **Date**________________

Reviewed by Provider (Signature) ________________________________ **Date** _______________

Isabella Citizens for Health, Inc.

Patient Centered Medical Home Patient-Provider Agreement

Name: ______________________________ Date of Birth: __________

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

As your primary care provider, we will:

- Ask what your goal is, or what you want to do to improve your health.
- Ask you to help us plan your care and to let us know if you think you can follow the plan.
- Create written copies of care plans for more complex illnesses.
- Remind you when tests are due so that you can receive the best quality of care.
- Ask you to have blood tests before your visit so the provider has the results at your visit.
- Explore methods to care for you better, including ways to help you care for yourself.

We trust you, our patient, to:

- Tell us what you know about your health and illnesses.
- Tell us about your needs and concerns.
- Take part in planning your care.
- Follow the care plan that is agreed upon – or let us know why you cannot so we can try to help or change the plan.
- Tell us what medications you are taking and ask for refills at your office visits.
- Let us know when you see other doctors and what medications they put you on or change.
- Ask other doctors to send us a report about your care when you see them.
- Seek our advice before you see other physicians. We may be able to care for your needs.
- 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 care.
- Keep your appointments as schedule, or call and let us know when you cannot.
- Pay your share of the visit fee when you are seen in the office.
- Give us feedback so we can improve our services. *(We may ask you to complete a survey.)*

We look forward to working with you as your primary care provider in your patient centered medical home.

______________________________ ______________
Patient/Parent/Guardian Signature Date

______________________________ ______________
Provider Signature Date

Family Medicine
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Phone: (989) 953-5320 • Fax: (989) 953-5329

Pediatrics
Isabella Citizens for Health II
2790 Health Parkway • Mt. Pleasant, MI 48858
Phone: (989) 779-5270 • Fax: (989) 779-5279

Patient Name: ______________________

DOB: ______________________

Cell Phone: ______________________

Email Address: ______________________

Patient Email and Text Message Informed Consent

Isabella Citizens for Health, Inc. (ICH) and its affiliates, agents, independent contractors and any "covered entity" or "business associate" (as those terms are defined by the HIPAA Privacy Rule) with which your information may be shared under HIPAA (collectively, "Isabella Citizens for Health, Inc.") may communicate with you by email, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es), or other locations reflected in your medical record or as otherwise provided below. This form provider information about ICH's use, risks, and conditions of Electronic Messaging. It will also be used to document your consent for ICH's communication with you by Electronic Messaging.

How we will use Electronic Messaging: ICH may use Electronic Messaging to communicate with you regarding a wide rage of healthcare related issues, including, but not limited to:

- Reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, including copies of lab and radiology results, and notices about preventive services, treatment options, coordination for your care, and other available health services;
- How to participate in patient satisfaction surveys or how to use our secure patient portal (NextMD); and
- Information regarding insurance, billing, eligibility for programs/benefits, and account balances.

ICH may use automatic dialers, broadcast messaging, or pre-recorded voice message when it communicates with you through Electronic Messaging. All Electronic Messaging may be made part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded, or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: ICH cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we sent. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING. CALL 911.**
- Electronic Messaging may be filed in your medical record.
- ICH is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you withdraw your consent earlier, this consent will expire upon the end of your treatment relationship with ICH. You may choose to stop participating in Electronic Messaging at any time by informing ICH in writing. You further understand that withdrawing this consent will not cause you to lose any benefits or right to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw your consent and stop participating in Electronic Messaging, please contact the ICH Privacy Officer as described in the Notice of Privacy Practices.

Patient Acknowledgement and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between ICH and me, and I consent to the conditions and instructions outlined, as well as any other instructions that ICH may impose to communicate with me by Electronic Messaging. By signing below, I consent to receiving text messages and emails from ICH. I understand that ICH will send Electronic Messaging to those telephone number(s) and email address(es) in listed in my medical record.

Release. In consideration of ICH's services and my request to receive Electronic Messaging as described herein, I hereby release ICH from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws.

Patient (or Authorized Representative) Signature	Patient's Printed Name	Date

Isabella Citizens for Health

2940 Health Pkwy
Mt. Pleasant, Michigan 48858

Authorization for Release or Disclosure of Health Information

Patient Name ____________________ Birthdate ____________ Social Security Number ____________

Address ____________________ City ____________ State ____ Zip ______

Telephone Number ____________________

Records to be disclosed FROM:

Name of Clinic/Doctor/Organization ____________________

Address ____________________

City/State/Zip ____________________

Phone/Fax (If available) ____________________

Records to be disclosed TO:

Name of Clinic/Doctor/Organization ____________________

Address ____________________

City/State/Zip ____________________

Phone/Fax (If available) ____________________

Specific type of information to be disclosed: Date(s) of Service: ____________________

☐ Admission face sheet ☐ History and physical ☐ Operative report ☐ Physician's Notes
☐ Consultation reports ☐ Discharge summary ☐ Entire Medical Record ☐ Nurse's Notes
☐ Billing records ☐ Commission On Aging Referral information
☐ Laboratory results from (date)____________________ to (date)____________
☐ Diagnostic Imaging (X-Rays) reports from (date) ____________________ to (date) ____________
☐ EKG & interpretations from (date) ____________ to (date) ____________
☐ Other ____

The purpose and need for disclosure:

☐ Continuation of Care ☐ Disability Determination ☐ Vocational Rehabilitation
☐ Social Service Referral ☐ Insurance Billing ☐ Legal Follow-Up
☐ School ☐ Individual Access Request ☐ Other ____________

I understand that any information in my records relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse may be disclosed. Post Result Counseling completed by:____________________date:__________(HIV test results only)

I understand that any disclosure of information carries with it the potential for redisclosure and that once disclosed to the individual or organization identified above, the information may not be protected by federal confidentiality rules.

I understand that I have a right to revoke this authorization at any time by sending a written revocation to Isabella Citizens for Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________

If I fail to specify an expiration date, event or condition, this authorization will expire in twelve (12) months.

I understand that I need not sign this form in order to ensure treatment, payment for treatment, or enrollment or eligibility for health benefits.

By signing below, I authorize the disclosure of the above named individual's health information as described above.

Signature of Patient or Legal Representative ____________________ Date ____________

If Signed by Legal Representative, State Relationship to Patient ____________________

Signature of Witness ____________________ Date ____________