NP

EASTMAN & VEMPATI MD, P.C.

30795 23 MILE RD SUITE 202 PHONE: (586)421-1740
CHESTERFIELD, MI 48047 FAX: (586)421-1744

Child's Full Legal Name: _____ **Birth Date:** _____

Circle Answer:

Sex: Male/Female **Child's Ethnicity:** Hispanic Not Hispanic **Preferred Language:** English Spanish Other _____

Child's Race (Circle): African American American Indian Asian Caucasian Native Hawaiian Other Pacific Islander

Child Resides With Whom: _____

Preferred Phone Number: _____ **Email:** _____

Mother's/ Legal Guardian's Name: _____ **Birth Date:** _____

Address: _____ **Home Phone Number:** _____

City/ State/ Zip: _____ **Cell Phone Number:** _____

Father's / Legal Guardian's Name: _____ **Birth Date:** _____

Address: _____ **Home Phone Number:** _____

City/ State/ Zip: _____ **Cell Phone Number:** _____

Primary Insurance Name: _____

Subscriber's Name: _____ **Birth Date:** _____

Contract #: _____ **Group Number:** _____

Relationship To Patient: _____ **Effective Date:** _____

Secondary Insurance Name: _____

Subscriber's Name: _____ **Birth Date:** _____

Contract #: _____ **Group Number:** _____

Relationship To Patient: _____ **Effective Date:** _____

Emergency Contact Name: _____
(Other Than Parent/Guardian)

Phone Number: _____ **Relationship:** _____

Signature: _____ **Date:** _____

Eastman & Vempati, MD, PC
30795 23 Mile Rd, Suite 202, Chesterfield Twp, MI 48047

- I hereby give Dr. Eastman, Dr. Vempati, Val Alef, NP and Sue Rice, NP my permission to examine and administer necessary medical treatment to my child/children_____ in my absence. (Names)

- I authorize the release of any medical records to process insurance claims on my behalf. I agree to be fully responsible for all lawful debts incurred for medical services by Eastman & Vempati MD, PC whether covered by insurance or not. I understand that I am responsible for knowing my insurance benefits and notifying us of any restrictions or maximums.

- We will verify that your insurance is in effect, but we can not verify what your benefits are. Verification that the policy is in effect does not guarantee payment. Your insurance is a contract between you and your insurance company.

- Co-pays must be paid at the time of the visit. Contact our billing department if necessary to make prior arrangements. We accept Cash, Checks, Visa, MasterCard, Discover and American Express and Debit and HSA Debit.

- For minors, payment is expected to be made by the parent/guardian who brings the child to the appointment at the time of service.

- Appointments: We have reserved a specific time for you to see the doctor. We understand that there are circumstances that require you to either cancel or reschedule your child's appointment. If unable to keep appointment, kindly give 24 hours notice. If you miss an appointment or do not call at least 24 hours in advance to cancel, you will be counted as a **"NO-SHOW" and charged a $25 fee**. If you incur **THREE (3) "NO-SHOWS" in the last 12 Months**, your privilege as a patient in our practice will be terminated and your child and siblings will be dismissed from the practice.

I understand the "no-show" policy and will cancel appointments at least 24 hours in advance.

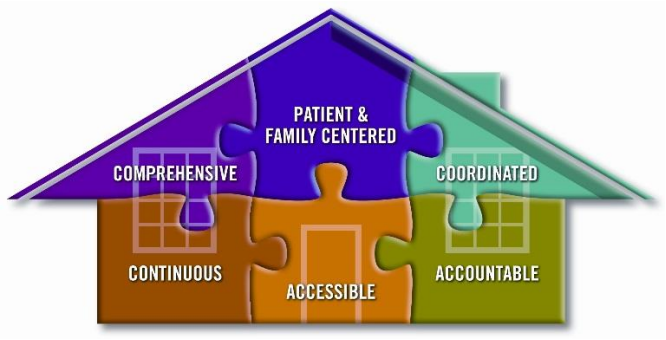
Signature_____ Date_____

Your signature will be updated annually. If you would like a copy please ask any one of our staff.

Signature_____ Date_____

PATIENT-CENTERED MEDICAL HOME

A patient-centered philosophy that drives primary care excellance.



What is the Medical Home?

The medical home is best described as a widely-accepted model for how primary care (your child's Pediatrician) should be organized and delivered throughout the health care system, with a strong emphasis placed on establishing trusting relationships between patients and providers. The medical home is not a final destination, instead it is a model for achieving primary care excellence. The major components of PCMH are as follows:

- **Patient-centered:** A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own or their child's care.
- **Comprehensive:** A team of care providers is wholly accountable for a patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** Care is organized across all elements of the broader health care system, including specialty care, hospitals, home health care, community services and supports.
- **Accessible:** Patients are able to access services with shorter waiting times, "after hours" care, 24/7 electronic or telephone access and strong communication through health IT innovations.
- **Committed to quality and safety:** Clinicians and staff enhance quality improvement to ensure that patients and families make informed decisions about their health.

I agree to take part in the PCMH approach to care with Eastman & Vempati, MD, PC.

Patient Name: _____ Date of Birth: _____ / _____ / _____

Parent Signature: _____ Date: _____ / _____ / _____

If you have any questions about PCMH – ask our staff!

HIPAA Notice of Privacy Practices

Eastman & Vempati, MD, PC
30795 23 Mile Rd
Chesterfield, MI. 48047
(586) 421-1740

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR CHILD MAY BE USED AND DISCLOSE AND HOW YOU (AS GUARDIAN) CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your child's protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your child's rights to access and control their protected health information. "Protected health information" is information about your child, including demographic information, that may identify your child and that relates to their past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your child's protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in care and treatment for the purpose of providing health care services to your child, to pay their health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your child's protected health information to provide, coordinate, or manage their health care and any related services. This includes the coordination or management of their health care with a third party. For example, protected health information may be provided to a physician to whom your child may have been referred to ensure that the physician has the necessary information to diagnose or treat them.

Payment: Their protected health information will be used, as needed, to obtain payment for their health care services. For example, obtaining approval for a hospital stay may require that their relevant protected health information be disclosed to the plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your child's protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your child's protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your child's name and indicate your physician. We may also call your child by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your child's appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to your child.

We may use or disclose your child's protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your child's protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your written consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR CHILD's RIGHTS

The following are statements of your rights with respect to your child's protected health information.

You have the right to inspect and copy your child's protected health information (fees may apply)- Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to your child to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your child's protected health information- This means you as your child's guardian may ask us not to use or disclose any part of their protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your child's protected health information not be disclose to family members or friends who may be involved in your child's care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications- You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your child's protected health information- If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures- You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of your new notice if you wish to obtain one.

COMPLAINTS:

You may, as guardian submit a complaint to us or to the Secretary of Health and Human Services if you believe your child's privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgement ". Please note that by signing the Acknowledgement Form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgement

I have read the above HIPAA Privacy Policies. As indicated above, I know my rights as a patient/Guardian and also know and agree to the policies and procedures set in place by Eastman & Vempati, MD, PC.

Signature _____ Date _____

Child's Name:_____
Birth Date:_____

Eastman & Vempati, MD, PC
30795 23 Mile Rd, Suite 202, Chesterfield Twp, MI 48047

Acknowledgement of Receipt of Notice of Privacy Information Practices

My signature on this form indicates that I have **reviewed** a Notice of Privacy Information Practices.

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, who will be able to answer my questions.

Privacy Contact/Chesterfield
Dianne
30795 23 Mile Rd, Suite 202
Chesterfield Twp, MI 48047
586-421-1740

The following person(s), **other than the biological parents/ legal guardians**, who may receive my child's protected health information and/or accompany them to the office:

Name:_____ Relation:_____ Birth date_____

Name:_____ Relation:_____ Birth date_____

Name:_____ Relation:_____ Birth date_____

As a parent or patient you have the right to:

- Inspect and receive a copy your child's medical information that may be used to make decisions about your care.
- Request an amendment to your child's medical records if you feel they are incorrect or incomplete. The physician may deny my request and notify me of the reason for her/his denial.
- Request an accounting of disclosures. This is a list of disclosures for other than treatment, payment or health care operations.
- Request a restriction or limitation on the medical information used or disclosed about your child for treatment, payment or health care operations. All requests must be in writing. However, the physician has the right to deny the restriction. If he/she does agree to the restriction, the office will comply with your request unless the information is needed to provide your child with emergency care.

_____ _____
Signature of Patient or Legal Representative Date

Office Use Only:

- Patient/legal guardian refused to sign consent, despite a good faith effort to receive acknowledgement.

_____ _____
Signature of Employee Date

Child's Full Legal Name: _____

Birth Date: _____ **Today's Date:** _____

Initial History Questionnaire

Household- ***Please list ALL those living in the child's home.***

Name	Relationship to child	Age	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there siblings not listed? Is so, please list their names and ages and where they live_____

_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status

_____

If one or both parents are not living in the home, how often does the child see the parent/parents not in the home

_____

Birth History – ***If you answer YES to any of the following questions please describe:***

1.) Did your child have any health issues after birth? ***Yes No*** _____

2.) Was your child premature at birth ? ***Yes No***

General History- ***If you answer YES to any of the following questions please describe:***

1.) Do you consider your child to be in good health? ***Yes No*** _____

2.)Does your child have any serious illness or medical conditions? ***Yes No*** _____

_____

3.)Has your child had any serious injuries or accidents? ***Yes No*** _____

4.)Has your child had any surgeries? ***Yes No*** _____

5.)Has your child ever been hospitalized? ***Yes No*** _____

6.)Is your child allergic to any medications or Food? ***Yes No*** _____

7.) Is your child taking any medications/Vitamins? ***Yes No*** _____

Emotional Problems

1.)Does your child have any difficulty playing or making friends? ***Yes No***

2.)Does your child have trouble sleeping or have nightmares? ***Yes No***

Child's Name:_____
Birth Date:_____

Development- ***If you answer YES to any of the following questions please describe:***

1.) Are you concerned about your child's physical development? ***Yes No***_____

2.) Are you concerned about your child's mental or emotional development? ***Yes No*** _____

3.) Are you concerned about your child's speech? ***Yes No*** _____

4.) Are you concerned about your child's attention span? ***Yes No*** _____

If your child is in school:

1.)Are you concerned about your child's behavior at school? ***Yes No*** _____

2.)Has your child failed or repeated a grade in school? ***Yes No*** _____

3.)How is your child in academic subjects? _____

4.)Is your child in any special or resource classes? ***Yes No*** _____

Family History

Please circle any of the following conditions that the baby's **blood** relatives have or have had. Identify relative having condition including parents, grandparents, aunt, uncle, brother or sister.

1.) Asthma/Allergies _____ **7.)**Tuberculosis/HIV _____

2.) Strokes/Epilepsy _____ **8.)** Diabetes/Thyroid _____

3.) Anemia/ Bleeding _____ **9.)** Deafness _____

4.) Kidney Problems_____ **10.)** Alcohol or Drug Abuse _____

5.) Liver Disease/ GI Problems _____ **11.)**Mental Illness _____

6.) High Blood Pressure / Heart / Cholesterol _____

Past History- ***Does your child have, or has ever had:***

Problems with ears/hearing ***Yes No*** _____ Nasal allergies ***Yes No*** _____

Problems with eyes/vision ***Yes No*** _____ Frequent headaches ***Yes No*** _____

Anemia or bleeding problems ***Yes No*** _____ Diabetes ***Yes No*** _____

Bladder or kidney infections ***Yes No*** _____ Bed-wetting (after age 5) ***Yes No*** _____

Asthma,Bronchitis,Bronchiolitis/ Pneumonia ***Yes No*** _____ Thyroid/Endocrine problems ***Yes No*** _____

Any heart problems or heart murmur ***Yes No*** _____

Frequent abdominal pain ***Yes No*** _____ Constipation requiring Doctor visits ***Yes No*** _____

(For Girls) Has she started her menstrual Period ***Yes No*** If Yes, any problems with her period?_____

Any chronic or recurrent skin problems (acne,eczema,etc.)_____

Convulsions or other neurologic problems ***Yes No*** _____

Use of alcohol or drugs ***Yes No*** _____ Any other significant problems ***Yes No***_____

Pharmacy Information

****Please fill out completely**

Child's Name_____Date of Birth_____

Name of Pharmacy _____

Pharmacy Phone Number _____

Pharmacy Address _____

Pharmacy Location (i.e. 23 Mile and Gratiot)_____

FollowMyHealth™ Universal Health Record

Patient Portal Invite

Patient Name(s):_____ D.O.B____/____/____

_____ D.O.B____/____/____

_____ D.O.B____/____/____

_____ D.O.B____/____/____

E-Mail:_____

Please see attached handout for instructions on how to sign your child up or see front desk for assistance today to sign up. Thank you