PATIENT-PROVIDER PARTNERSHIP AGREEMENT

Dear Patient,

Welcome and thank you for choosing our practice. We are committed to providing you with the best medical care based on your health needs. Our hope is that we can form a partnership to keep your whole self as healthy as possible, no matter what your 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 you. You will have better access to us through phone and email.

As your primary care provider, I will:

- Learn about you, your family, life situation, and health goals and preferences. We will remember these and your health history every time you seek care and suggest treatments that make sense for you.
- Take care of any short-term illness, long-term chronic disease, and your all-around well-being.
- Keep you up-to-date on all your vaccines and preventive screening tests.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.
- Be available to you after hours for your urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings. We will respond promptly to you – and your calls – in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.

We trust you, as our patient, to:

- Know that you are a full partner with us in your care.
- Come to each visit with any updates on medications, dietary supplements, 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 for you.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your health condition: ask questions about your care and tell us when you don't understand something.
- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Call if you do not receive your test results within two weeks.
- Contact us after hours only if your issue cannot wait until the next work day.
- If possible, contact us before going to the emergency room so someone who knows your medical history can care for you.
- Agree that all health care providers in our care team will receive all information related to your health care.

- Learn about your health insurance coverage and contact your insurance company if you have any questions about your benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for you.

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

Parent/Guardian Signature Printed Parent/Guardian Name Date

_____ _____ _____

Child/Children

_____

* Cell Phone Number _____

* Email Address _____

Pediatric Specialists of Bloomfield Hills & PSBH North

Financial Agreement

1. It is important that you know what your insurance plan covers.
   Services not covered by your insurance company are your responsibility.

2. All co-payments, deductibles and non-covered services must be paid in full at the time of service. If your office visit co-pay and/or account balance is not paid on the day of service, there will be an additional $15 added to your balance as a statement fee.

3. We gladly accept cash, MasterCard, Visa, Discover and American Express.

4. If you cannot provide adequate proof of insurance, you will be responsible for the cost of the entire visit at the time services are rendered.

5. Accounts over 90 days past due may be referred to a collection agency. Accounts referred to a collection agency will be subject to a 30% collections fee in addition to the unpaid balance. Your account being sent to collections for lack of payment is cause for dismissal from our practice.

6. If your insurance company requires laboratory specimens to be sent to a specific lab, it is your responsibility to know the participating lab. Please make us aware.

7. If your insurance is a managed care plan, please review the coverage. If you or your child receives services that require a referral, adequate planning is essential. Referrals must be authorized by your doctor and usually require an office visit. Authorization from managed care plans for your referrals may take up to one week. Please be aware that we are often unable to accommodate call in requests for referrals. Upon receipt of a referral to a specialist or ancillary service, it is your responsibility to be aware of what has been authorized. Subsequent visits, procedures, surgeries and hospitalizations typically require additional responsibility. Do not expect the referral specialist or service to obtain approval for these additional services – this is your responsibility. Failure to obtain necessary authorizations often leads to out of pocket expense. We are happy to assist you in any way with your managed care plan, however; our experience with these plans has demonstrated that planning and adequate lead time is essential. Your knowledge of the plan regulations as well as benefits along with adequate planning will help avoid delays and denied claims.

8. We expect 24 hour notice for all cancellations. We reserve the right to charge a $25 cancellation fee for all appointments not cancelled 24 hours in advance. In order to cancel an appointment you must SPEAK to one of our staff members. Voicemail or any form of messaging (text or email) is not an acceptable form of cancellation, as there is no way to guarantee that your message will be received in time.

We appreciate your cooperation and are happy to assist you in any way we can.

Respectfully,

Christa A. Shilling, MD & Staff

I understand and accept the above statements.

_____ _____

Patient/Guardian Signature Date

_____

Patient or Guardian Name (Print)

Pediatric Specialists of Bloomfield Hills, PC
43097 Woodward, Ave Ste. 201
Bloomfield Hills, MI, 48302

PSBH - North
3226 Hidden Timber Dr. Suite A
Lake Orion, MI 48359

Patient Packet

Patient Name:	**M☐ F☐**	**Date of Birth:**
Address:		
City:	**State:**	**Zip:**
Parent/Guardian:	**M☐ F☐**	**Date of Birth:**
Phone:	**Social Security #:**	
Address (if different from pt):		
City:	**State:**	**Zip:**
Employer:	**Work Phone:**	
Parent/Guardian:	**M☐ F☐**	**Date of Birth:**
Phone:	**Social Security #:**	
Address (if different from pt):		
City:	**State:**	**Zip:**
Employer:	**Work Phone:**	
Main Email Address:		
Insurance:	**ID #**	**Group #**
Effective Date:	**Co-Pay:**	
Policy Holder:		
Preferred Pharmacy/Address:		**Phone:**
Emergency contact:	**Relationship:**	**Phone:**
How did you hear about our practice:		
Signature of Patient over 18/Parent:		
Today's Date:		

THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S STATUS. I CERTIFY THAT MY CHILD IS COVERED BY THE ABOVE NAMED INSURANCE AND ASSIGN DIRECTLY TO THE DOCTOR'S AT PEDIATRIC SPECIALISTS OF BLOOMFIELD HILLS ALL INSURANCE BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL MY INSURANCE SUBMISSIONS WHETHER MANUAL OR ELECTRONIC.

Pediatric Specialists of Bloomfield Hills & PSBH North

Financial Agreement

1. It is important that you know what your insurance plan covers.
   Services not covered by your insurance company are your responsibility.

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Respectfully,

Christa A. Shilling, MD & Staff

I understand and accept the above statements.

_____ _____

Patient/Guardian Signature Date

_____

Patient or Guardian Name (Print)

Pediatric Specialists of BH, P.C..
43097 Woodward Ave, Suite 201
Bloomfield Hills, MI 48302

PSBH - North
3226 Hidden Timber Dr. Ste. A
Orion, MI 48359

HIPAA Regulations

In our quest to maintain your personal health information as confidential as possible and to meet the federal guidelines under HIPAA regulations, we have implemented the following authorizations.

Please read and initial each statement:

_____ I authorize the use of myself and/or my child's personal health information to carry out treatment, payment or health care operation.

_____ I authorize the use of myself and/or my child's personal health information in order to obtain medical reports from other physicians or hospitals (e.g. laboratory reports, consultation, outpatient procedures).

_____ I authorize the use of myself and/or my child's personal health information in order to have prescriptions phoned, faxed or electronically transmitted to my pharmacy as needed for the treatment of myself and/or child.

I understand that:

I may revoke consent for the above in writing at any time, except to the extent that Pediatric Specialists of Bloomfield Hills, P.C. and or PSBH - North has taken action in reliance on the consent.

I may request restrictions on the uses or disclosures of health information for the treatment, payment or health care operations.

I may request to review Pediatric Specialists of Bloomfield Hills, P.C.'s and or PSBH – North Privacy Practice Policy prior to signing this consent.

I have read and understand all of the above statements.

_____

Signature Date

Medical History

Name of previous doctor:_____ Dr.'s Phone: _____
Date of last medical exam: _____/_____/_____

Is the patient currently under treatment now for an illness or medical condition? Yes No
If yes, for what?_____
With whom?_____

List all medications taken regularly: (including oral contraceptives, over the counter medications, home remedies, etc.)

_____
_____

Any allergies to medications? Yes No
If yes, explain:_____
_____

List all major injuries, surgeries and hospitalizations: _____
_____

Pregnancy & Birth (if applicable)

- Mother's age at child's birth: _____
- Did mother have any illnesses during pregnancy? _____
- Did mother take any medications during pregnancy? _____
- Was baby born on time? Yes No
- What was the baby's birth weight? _____
- Did the baby have any trouble starting to breath? Yes No
- Did the baby have any trouble in the hospital? Yes No
  If yes:_____

Social History (16 years of age and older)

Does the patient:

Drive	Yes	No
Drink alcohol	Yes	No
Use illegal drugs	Yes	No

Review of Systems:

Has the patient ever had or currently have problems in the following areas?

Fever, Weight Loss/Gain	Yes	No
Skin	Yes	No
Headaches/Migraines	Yes	No
Seizures	Yes	No
Loss of Vision	Yes	No
Blurred Vision	Yes	No
Allergies	Yes	No
Chronic Cough	Yes	No
Dry Throat/Mouth	Yes	No
Asthma	Yes	No

Diabetes	Yes	No
Heart Pain	Yes	No
High Blood Pressure	Yes	No
Vascular Disease	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Genitals	Yes	No
Kidneys	Yes	No
Bladder	Yes	No
Arthritis	Yes	No
Anemia	Yes	No
Bleeding Problems	Yes	No
Thyroid	Yes	No
Psychiatric	Yes	No

If you answered YES to any of the above or have a condition not listed, please explain & list medications: _____

_____

_____

_____

Family History

Has any family member (parents, grandparents, siblings, children; living or deceased) had any of the following conditions? PLEASE CIRCLE ALL THAT APPLY:

	RELATIONSHIP TO YOU
Blindness	_____
Cataract	_____
Glaucoma	_____
Macular Degeneration	_____
Arthritis	_____
Cancer	_____
Diabetes	_____
Heart Disease	_____
High Blood Pressure	_____
Kidney Disease	_____
Lupus	_____
Thyroid Disease	_____
Other	_____

TB AND LEAD RISK FACTOR QUESTIONNAIRE

LEAD

1. Does your child live in or regularly visit a house built before 1960 with peeling, chipping paint, recent, ongoing or planned renovation or remodeling? This could include a day care, preschool, home or babysitter or relative etc.
   Yes No
2. Does your child have a brother or sister, housemate or playmate with lead poisoning?
   Yes No
3. Does your child live with an adult whose job or hobby involves exposure to lead? (Examples Below)
   Yes No
4. Does your child live near a busy street or highway? Yes No

If you answered yes to any of these questions, your child is at risk for lead poisoning. The only way to know for sure if to have your child tested.

OCCUPATIONAL AND HOBBY SOURCES OF LEAD POISONING

1. Storage batteries (lead batteries)
2. Plumbing fixture fitting and trim (brass goods)
3. Bridge, tunnel, and elevated highway construction
4. Automotive repair shops
5. Using fitting ranges
6. Refinishing furniture
7. Making stained glass or pottery
8. Casting aluminum
9. Making fishing weights
10. Using lead solder
11. Using artists' paints that contain lead
12. Burning wood covered with lead-based paint

TB

1. Has your child had contact with an adult with TB? Yes No
2. Has your child been to, if from, or has had contact with persons from a region of the world with a high TB prevalence (Central and South America, Southeast Asia) or are the parents from one of these areas?
3. Is your child HIV positive? Yes No
4. Does your child have a nanny or caretaker who is from an area with high TB prevalence (include inner city dwellers)? Yes No
5. If your child in foster care? Yes No
6. Has your child had contact frequently with HIV infected individuals, homeless persons, IV / street drug users, poor and medically indigent city dwellers, nursing home residents, migrant farm workers, or a person who has been in prison within the past five year? Yes No

Patient Health Questionnaire (PHQ-9)

NAME..... DATE.....

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "✔" to indicate your answer).*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	**TOTAL:**			

10. If you checked off *any* problems, how *difficult* have these problems made it for you to to do your work, take care of things at home, or get along with other people.

- Not difficult at all .....
- Somewhat difficult .....
- Very difficult .....
- Extremely difficult .....

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Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks.*

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	❑	❑	❑
2. S/he didn't enjoy anything at all	❑	❑	❑
3. S/he felt so tired that s/he just sat around and did nothing	❑	❑	❑
4. S/he was very restless	❑	❑	❑
5. S/he felt s/he was no good any more	❑	❑	❑
6. S/he cried a lot	❑	❑	❑
7. S/he found it hard to think properly or concentrate	❑	❑	❑
8. S/he hated him/herself	❑	❑	❑
9. S/he felt s/he was a bad person	❑	❑	❑
10. S/he felt lonely	❑	❑	❑
11. S/he thought nobody really loved him/her	❑	❑	❑
12. S/he thought s/he could never be as good as other kids	❑	❑	❑
13. S/he felt s/he did everything wrong	❑	❑	❑

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GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a tracemark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety