**New Patient Paperwork**

Please fill out these forms in their entirety to the best of your knowledge. If there are any questions, we will be happy to assist you.

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_

Other children and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_American Indian/Alaskan Native \_\_Asian \_\_ Black/African American \_\_White \_\_Native Hawaiian or Other Pacific Islander \_\_Other \_\_Declined

Ethnicity: \_\_Hispanic \_\_Non-Hispanic \_\_Other \_\_Declined

Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_Do not wish to disclose

Main Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which is your preferred method of contact: \_\_\_ Phone Call \_\_\_\_Text Message \_\_\_\_Email

Father’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Address if different: Address if different:

Name of Primary Caretaker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_

SSN of Primary Caretaker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_ Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact other than parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Coverage:**

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB of Subscriber: \_\_\_\_\_\_\_\_\_\_Patient Relation to Subscriber: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract/Member Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Claim Authorization**

To submit a claim for services covered under your policy, we must have your permission to release medical information to your insurance carrier. Your signature below will authorize release of any medical information necessary to process your claim and request payment of benefits to the insurance or party who accepts assignment.

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information Release Form**

I, (guardian of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (previous Doctor’s office name, address and telephone number) to release the following medical records the following patients to Dr. Kostecke.

Patient’s Name and DOB:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check appropriate line:

\_\_\_\_\_\_Any and all of my medical records

\_\_\_\_\_\_Any and all of my medical records EXCEPT the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This release also specifically allows the release of the following information (this information will not be released unless the appropriate line is checked).

\_\_\_\_\_\_ Any record of treatment for drug/alcohol dependency/abuse

\_\_\_\_\_\_ Any record of mental health treatment

\_\_\_\_\_\_ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV or HIV related diseases.

This release is effective for 6 months from the date of execution; however, it may be revoked by me at any time by providing notice in writing to the above named parties.

Signature :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We request these records be sent by mail, on a disc or paper if larger than 10 pages. Records less than 10 pages can be faxed to the office.**

|  |  |  |  |
| --- | --- | --- | --- |
|   | **Payment Responsibility**: The patient or legal guardian is ultimately responsible for ALL charges that are incurred |  | **Payment Methods**: The following payment methods will be accepted: cash, check money order and if balance exceeds, most charge cards |
|  | **Non-Discrimination of Services**: That necessary medical treatment will be provided regardless of a patient’s ability to pay |  | **Returned Check Fee**: A fee of **$30** will be added for each returned check |
|  | **Assignment of Benefits**: Our office will bill insurance as a courtesy if the patient supplies the required information to do so |  | **Statements**: Statements are sent out monthly. If a balance is over **30 days** old, you may be subjected to a **$10 late fee** posted on your account |
|  | **Insurance Coverage**: Patients with insurance that cover only a portion of a service must pay all deductibles, co-pays, coinsurance and mot covered benefit charges |  | **Referral to an outside collection**: Accounts that cannot be collected after **90** days may be referred to an outside collection agency |
|  | **Uninsured Patients**: Insurance is verified prior to services. IF the insurance is not active, the patient is responsible for all charges incurred that day. Payment is expected same day of services |  | **Charity Allowances**: All charity allowances must be approved by the Dr. or delegated representative |
|  | **Verification of Information**: All information regarding the ability to pay; third party insurance, employment, etc. will be subject to verification |  | **Discount**s: Accounts will not be reduced or discounted unless approved by the Dr. or delegated representative |
|  | **Insurance Contract**: Your insurance contract is between you, your employer, and the insurance company. We cannot and will not guarantee payment of any or all claims |  | **Payment Agreements**: If a patient is unable to make a full payment for the balance owed, a payment plan may be worked out with the billing department. This should be done prior to scheduling further appointments. |
|  | **HMO Patients:** Please make sure you have the proper authorization to be seen in our office. Your PCP should be listed as Dr. Kostecke prior to being seen, otherwise, you may be required to reschedule.  |  | **Refunds**: Patient refunds over $20 will be issued. Those who are owed less than $20 may request a refund. All active and/or past accounts must be paid in full to receive a refund |
|  | **Prior Unpaid Balances**: Prior to providing services, a payment may be required, or payment arrangements must be approved |  | **No-Show/Late Fees**: The appointment scheduled is the appointment you made. If you for any reason cannot keep this appointment time, please call 2 hours in advanced or you may be subject to a **$25 fee**. If you are over 30 mins late, there may be a **$5 charge** |

**Financial Policy**

Please read the financial policy and initial next to each box if you agree to abide by the statement.

**Financial Policy cont.**



To maximize the time Doctor spends with you and minimize your wait times, we have made changes to our scheduling policies as follows:

**NO SHOW POLICY:**

Effective February 1, 2022, we will implement this no-show policies effecting all patients who do not keep their scheduled/verified appointments.

* First occurrence: Patient will receive a copy of the policy either via mail or the patient portal
* Second occurrence: Patient will receive a 2nd copy of the policy and a $25 no show fee
* Third and subsequent occurrences: Will result in $25 no show fee, plus $10 late fee to those past fees not paid and possible dismissal from the practice

**LATE ARRIVAL POLICY:**

Patients arriving more than 10 minutes late for their scheduled visit may be asked to reschedule the appointment for another day.

Those patients arriving more than 30 mins late, may be subjected to a $5 fee and may be asked to reschedule for another day.

Providing the schedule will allow it, the patient may be seen later that same day

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to use and Disclose Health Information**

This consent form is an authorization to use or disclose protected health information. I understand that I may inspect or copy the protected health information described by this authorization.

This form is an agreement between you (parent/guardian), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And Dr. Rekha Kostecke. For the purposes of this consent form, the word “you” below may refer to you, your child, a relative or other person if you have written their name here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When I, or anyone associated with this office provides examination, testing, diagnosis, treatment, or a referral for you, this will be included in the collection of what the law calls Protected Healthcare Information. This information is necessary in order to decide what treatment is best for you and to provide it. This information may be shared with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions. By signing this consent form, you are agreeing to allow the use of your information here or with others as is explained in more detail in the HIPAA, Notices of Privacy Practices (NPP). It also details your rights. You consenting to this form approves the practices detailed in the NPP summary and full NPP. You can get a copy by asking me.

If you have concerns about some of your information, you have the right to ask me to not use or to share some of your information for treatment, payment, or administrative purposes. You would have to communicate in writing what you are asking. After you have signed this consent, you have the right to revoke it by writing a letter to me, in my role of Privacy Officer. You must write and inform me you no longer consent. IF I receive such a revocation, I will comply with your wishes about using or sharing your information from that time on but I may have already used or shared some information in accord with this consent and of course would have no way to change that.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date; if no date is stated, the expiration date wll be six years from the date of the authorization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Refusal Date; On this date, this form was presented to (patient name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and parent/guardian refused to sign

**Insurance Responsibility Agreement**

This is to inform you that service rendered today will be billed to the insurance information that we have on file. It is your responsibility to inform us immediately of any changes. Please keep your child’s last physical in mind, so that we will know if the insurance will cover one. If it does not, it will be your responsibility to pay for the physical visit.

We bill the participating insurance companies as a courtesy for to you. You are expected to pay any deductible and co-payments at the time of service. And you may be expected to pay the balance in full. You are responsible for making sure all charges are paid for whether by your insurance company or you, in a timely manner. Accounts left unpaid for over 90 days may be turned over to an outside collection agency.

**Non- Covered and Out of Network Services:**

Medical services that are considered by your insurance to be non-covered, out of network, or not medically necessary will be your responsibility. Please review your insurance coverage prior to your visit, all policies are not the same and it is your responsibility to know what is, and what is not covered. You can request a copy of your services rendered in a well child visit if you are not sure what a covered benefit is in your policy.

|  |  |
| --- | --- |
| \_\_\_\_ 96110 Developmental Screening | \_\_\_\_ 92551 Hearing Test |
| \_\_\_\_81002 Urinalysis | \_\_\_\_85018 Hemoglobin |
| \_\_\_\_83655 Blood Lead Test | \_\_\_\_99173 Vision Test |
| \_\_\_\_87880 Strep Test | \_\_\_\_87804 Flu Test |
| \_\_\_\_Glucose Test | \_\_\_\_ 86308 Mono Test |
| \_\_\_\_90460 Vaccination Administration | \_\_\_\_ 97802 Dietary Counseling |

I have read and understand this policy as well as the financial policy and understand that I am responsible for any charge not covered by my insurance.

Signature of insured or authorized representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Telehealth Informed Consent Form**

Telehealth services involve the use of secure HIPAA compliant software that enables health care providers to deliver health care services to patients.

1. I understand that telehealth-based services may not be as comprehensive as in person visits, but the same standard of care applies to a telehealth visit as an in-person visit.
2. I understand that I will not be in the same room as my health care provider. I will be notified, and my consent will be obtained for anyone other than my health care provider to be in the room. I am responsible for people in the same room physically, as me.
3. I understand that there are potential risks to using technology, including services interruptions, interception, and technical difficulties.
	1. If it is determined that any equipment and/or connection is not adequate, I understand that my health care provider and /or myself may discontinue the telehealth visit and make other arrangements to continue the visit
4. I understand that I have the right to refuse to participate in or decide to stop participation of a telehealth visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care/treatment.
	1. I can revoke my right at any time by contacting the office at 248-676-0991
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telehealth services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
	1. I understand that my insurance carrier will have access to my medical records for quality review/audit
	2. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telehealth visit
	3. I understand that health plan payment policies for telehealth visits may be different than in person visits.
7. I understand that this document will become part of my medical record.

By signing this form, I agree that certain situations, including emergency and crises are inappropriate for audio, video and/or computer-based visits. If I am in a crisis or am expecting a medical emergency, I should immediately call 911 or go the nearest hospital.

By signing this form, I attest that I have personally read this form and fully understand and agree to its contents; I understand the risks, benefits, and responsibilities of telehealth visits; and I am in the state of Michigan and will be in the state of Michigan during the time of my telehealth visits.

Patient’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guradian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Portal Consent Form**

This form will give you access to the patient portal. It is here you can find vitals, lab results, and immunization records. You will also have the ability to request appointments, request prescription refills WITHOUT making a phone call, and sending messages directly to Dr. Kostecke.

Please fill out the following information to receive an invitation:

|  |  |
| --- | --- |
| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This will be the answer for the security question!

The above email will be sent an invitation. Follow the prompts through that email to complete registration.

Please sign below to agree to Cerner Health Terms of Use and Privacy Policy

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To access your child’s account, go to [www.iqhealth.com](http://www.iqhealth.com)

Thank you for setting up the Patient Portal. We hope you find this easy to use and as a great tool in communicating with the office. Please feel free to contact the office with any questions regarding this Patient Portal.