Dundee Pediatrics, PLLC
Dr. Michelle Daill

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Dundee Pediatrics, PLLC, its affiliates and its employees. Dundee Pediatrics, PLLC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Dundee Pediatrics, PLLC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment.

Operations: We will make uses and disclosures of your protected health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your protected health information for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your protected health information to designated family, friends and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information with such individuals without your approval. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Dundee Pediatrics, PLLC Privacy Officer by phone at (734) 823-5437 or at our office at the following address: 120 Waterstradt Commerce Dr., Suite 1, Dundee, MI 48131. A summary of HIPPA for Patients can be found at https://www.hhs.gov/hipaa/for-individuals/index.html

I have read the above and agree to allow Dundee Pediatrics, PLLC staff and Dr. Michelle L. Daill to use and disclose protected health information for treatment, payment or healthcare operations for myself and my child/children.

Signature of Patient/Guardian	Signature of Witness
Printed Name	Printed Name
Date	Date

OFFICE USE ONLY

Patient Name: _____
Last name, First name

Patient Date of Birth: _____
MM/DD/YYYY

Dundee Pediatrics, PLLC
120 Waterstradt Commerce Dr., Suite 1
Michelle L. Daill, MD **Dundee, MI 48131**

Office Policies
Please Read Carefully

Please Initial Each Section and Sign Below:

_____ I understand that Dundee Pediatrics PLLC will contact my insurance carrier to verify coverage of services and bill these services for me; however, I am responsible for any non-covered services, deductibles, co-pays, and coinsurance. **Co-pays must be paid at time of service.**

_____ I understand that it is my responsibility to add my newborn to my insurance within 30 days of birth to avoid pre-existing conditions and to avoid denials on submitted claims. **If my newborn is not added in a timely manner, any balance for denied services is my responsibility.**

_____ If you do not have health insurance, we must look to you for full payment of your bill at the time services are rendered (unless other arrangements have been made in advanced).

_____ I understand that I must provide accurate health insurance information at the time of services, or I will be held liable for denied charges.

_____ **When my health insurance changes, I understand that I must provide the new health insurance information upon check-in. If you have not made us aware of the changes in health insurance and services are denied by your insurance, you are responsible for any non-paid services.**

_____ There are some insurance plans that we accept assignment on. If this applies, we will reduce your bill to the approved amount from your health insurance carrier. You are responsible for all amounts for non-covered services or services that your health insurance carrier deems as patient responsibility.

_____ Dundee Pediatrics PLLC will only except the following Medicaid payers. If you don't have one of these Medicaid policies and choose to be seen, the balance will be your responsibility.

_____Michigan Medicaid (Straight Medicaid)
_____Meridian Medicaid
_____UHC Community Care

_____ I understand that if my Medicaid coverage has been changed to any payer other than the straight Medicaid or Meridian Medicaid, it is my responsibility to have the coverage changed to straight Medicaid or Meridian Medicaid. If I do not change to a plan that is accepted, **I am responsible for any denied service balances.**

_____ I understand that when my address is changed, I must update my address with Dundee Pediatrics PLLC to prevent statements from being returned as undeliverable.

_____ I understand that any balance due on my child's account is the responsibility of both parents. In the case of divorce, both parents are still responsible unless I provide legal documentation that only 1 parent is responsible.

_____I understand that if I receive a statement for denied services, I will contact my insurance to determine the reason for denial and then contact Dundee Pediatrics PLLC billing department if the services can be resubmitted to my insurance for payment. The billing department can be reached by phone, fax, or text at 734-822-6796, or by email at dundeepediatrics.biller@gmail.com.

_____ I understand that if my balance becomes past due, I will make payment in full prior to my next visit or agree to a payment arrangement (automatic monthly credit card payments) with Dundee Pediatrics PLLC prior to my next visit. Payment arrangements are as follows: Balances Under $500 = 6 monthly payments, Balances Over $500 = 12 monthly payments. If you are unable to meet the monthly dollar amount, please contact our billing department by phone, fax, or text at 734-822-6796, or by email at dundeepediatrics.biller@gmail.com.

_____ I understand that should I need to cancel; I will contact the office at least 2 hours prior to appointment time. If I don't cancel my appointment prior to this, I will be charged a $25.00 No Show Charge. Excessive No Shows could result in release from our practice.

If you do not understand the above outlined policies or if you have further questions, please ask the front desk or office manager. We are more than happy to determine in ***advance*** if payment arrangements can be extended for services.

Signature of Responsible Party	Printed Name	Date
Witness Signature	Printed Name	Date

OFFICE USE ONLY Updated: 4/23/24

Dundee Pediatrics, PLLC
120 Waterstradt Commerce Dr., Suite 1
Michelle L. Daill, MD **Dundee, MI 48131**

Signature on File

Please Read Carefully

I authorize any holder of Medical or other information about my child/children or myself to be released to the Social Security Administration and Health Care Financing Administration or it's intermediaries, Medical Insurance Carriers or to the Billing Agent of this office any information needed for this or a related insurance claim.

I permit a copy of this authorization be used in place of the original and request payment of Medical Insurance Benefits to Dundee Pediatrics PLLC.

I also understand that my insurance may set a limit upon the care and treatments performed in the office and that I will be responsible for my deductible, co-pay, non-covered services and the percentage required by my insurance at the time of services.

I understand Dundee Pediatrics, PLLC will only file to one insurance company.

I request that payment of authorized medical benefits be paid on my behalf to Dundee Pediatrics, PLLC. I authorize any holder of medical information about my child/children or myself to be released to my insurance company and any information needed to determine these benefits of the benefits payable for related services.

I agree to pay all reasonable attorney fees and collection costs in the event of default of payment on my child/children's or my charges.

If you do not understand the above outlined policies or if you have further questions, please ask the front desk or office manager. We are more than happy to determine in *advance* if payment arrangements can be extended for services.

_____	_____	_____
Signature of Responsible Party	Printed Name	Date
_____	_____	_____
Witness Signature	Printed Name	Date

Healthy Physical Exam Schedule

Dundee Pediatrics practices medicine in accordance with the guidelines set by the American Academy of Pediatrics (AAP). ***ALL HEALTHY CHECK-UPS INCLUDE A COMPREHENSIVE PHYSICAL EXAMINATION.*** Hemoglobin testing for anemia will occur during each yearly check-up starting at age 1. Additionally, you can expect the following routine services at your child's periodic check-ups:

Newborn:	Comp. physical, Hep B vaccine (if not given at birth)
2 Week:	Comp. physical, No additional routine services
2 Months:	Comp. physical, Dtap, Hep B, IPV (Pediatrix), Pneumococcal (Prevnar 20), Rotavirus (Rotarix), HIB (Havrix)
4 Months:	Comp. physical, 2nd dose - Dtap, Hep B, IPV (Pediatrix), Pneumococcal (Prevnar 20), Rotavirus (Rotarix), HIB (Havrix)
6 Months:	Comp. physical, 3rd dose - Dtap, Hep B, IPV (Pediatrix), Pneumococcal (Prevnar 20), HIB (Havrix)
9 Months:	Comp. physical, No additional routine services
12 Months:	Comp. physical, MMR, Chicken Pox (Varicella), Hep A, and Lead Level Testing
15 Months:	Comp. physical, 4th dose – Dtap, Pneumococcal (Prevnar 20), 3rd dose HIB,
18 Months:	Comp. physical, 2nd dose – Hep A
2 Years:	Comp. physical, Lead Level Testing
3 Years:	Comp. physical, Vision and Hearing screen
4 Years:	Comp. physical, 5th dose - Dtap, 1st dose -IPV (Kinrix), 2nd dose – MMR, Chicken Pox (Varicella), Vision and Hearing screen
5 Years:	Comp. physical, Vision and Hearing screen
6 Years:	Comp. physical, Vision and Hearing screen
7 Years:	Comp. physical, No additional routine services
8 Years:	Comp. physical, Vision and Hearing screen
9 Years:	Comp. physical, No additional routine services
10 Years:	Comp. physical, Vision and Hearing screen
11 Years:	Comp. physical, HPV (Gardasil), Tdap (Boostrix), Meningococcal (Menveo)
12 Years:	Comp. physical, Vision and Hearing screen, HPV (Gardasil), Tdap (Boostrix), Meningococcal (Menveo) (If not given at age 11 physical)
13-14 Years:	Comp. physical, No additional routine services
15 Years:	Comp. physical, Vision and Hearing screen
16-17 Years:	Comp. physical, Meningococcal (Menveo)(Bexsero)
18 Years:	Comp. physical, Vision and Hearing screen
19-21 Years:	Comp. physical, No additional routine services

I understand that mu child's healthcare will be held to the standards set by the AAP. Many insurance companies cover routine well child care. If insurance does not cover the above-mentioned care, the parent/guardian is responsible for the cost.

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

Patient Demographic Form

Date

PATIENT INFORMATION

Last Name First Name Middle Initial Nickname

Date of Birth Social Security Number Gender

Home Address Apt #

City State Zip

Preferred Phone ☐ Cell ☐ Work ☐ Other Alternate Phone:

Race (Optional) ☐ Caucasian ☐ Black/Non-Hispanic ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other

PHYSICIAN REFERRAL INFORAMTION

Referring Physician

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Parent ☐ Legal Guardian ☐ Other

Last Name First Name Middle Initial

Date of Birth Social Security Number Email Email Statements

Yes ☐ No ☐

Home Address City State Zip

Preferred Phone ☐ Cell ☐ Work ☐ Other Alternate Phone:

Employer: Employment Status ☐ Employed Full-Time ☐ Self-Employed ☐ Active Duty Military ☐ Employed Part-Time ☐ Retired ☐ Retired Military

Primary Insurance	Subscriber	Date of Birth	Member ID	Group #	Customer Service Phone #

Secondary Insurance	Subscriber	Date of Birth	Member ID	Group #	Customer Service Phone #

NEWBORNS: Insurance must be provided within 30 days from the date of birth or we will bill you directly

PARENT/GUARDIAN INFORMATION

Father/Primary Guardian ☐ Parent ☐ Legal Guardian ☐ Other

Last Name First Name Middle Initial

Date of Birth SSN Email

Home Address City State Zip

Preferred Phone ☐ Cell ☐ Work ☐ Other Alternate Phone:

Mother/Secondary Guardian ☐ Parent ☐ Legal Guardian ☐ Other

Last Name First Name Middle Initial

Date of Birth SSN Email

Home Address City State Zip

Preferred Phone ☐ Cell ☐ Work ☐ Other Alternate Phone:

ADDITIONAL INFORMATION

Allergies:

Other Health Conditions:

Dundee Pediatrics, PLLC
120 Waterstradt Commerce Dr., Suite 1
Dundee, MI 48131

Michelle L. Daill, MD

Pediatric Patient History

Patients Name | Today's Date

Previous Physician | Referring Physician

Birth History

Adopted: Yes ☐ No ☐ | If yes, is the child aware: Yes ☐ No ☐

Date of Birth: | Hospital:

Problems during pregnancy: Yes ☐ No ☐

If yes, please list:

Full Term: Yes ☐ No ☐ | Type of Delivery: Vaginal ☐ C-Section ☐

List any delivery complications:

NICU: Yes ☐ No ☐ | Special Care Nursery: Yes ☐ No ☐

If yes, why:

Birthweight: Length: Head Circumference: Apgar Score: 1min 5min

Problems After Birth or During First Week

Birthing Problems: Yes ☐ No ☐ | Convulsions/Seizures: Yes ☐ No ☐

Jaundice: Yes ☐ No ☐ | Was Treatment Needed: Yes ☐ No ☐

What treatment:

Feeding Problems:

Hip Problems:

Other Problems:

Social History

Mothers Name: | Age: | Health:

Occupation: | Education (last grade):

Fathers Name: | Age: | Health:

Occupation: | Education (last grade):

Siblings (Name, Gender, Age, Health):

Who does child live with: Mother ☐ Father ☐ Both ☐ Sister/Brother ☐

** If Divorced, who has legal custody:

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Patients Name Today's Date

Nutrition and Feeding

Breast Fed: Yes ☐ No ☐ If yes, how long:

Has your child had any unusual feeding/dietary problems: Yes ☐ No ☐

If yes, please specify:

What type of milk does your child drink now:

Average ounces per day (8oz = 1 cup):

Sleep

Hours per night: Naps (number and length): Any Sleep Problems:

Development – Age Milestones

Sit alone: Walk alone: Say words: Toilet train (daytime):

GIRLS Only: First menstrual period:

Dental History

Has your child seen a dentist: Yes ☐ No ☐ If yes, how often: Date of last visit:

Immunizations/Infectious Disease

Please bring your child's immunization records to your appointment

Has your child had any of the following diseases:

Chicken Pox: Yes ☐ No ☐ Measles: Yes ☐ No ☐ Mumps: Yes ☐ No ☐

Rubella: Yes ☐ No ☐ Meningitis: Yes ☐ No ☐ Tuberculosis (TB): Yes ☐ No ☐

Exposures/Habits

Concerns about Lead Exposure (Old Home, Plumbing, Peeling Paint): Yes ☐ No ☐

Do any household members smoke: Yes ☐ No ☐ Are there smoke detectors in your home: Yes ☐ No ☐

Are there guns in your home: Yes ☐ No ☐ If yes, are they locked and unloaded: Yes ☐ No ☐

Seat belt use: Yes ☐ No ☐ Car/booster seat: Yes ☐ No ☐

Is violence at home a concern: Yes ☐ No ☐

TV hours per day: Computer hours per day: Video game hours per day:

Past Medical History

Please describe any major medical problems and their dates:

Hospitalization/Operations with dates:

Broken bones or severe sprains:

Patients Name Today's Date

Family History

Please indicate any deaths of your immediate family:

Please indicate family members (parents, siblings, grandparents, aunts or uncles) with any of the following conditions:

Alcoholism: Yes☐ No☐ If yes, who:

High Cholesterol: Yes☐ No☐ If yes, who:

Cancer: Yes☐ No☐ If yes, who & what type:

High Blood Pressure: Yes☐ No☐ If yes, who:

Heart Disease: Yes☐ No☐ If yes, who:

Stroke: Yes☐ No☐ If yes, who:

Depression/Suicide: Yes☐ No☐ If yes, who:

Bleeding/Clotting Disorders: Yes☐ No☐ If yes, who:

Genetic Disorders: Yes☐ No☐ If yes, who:

Asthma/COPD: Yes☐ No☐ If yes, who:

Diabetes: Yes☐ No☐ If yes, who:

Other: Yes☐ No☐ If yes, who:

Behavior/School

Does your child attend school or pre-school: Yes☐ No☐ Name/Grade:

Any concerns about school performance: Yes☐ No☐ Please list:

Any concerns about relationships with teachers: Yes☐ No☐ Please list:

Any concerns about relationships with peers: Yes☐ No☐ Please list:

Sports/Exercise: Yes☐ No☐ How often: How long (min.):

Please list:

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120 Waterstradt Commerce Dr., Suite 1
Dundee, MI 48131

Michelle L. Daill, MD

Review of Symptoms

General
- ☐ Fevers/Chills/Excessive Sweating
- ☐ Unexplained Weight loss/gain

Eyes
- ☐ Squinting
- ☐ "Crossed" Eyes
- ☐ Asymmetric Gaze

Ears/Nose/Throat
- ☐ Unusually loud voice/Hard of hearing
- ☐ Bad Breath
- ☐ Problems with teeth and/or gums
- ☐ Mouth breathing/snoring
- ☐ Frequent runny nose

Cardiovascular
- ☐ Tires easily with exertion
- ☐ Fainting
- ☐ Shortness of breath

Respiratory
- ☐ Cough/Wheeze
- ☐ Chest Pain

Gastrointestinal
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Blood in bowel movement
- ☐ Constipation

Genitourinary
- ☐ Bedwetting
- ☐ Discharge: Penis or Vagina
- ☐ Pain with urination

Musculoskeletal
- ☐ Muscle/Joint Pain

Skin
- ☐ Rashes
- ☐ Unusual Moles

Allergy
- ☐ Hay fever/Itchy Eyes

Neurological
- ☐ Headaches
- ☐ Clumsiness
- ☐ Weakness

Psychiatric/Emotional
- ☐ Speech Problems
- ☐ Sleep Issues
- ☐ Nail Biting/Thumb Sucking
- ☐ Jealousy
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Bad Temper
- ☐ Breath Holding

Blood/Lymph
- ☐ Unexplained Lumps
- ☐ Easy Bruising/Bleeding

Dundee Pediatrics, PLLC
120 Waterstradt Commerce Dr., Suite 1
Michelle L. Daill, MD **Dundee, MI 48131**

Patient Name:_____ Date: _____

Authorization to Treat

Dundee Pediatrics, PLLC, Dr. Michelle L. Daill and Staff, has my permission to examine and treat my child/children or myself. I also give my permission to examine or treat my child/children in my absence and/or with the individuals listed below (Grandparents, Aunts, and Uncles etc.)

_____ _____
First and Last Name Relationship to Patient

_____ _____
First and Last Name Relationship to Patient

_____ _____
First and Last Name Relationship to Patient

_____ _____
First and Last Name Relationship to Patient

If there are certain medical conditions or medications you decline treatment of/for/with, Please List them below:

_____

_____

_____

I understand all of the above and I understand that the standards set forth by medical associations, such as The American Academy of Pediatrics and the like, will be used by the office. If you should have any questions about the information above, please call our office, 734-823-5437.

_____ _____ _____
Patient/Parent/Guardian Signature Printed Name Date

_____ _____ _____
Witness Signature Printed Name Date

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