



Sweety A. Srivastava, MD
3020 S. Genesee Rd Burton MI 48519
810-744-3321

WELCOME TO OUR PRACTICE

This form is designed to acquaint you with our office policies and procedures. You can question, at this time and prior to service, the office policies and procedures in the following areas of concerns. **Please initial each item below.**

_____ **Policy on cancellation and rescheduling** (Must cancel before the appointment time or you will be charged a \$10 no show fee) After 3 consecutive no shows, the patient will be discharged from the practice.

_____ **NSF Check recovery policy** (You will be charged \$30 for any returned check)

_____ **Policy for insurance billing** (All billing will be done daily; no claims will be held)

_____ **Patient Statements** (We will mail all statements once per month. If no payments have been received after 3 mailings, the account balance may be transferred to a collection agency.)

_____ **Address, Phone Number or Insurance Changes** (When checking in, it is your responsibility to notify the receptionist of any changes.)

_____ **It is State Law for parent/guardian of a child under the age of 18 to remain in the office while the child is being treated. The consent to treat without parent or guardian must be on file for any minor child to be seen.**

_____ **The Health Insurance Portability and Accountability Act (HIPAA)** Privacy rule provides consumers with important privacy rights and protections with respect to their health information including important controls over how their health information is used and disclosed by health plans and health care providers.

My initials above and my signature below signify I have read and understand the counseling I have received.

Patient Name: _____ Date: _____

Parent/Guardian Signature: _____

Infant Health History

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YOUR CHILDS MEDICAL RECORD

Form completed by: _____ Date: _____

Childs Name: _____ Gender: _____ DOB: _____

Prenatal History:

Gestational Diabetes	Y or N
Group B Strep	Y or N
Hypertension	Y or N
Smoking during pregnancy	Y or N
Alcohol or recreational drugs during pregnancy	Y or N

Birth History: (Circle answer)

Vaginal Delivery	Cesarean Section	Other
On Time	Before 37 weeks	After 42 weeks
Birth Weight: _____	Birth Height: _____	

Does the child have any medical conditions? _____
Is the child on any medications? _____
Surgeries? (Includes circumcision) _____
Does the child have any allergies? _____

Diet and Environment: (Circle Answer)

Breastfed	Formula	Both
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How many children in the home? _____
How many adults live in the home? _____
Are the parents of the child married? Yes No

Does your home have adequate heat, a telephone and enough food?	Yes	No
Was your home built before 1950?	Yes	No
Does your home have mold?	Yes	No
Are there guns in the home?	Yes	No
Does anyone smoke in the home?	Yes	No
Do you have a smoke detector in the home?	Yes	No
Are there any pets in the home? If so, what? _____	Yes	No
Do you always use a car seat?	Yes	No
Is there any family abuse?	Yes	No

Family Health History:

Have any of the family members had the following? If so, note the relationship to the child (circle yes or no)

Deafness	Yes or No	Bleeding Disorder	Yes or No
Liver or kidney disease	Yes or No	High cholesterol	Yes or No
Alcohol or drug abuse	Yes or No	Mental Illness	Yes or No
Anemia	Yes or No	Heart Disease	Yes or No
Diabetes	Yes or No	Epilepsy or convulsions	Yes or No
High Blood Pressure	Yes or No	Immune deficiency	Yes or No
Depression	Yes or No	Cancer	Yes or No

Any other concerns? Please list

Patient Registration

Patient name: _____ DOB: _____

Gender: _____ Race: _____ Ethnicity: _____

Language: _____

Mothers name: _____ DOB: _____

Fathers name: _____ DOB: _____

Address: _____ City: _____ ZIP: _____

Phone number: _____

Secondary number: _____

Email: _____

Emergency contact: _____ Relation: _____

Phone number: _____

Insurance Information

Insurance Name: _____

Group: _____ Member Id: _____

Subscriber: _____

DOB: _____ Relation to patient: _____

Secondary Insurance Name: _____

Group: _____ Member Id: _____

Subscriber: _____

DOB: _____ Relation to patient: _____

Pharmacy name and location: _____

Sweety A. Srivastava, MD.
3020 S. Genesee Rd Burton MI 48519
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I hereby authorize Dr. Sweety Srivastava to apply for benefits on my behalf for covered services rendered by her, or her order. I request that payment from my insurance company be made directly to Dr. Sweety Srivastava. Should any of these services be rejected, including physicals and vaccinations, I will be held liable for payment.

I certify that the information I have reported about my insurance coverage is correct.

Patient Name: _____ DOB _____

Parent/Guardian Signature: _____

VACCINE POLICY STATEMENT

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the CDC and prevention and the AAP. We firmly believe that vaccinating children and young adults may be the single most important health promoting intervention we perform as healthcare providers and that you can perform as parents/caregivers. The recommended vaccines and the vaccine schedules are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

We recognize that there has always been and will be a controversy surrounding vaccinations. When you don't vaccinate you take a significant risk with your child's health and the health of others around them. Because we are committed to protecting the health of your children through vaccination, we require all of our patients to be vaccinated. If you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another healthcare provider who shares your views. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life threatening illness, disability, and even death.

By signing this, I am agreeing to vaccinating my child through the American Academy of Pediatrics vaccination schedule.

Patients name: _____ Date: _____

Parent/Guardian Signature: _____

Pediatric Consent form

(in the absence of a parent or guardian)

Child's Name: _____ DOB: _____

I(we) the parent(s) or legal guardian(s) authorize the individual(s) listed below to act in my (our) behalf with the full authority to grant permission for any medical treatment, including administration of immunizations if recommended, the use of AI tools for note charting and/or any medical procedures that take place in the office of Dr. Sweety Srivastava. In addition, the provider is hereby authorized in an emergent situation to perform whatever acts that her professional opinion is in the best interests of the above-mentioned child. I understand that the provider may request to contact the parent/guardian prior to providing medical treatment even though the consent is presented. I understand that as a parent(s) or legal guardian(s) I am financially responsible for all care received as a result of this consent.

ADULTS THAT MAY SIGN FOR MEDICAL TREATMENT IN MY(OUR) ABSENCE:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

AUTHORIZED BY:

Name: _____ Relation to patient: _____

Signature: _____ Date: _____

ANY CHANGES MADE TO THIS CONSENT MUST BE MADE IN PERION AT THE OFFICE.

The Pediatric Place
Dr. Sweety A. Srivastava, MD
3020 S. Genesee Rd Burton, MI 48519
P: 810-744-3321 F: 810-744-2850

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient: _____
Address _____

Release from: _____

DOB: _____
Phone: _____
Release to: _____

Specific type of information to be disclosed:

☐ Any and all records ☐ Diagnostic Reports ☐ Immunizations ☐ Lab results only
☐ Chart notes only ☐ Consultations only ☐ Other: _____

*Communicable disease and infection information as defined by the statute and Michigan Department of Public Health Rules (which include Venereal Disease "VD", Tuberculosis "TB", Hepatitis B, Human Immunodeficiency Virus "HIV", acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC")

*Alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.

*Mental Health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

Purpose for disclosure:

☐ Transfer of care ☐ Attorney Request ☐ Disability ☐ Workers Comp
☐ Social security ☐ Insurance ☐ Other: _____

*I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

*I understand that I have the right to refuse to sign this authorization or to inspect my protected health information to be used or disclosed as permitted under federal state laws.

*I understand that the practice will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure. Further, if the practice will receive payment for obtaining this information, I understand I will be notified of the same.

*I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Signature of ☐ Patient ☐ Personal Representative Printed Name Date
Dr Sweety Srivastava, MD

3020 S. Genesee Rd.
Burton, MI 48519
(810)744-3321

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED – PLEASE REVIEW CAREFULLY

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

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

We may use or disclose your protected health information in the following situations without your authorization: As required by law, public health issues are required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Child Protective Services, Food and Drug Administration, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers Compensation. Required uses and disclosures: Under the law, we must make disclosures to your child and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your child's protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your child's protected health information not be disclosed to family members or friends who may be involved in your child's care or for notification purposes as described in this Notice of Privacy Practices. The request must state the specific restrictions requested and for whom the restrictions are in place. Our organization is not required to agree to a restriction of your request if our organization believes it is in your child's best interest to permit, use and disclose your child's Protected Health Information, then your child's protected health information will not be restricted. You have the right to use another Healthcare Professional.

We Welcome your Comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality of Services!

Patients Name: _____ D.O.B: ____/____/____

Address: _____

Phone Number: _____

Parent/Guardian Signature: _____

Date: ____/____/____