Pediatric Center of Jackson
Social Determinants of Health Screening

Patient Centered Medical Home

Patient Name: _____ Date of Birth: _____

Parent Name: _____ Phone: _____

DID YOU KNOW?
20% of the factors that influence a person's health are related to access and quality of care. The other 80% are due to social, economic, environmental, and behavioral factors. This health screening is intended to address that other 80%. We are working beyond clinical walls to empower people to better care for themselves and their loved ones.

Parents, please answer the following questions:		***Circle One***
Healthcare	Does your physical or mental health keep you from doing things you need or want to do? (Work, school, the ability to take care of yourself and family)	Yes No
	In the past year was there a time when you needed to see a doctor but couldn't because of cost?	Yes No
Food	Do you struggle to get the food you need for you and your family?	Yes No
Housing	Do you need help with housing?	Yes No
Utilities	Do you have a hard time paying your utility bills?	Yes No
Family Care	Do you need help finding or paying for care for loved one? (For example, child care or adult day care)	Yes No
Transportation	Do you have trouble with transportation?	Yes No
Literacy	Do you ever need help reading important papers?	Yes No
Employment/ Income	Do you need help finding a job, a better job, or a steady source of income?	Yes No
Education	Do you think more education could be helpful for you?	Yes No
Social Connections	Do you struggle to get together with friends or family on a regular basis?	Yes No
Legal	Do you have any legal concerns at this time?	Yes No
Safety	Are you afraid you, or our children, might be hurt in your living environment?	Yes No
****Assistance**	Would you like assistance with any of these needs? ***(By answering "yes", you agree to allow us to share your information with a 2-1-1 Social Service Navigator who will link you to applicable resources in the community)***	Yes No
	Are any of your needs urgent?	Yes No

IMPORTANT! Participation in this program is voluntary. If you do not wish to participate, do not answer the questions and circle the word "decline" : DECLINE

Michigan 211 is a free service that connects people to community resources when they need help. It is confidential and offers access to thousands of programs and services statewide. **Anyone *can use 211 at any time to find the assistance they need*-** a referral from a health care provider is not required. ***Our office is participating in this program as part of the Patient Centered Medical Home collaborative effort to assist our patients and their families when help may be needed.***

Rev.1/31/2019
2-1-1 fax# 517-789-1271

Today's Date: _____

Patient Demographics:

Child's Name: _____ M/F Birth Date: ____/____/____

Address: _____ City: _____ Zip: _____

Home Phone #:_____ Cell Phone: _____

Was child adopted? Yes or No

Race: American Indian or Alaskan Native___ Asian___ Black/African American___

Native Hawaiian___ White___ Other Pacific Islander___

Ethnicity: Hispanic___ Non-Hispanic___

Language_____

Mother's Name: _____ Fathers Name: _____

Mother's Birth Date: ____/____/____ Father's Birth Date: ____/____/____

Soc. Sec. #____-____-____ Soc. Sec. #____-____-____

Who does child live with? _____

Emergency Contact: _____ Phone #:_____

Other Family Members That Come Here:

_____ _____

_____ _____

_____ _____

_____ _____

Any Other Person(s) Authorized to Bring Child to Appointment or Leave Message With:

Name/Relationship: _____ Phone #:_____

Name/Relationship: _____ Phone #:_____

Name/Relationship: _____ Phone #:_____

Name/Relationship: _____ Phone #:_____

Insurance Information:

Primary Insurance Name: _____ Group #:_____

Policy Holder Name: _____ Contract #:_____

Secondary Insurance Name: _____ Group #:_____

Policy Holder Name: _____ Contract #:_____

Parent/Patient Signature: _____ Date: ____/____/____

Patient Name: _____ **DOB:** ____/____/____

Patient Medical History:

Please list below ANY surgeries, hospitalizations, chronic disease or conditions your child has had with the date.

_____
_____
_____
_____.

Medications:

Please list ALL of the medications your child is taking, including over the counter medications and herbal supplements. Please include dose and how often they take this medication.

_____
_____.

Allergies:

Please list ALL medications your child is allergic to: _____
_____.

If NO allergies check here: _____

Patient's Birth History:

Type of Delivery: Vaginal or C-Section Problems at time of delivery? Yes or No

If yes, what? _____

In the nursery (please select all that apply):

Neonatal ICU admission Antibiotics Lights for jaundice Blood transfusion Oxygen needed

Time of Birth: _____ Birth Weight: _____ Birth Length: _____ Head Size: _____

Hepatitis B given? Yes or No If yes Date: ____/____/____

Hearing: Pass or Fail If fail which ear? R_____ L_____ Both_____

Circumcised? Yes or No If yes date and Dr: _____

Please list any other problems: _____.

Mom's Pregnancy History:

Gestational age at birth: Weeks: _____ Days: _____

Please list any illnesses mom experienced during this pregnancy:
_____.

Please list any medications mom took during pregnancy: _____

Did mom smoke during pregnancy: Yes or No

Alcohol consumption? Yes or No

Drug use? Yes or No

Patient Name: _____

Family History

Does anyone have or ever had any of the following:
Including: Mom, Dad, Sister, Brother (***Please list relation)***

Acid Reflux:	NO	YES
ADD/ADHD:	NO	YES
Allergies:	NO	YES
Anemia:	NO	YES
Anxiety:	NO	YES
Asthma:	NO	YES
Autism:	NO	YES
Birth Defects:	NO	YES
Bipolar:	NO	YES
Bleeding Disorders:	NO	YES
Blood Disease:	NO	YES
Cancer:	NO	YES
Type of Cancer:	_____	
Crohn's Disease:	NO	YES
Deafness:	NO	YES
Depression:	NO	YES
Developmental Delay:	NO	YES
Diabetes:	NO	YES
Eczema:	NO	YES
Hearing Loss:	NO	YES
Heart Disease:	NO	YES
High Cholesterol:	NO	YES
Hypertension:	NO	YES
Kidney Disease:	NO	YES
Learning Disability:	NO	YES
Lupus:	NO	YES
Mental Retardation:	NO	YES
Migraines:	NO	YES
Obesity:	NO	YES

Panic Attacks:	NO	YES
Polio:	NO	YES
Scoliosis:	NO	YES
Seizure Disorders:	NO	YES
Sickle Cell Trait:	NO	YES
SIDS:	NO	YES
Stroke:	NO	YES
Thyroid Disease:	NO	YES

OTHER: _____

Pediatric Center of Jackson
Souha S Hakim MD
1418 E. Michigan Avenue
Jackson, MI 49202

Patient Name: _____ Patient DOB: _____

Privacy Notice Acknowledgement

By signing below, I acknowledge that:

A copy of the Privacy Notice was made available to me at Pediatric Center of Jackson. The Privacy Notice is posted in a clear and prominent location where I can read it. I know that I can ask for a copy of the Privacy Notice to take with me. If health care services were provided in an emergency treatment situation, I know that I would be able to view the Privacy Notice as soon as reasonably practical once the emergency treatment situation was over.

I understand that the hospital, physicians, and other health care providers included in this organized health care arrangement are participating solely for the limited purpose of coordinating the protection of my privacy rights. This is in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the members of the medical staff of the hospital and other health care providers who provide services at the hospital or who use the hospital to provide care to their patients are not agents or employees of the hospital by virtue of their participation in this arrangement.

Agreement to Pay for Services:

By signing below, I authorize Pediatric Center of Jackson to release any medical information deemed necessary in order to process claims to my insurance company and/or Medicaid. I further authorize payment of medical benefits payable directly to Pediatric Center of Jackson and/or Souha S Hakim MD.

In addition, my signature below indicates that I have read, and understand, the following:

- Pediatric Center of Jackson will complete all necessary steps to collect payment from my insurance company. However, the ultimate responsibility for ensuring complete payment lies with me, not the insurance company.
- I am responsible for any account balance that is not covered by insurance for services rendered at Pediatric Center of Jackson.
- I am responsible for any deductible amounts, co-pay amounts, and co-insurance amounts that remain after the insurance company has issued payment.
- Payment in full is due at the time of service for all self-pay patients.
- There is a $25.00 fee for all returned checks. Once a check has been returned, I will no longer be able to write checks without speaking with the billing department and/or Dr. Souha Hakim.
- Any delinquent account older than **90 days** will be subject to a collection service fee. I agree to reimburse the fees of any collection agency at the rate of **40% of the debt**, and all costs, and expenses, including reasonable attorney fees, that are incurred in such collection efforts.

_____ _____

Patient or Patient Representative Signature Date

PATIENT AUTHORIZATION FOR PROVIDER'S ACCESS, USE AND DISCLOSURE OF RECORDS AND/OR PROTECTED HEALTH INFORMATION THROUGH JACKSON COMMUNITY MEDICAL RECORD, L3C

Souha S Hakim MD ("Provider") is participating in a community wide electronic health record system ("EHR System") established by Jackson Community Medical Record L3C ("JCMR") and has obtained a Sub-License to use the EHR Software. This means that my Provider will create an individual electronic health record for me in the JCMR EHR System which consists of my private health information ("PHI") which will be available electronically to my Provider and other healthcare Providers and their respective Permitted Users for purposes of providing healthcare services to me including treatment, payment and other healthcare operations. Examples of PHI include but are not limited to my name, address, insurance information, payment history, social security number, laboratory and other diagnostic test results or reports, medications, medical history, surgery information, immunization records and any notes kept by my Provider or the Provider's office related to my care. In order to create the EHR for me, my Provider and his Permitted Users will be required to disclosed my PHI to JCMR, who operates and maintains the community wide EHR.

CONSENT TO ACCESS, USE OR DISCLOSE OF PROTECTED HEALTH INFORMATION.

I understand that it is the intent of Provider to hold all of my individually identifiable health information (medical information or "PHI") with the utmost level of confidentiality. I authorize and give consent to my Provider, his/her/its Permitted Users, to create and use an EHR which includes disclosing my PHI to JCMR and other healthcare Providers who provide me with healthcare services, for my continuing care and treatment, payment, healthcare operations, and as described in each Provider's Privacy Notice. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claim(s) on my behalf. I also authorize payment of medical health insurance benefits to be made directly to Provider and/or his/her/its designees for services rendered.

AUTHORIZATION FOR ACCESS TO JCMR MEDICAL RECORD AND RELEASE OF INFORMATION.

If a JCMR EHR has already been created for me, I consent and authorize Provider and his/her/its Permitted Users to access my JCMR EHR for my continuing care and treatment, payment or healthcare operations. This includes my consent and authorization for the release and disclosure of any medical information necessary to process insurance claim(s) on my behalf. I also authorize payment of medical health insurance benefits to be made directly to Provider and/or his/her/its designees for services rendered.

I have read this form in its entirety or have had it read to me. Additionally, I have had the opportunity to ask any questions that I may have and they have been answered to my satisfaction.

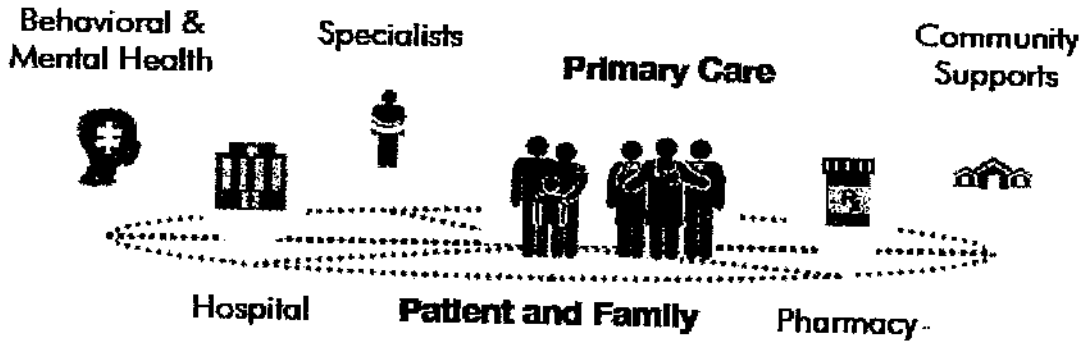
Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name and Address of Patient: _____

Be a Partner in Your Health!

A Patient-Centered Medical Home (PCMH) *is a system of care in which a team of health professionals' work together to provide all of your health care needs. You, the patient, are the most important part of a PCMH - take an active role in your health and work closely with us.*



We are partnering with your Primary Care Physician and your Medical Home to co-manage your care over time. Co-management of your care is specifically related to your pediatric care needs

As a member of your healthcare team, I will:

- ***Listen and clearly explain*** your condition in order to help you make an informed decision.
- ***Communicate*** your care plan to vital players in your medical home.
- ***Protect*** your medical information/records.
- ***Schedule*** future appointments and referrals.
- ***Ensure*** you receive necessary test reminders and results.

As a partner in your health, I need you to:

- ***Follow through*** on all appointments.
- ***Learn*** about your insurance coverage.
- ***Tell us what medications*** you are taking and ask for refills when needed.
- ***Follow the care plan*** agreed upon and let us know of any barriers.
- ***Seek advice*** from your PCP before seeing other physicians.

To assist you in managing your health, please note the following:

Test Results

All normal test results are communicated within 7 business days and all abnormal test results are communicated within 48 hours. If you have not received test results, please give our office a call at (517) 783-1779.

Community Resources

Resources are available to act as an additional resource in reaching your goals. Please contact the 2-1-1 hotline or a listing of Jackson Health Networks resources at http://www.jacksonhealthnetwork.org

After Hours Care

After Hours Phone:

(517) 783-1779

Patient web-portal

Ask us how to sign up to receive and send secure, compliant communications.

Practice Name: Pediatric Center of Jackson, PC
Address: 1418 E. Michigan Avenue
Jackson, MI 49202
Phone Number: (517) 783-1779
Practice Hours: Mon., Tues., Thurs. 8:30 AM - 4:30 PM
Wed. 8:30 AM – 5:30 PM
Fri. 8:30 AM - Noon