CHILD HEALTH ASSOCIATES, P.C.

1800 W. Big Beaver Road
Suite: 200
Troy, MI 48084
(248) 205-3535 – Phone
(248) 649-5920 – Fax

25500 Meadowbrook
Suite: 190
Novi, MI 48375
(248) 788-2100 – Phone
(248) 513-4144 – Fax

As your pediatricians, we had the pleasure of watching you grow into a young adult while caring for your healthcare needs. The transition from a pediatrician's office to an adult medical office can be stressful; however, you are now in a position to make medical decisions for yourself and/or consult with a family member. Gone are the days of being asked if you would like a sticker at the end of your visit. You will be happy to know some adult medical practices still have a fish tank for your enjoyment.

Child Health Associates, P.C. can schedule your final physical exam (18-year) and see you for sick visits and medication checks until you are about to turn 20 years old. During your 18-year physical exam we will address health maintenance, healthy lifestyle choices, immunizations and perform a physician exam. If you have a chronic medical condition that requires medication, the doctor will discuss medication maintenance until you establish care with a new doctor.

Please let your doctor or front desk staff member know the new doctor you choose to continue care, so the transition process can begin.

We wish you continued success into adulthood.

Sincerely,

Child Health Associates, P.C.

CHILD HEALTH ASSOCIATES

I, _____, give permission for Child Health Associates, P.C. to provide all
(name of patient)necessary medical care.

PLEASE LIST NAME AND DATE OF BIRTH

Sex Assigned at birth: ___ MALE ___ FEMALE DOB _____/_____/_____

LEGAL First LEGAL Middle Initial LEGAL Last

Preferred name/Pronoun _____

Address

Patient Street number and name City State Zip code

Patient Main Phone Number Alternate phone Number

Patient E-mail address (we will only use this to communicate information with you)

Billing Address (if different)

Street number and name City State Zip code

Main Phone Number Alternate phone Number

Parent and/or Guardian

First Middle Initial Last

Occupation Employer

Employer address work number

Parent and/or Guardian

First Middle Initial Last

Occupation Employer

Employer address work number

Signature:_____Date:_____

Child Health Associates, P.C.

TEST RESULT/ MEDICAL HEALTH INFORMATION RELEASE

I understand that this information can be updated or changed at any time.

I, _____, give my permission for test results and /or health information to be released to:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Signature	Date

I, _____, DO NOT give my permission for any test results and / or health information to be released to anyone other than myself.

_____	_____
Signature	date

CHILD HEALTH ASSOCIATES, P.C.

With my consent, Child Health Associates (CHA) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to CHA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CHA Privacy Officer at 1800 W. Big Beaver, Suite #200, Troy, MI 48084.

With my consent, CHA may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminder, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, CHA may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that CHA restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to CHA's uses and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, CHA may decline to provide treatment for me.

_____ _____

Patient Signature Date

_____

Print Legal Name of Patient

I acknowledge that I have had the opportunity to review Child Health Associates, P.C.'s Notice of Privacy Practices.

Child Health Associates reserves the right to revise its Notice of Privacy Practices at any time.

_____ _____

Patient Signature Date