Bright Start Pediatrics
where kids shine the brightest

Access our Patient Portal & Facebook through our website
www.brightstart-pediatrics.com

PLEASE LIST ALL CHILDREN WHO WILL BE PATIENTS AT BRIGHT START PEDIATRICS BELOW:

1. **Name** _____ (Last) (First) (M.I.) **Nickname** _____ **Date of Birth** _____ **Male / Female (circle)**
   Social Security # _____ **Primary Physician** _____ **Medicaid ID #:** _____
   Race/Ethnicity _____ **Preferred Language** _____

2. **Name** _____ (Last) (First) (M.I.) **Nickname** _____ **Date of Birth** _____ **Male / Female (circle)**
   Social Security # _____ **Primary Physician** _____ **Medicaid ID #:** _____
   Race/Ethnicity _____ **Preferred Language** _____

3. **Name** _____ (Last) (First) (M.I.) **Nickname** _____ **Date of Birth** _____ **Male / Female (circle)**
   Social Security # _____ **Primary Physician** _____ **Medicaid ID #:** _____
   Race/Ethnicity _____ **Preferred Language** _____

4. **Name** _____ (Last) (First) (M.I.) **Nickname** _____ **Date of Birth** _____ **Male / Female (circle)**
   Social Security # _____ **Primary Physician** _____ **Medicaid ID #:** _____
   Race/Ethnicity _____ **Preferred Language** _____

****If the parents are separated, which household do/does the child/children reside at?** _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Location: _____

PARENT OR GUARDIAN INFORMATION

FATHER:

Name: _____ (Last) (First) (M.I.) Date of Birth _____ Marital Status _____ **E-Mail** _____

Address: _____ (Street Address) City / State / Zip Social Security #: _____ Employer _____

Primary Phone: (___) _____ Alternative Phone: (___) _____ Alternative #2 Phone: (___) _____

MOTHER:

Name: _____ (Last) (First) (M.I.) Date of Birth _____ Marital Status _____ **E-Mail** _____

Address: _____ (Street Address) City / State / Zip Social Security #: _____ Employer _____

Primary Phone: (___) _____ Alternative Phone: (___) _____ Alternative #2 Phone: (___) _____

****OVER****

INSURANCE INFORMATION:

Primary Insurance:

Subscriber's Name: _____ Relationship to Patient: _____
(Last) (First) (M.I.)

Insurance Carrier: _____ Policy No: _____ Group No: _____

Secondary Insurance:

Subscriber's Name: _____ Relationship to Patient: _____
(Last) (First) (M.I.)

Insurance Carrier: _____ Policy No: _____ Group No: _____

I authorize payment of medical benefits by the insured directly to Bright Start Pediatrics PLLC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to my family member and for any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize Bright Start Pediatrics PLLC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature _____ **Date**_____

I authorize the following person (people) to bring my child (children) to Bright Start Pediatrics for the following types of visits. (Please include any Step-Parents.)

- o Evaluation and Treatment
- o Well Visits
- o Lab Tests
- o Immunizations

Name: _____ Phone:_____ Relationship to Patient _____
Name: _____ Phone:_____ Relationship to Patient _____

Signature _____ **Date**_____

Authorization For Specific Confidential Communications

Is it ok to leave a detailed message including medical information on your voicemail? No ___ Yes ___ List Ph # _____

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:
(List anyone *other than* parents)

Name: _____ Relationship to Patient _____
Name: _____ Relationship to Patient _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- o Medical Care / Treatment: **Yes** ____ **No** ____ **Level of Information** _____
- o Billing Information **Yes** ____ **No** ____
- o Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes** ____ **No** ____
- o Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.)

_____
_____

This authorization shall be in force and effect and will expire one year from the date signed below. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Bright Start Pediatrics PLLC – 1375 W. Green St #3 Hastings, MI 49058. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ Date _____
Patient / Parent / Guardian Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of this office's Notice of privacy Practice Form.

_____ _____
Patient / Parent's / Guardian's Signature **Date**

Medical History Questionnaire

Date	
Patient Name	

Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):	

CHILD'S MEDICAL HISTORY

Has your child ever had:

Allergies (Food, Meds or Seasonal)	❑ No	❑ Yes
Acid reflux/heartburn	❑ No	❑ Yes
Anemia	❑ No	❑ Yes
Asthma/Wheezing	❑ No	❑ Yes
Asthma Action Plan	❑ No	❑ Yes
Bladder Infections / Kidney Disease	❑ No	❑ Yes
Bleeding Disorders/Hemophilia	❑ No	❑ Yes
Bone or Joint Injuries	❑ No	❑ Yes
Cancer	❑ No	❑ Yes
Chicken Pox (Year)	❑ No	❑ Yes
Dental Problems	❑ No	❑ Yes
Depression/Suicidal Thoughts	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes
Eating Disorders (Bulimia / Anorexia)	❑ No	❑ Yes
Emotional Abuse/Sexual Abuse	❑ No	❑ Yes
Emotional/Behavioral/Psychiatric Problems	❑ No	❑ Yes
Frequent Ear Infections	❑ No	❑ Yes
Head Injury	❑ No	❑ Yes
Hearing Problems	❑ No	❑ Yes
Heart Defects/Disease	❑ No	❑ Yes
Hernia	❑ No	❑ Yes
High Blood Pressure	❑ No	❑ Yes
Language Delay / Speech Problems	❑ No	❑ Yes
Lead Poisoning	❑ No	❑ Yes
Learning Disabilities (Including ADD / ADHD)	❑ No	❑ Yes
Liver Disease/Hepatitis	❑ No	❑ Yes
Migraine Headaches	❑ No	❑ Yes
Mononucleosis	❑ No	❑ Yes
Obesity/Overweight	❑ No	❑ Yes
Physical Disabilities	❑ No	❑ Yes
Pneumonia	❑ No	❑ Yes
RSV	❑ No	❑ Yes
Seizures/Epilepsy	❑ No	❑ Yes
Sexually Transmitted Infections	❑ No	❑ Yes
Sinusitis	❑ No	❑ Yes
Skin Problems/Eczema/Hives	❑ No	❑ Yes
Specialty Doctors … Has Your Child Seen?	❑ No	❑ Yes
Who?		
TB/Lung Disease	❑ No	❑ Yes
Tonsillitis	❑ No	❑ Yes
Vision Problems	❑ No	❑ Yes
Wetting (Day / Night)	❑ No	❑ Yes

Other Concerns:

Current Medication(s): List:

Reviewed by: Date:

FAMILY MEDICAL HISTORY

Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:

Allergies (List)	❑ No	❑ Yes	Who?
Asthma/Wheezing	❑ No	❑ Yes	Who?
TB/Lung Disease	❑ No	❑ Yes	Who?
Cystic Fibrosis	❑ No	❑ Yes	Who?
HIV/AIDS	❑ No	❑ Yes	Who?
Heart Disease	❑ No	❑ Yes	Who?
Sudden Cardiac Death	❑ No	❑ Yes	Who?
High Blood Pressure/Stroke	❑ No	❑ Yes	Who?
High Cholesterol	❑ No	❑ Yes	Who?
Blood Disorders			
Anemia	❑ No	❑ Yes	Who?
Clotting Disorders	❑ No	❑ Yes	Who?
Hemophilia	❑ No	❑ Yes	Who?
Sickle Cell	❑ No	❑ Yes	Who?
Thalassemia	❑ No	❑ Yes	Who?
Diabetes	❑ No	❑ Yes	Who?
Seizures	❑ No	❑ Yes	Who?
Mental Illness	❑ No	❑ Yes	Who?
Depression/Anxiety/Bipolar	❑ No	❑ Yes	Who?
Other	❑ No	❑ Yes	Who?
Cancer	❑ No	❑ Yes	Who?
Birth Defects	❑ No	❑ Yes	Who?
Hearing Loss	❑ No	❑ Yes	Who?
Speech Problems	❑ No	❑ Yes	Who?
Kidney Disease	❑ No	❑ Yes	Who?
Alcohol/Drug Abuse	❑ No	❑ Yes	Who?
Hepatitis/Liver Disease	❑ No	❑ Yes	Who?
Thyroid Disease	❑ No	❑ Yes	Who?
Learning Problems (Including ADD/ADHD)	❑ No	❑ Yes	Who?
Attention Deficit Disorder	❑ No	❑ Yes	Who?
Mental Retardation	❑ No	❑ Yes	Who?
Family Violence	❑ No	❑ Yes	Who?

Other Concerns:

Has any family member ever had an unexplained, unexpected death before age 50?
❑ No ❑ Yes (If yes, describe on back)

Reviewed by: Date:

continued>

Medical History Questionnaire

<continued

PREGNANCY AND BIRTH HISTORY

Adopted ❑ No ❑ Yes

Prenatal care ❑ No ❑ Yes

Illnesses during pregnancy ❑ No ❑ Yes

Medications during pregnancy ❑ No ❑ Yes

Alcohol/drug abuse ❑ No ❑ Yes

Tobacco use ❑ No ❑ Yes

Problems at birth ❑ No ❑ Yes

Baby

- Jaundice ❑ No ❑ Yes
- Heart Murmur ❑ No ❑ Yes
- Infection ❑ No ❑ Yes
- Breathing Problems ❑ No ❑ Yes
- Birth Defects ❑ No ❑ Yes

Other:

Name of Hospital:

Full-Term Delivery: ❑ No ❑ Yes

Type of delivery: ❑ Vaginal ❑ C-section ❑ VBAC

Birth Weight:

Newborn Hearing Screen Passed? ❑ No ❑ Yes

Did baby receive Hep B vaccine ❑ No ❑ Yes

If Born Premature, how early?

FEEDING AND DIGESTION

Breast fed ❑ Formula ❑

Severe colic in first 3 months ❑ No ❑ Yes

Feeding problems ❑ No ❑ Yes

Takes vitamins ❑ No ❑ Yes

Constipation problems ❑ No ❑ Yes

Food allergies/issues ❑ No ❑ Yes

PSYCHOSOCIAL HISTORY

Who lives in household:

❑ Rent ❑ Own ❑ Shelter

Who cares for child:

Is child in daycare: ❑ No ❑ Yes

Type: ❑ Center

❑ Private home

Date of Birth:

Mother:

Father:

Parents divorced/separated: ❑ No ❑ Yes

Parents working:

Mother: ❑ No ❑ Yes

Father: ❑ No ❑ Yes

Parents use tobacco:

Mother: ❑ No ❑ Yes

Father: ❑ No ❑ Yes

Child use tobacco (12 years +) ❑ No ❑ Yes

Child Sleep Problems ❑ No ❑ Yes

Foster Care:

Dates: _____ _____

Other Languages:

MEDICAL HISTORY

Broken bones ❑ No ❑ Yes

Serious accidents ❑ No ❑ Yes

Operations ❑ No ❑ Yes

Hospitalizations ❑ No ❑ Yes

Explain:

Additional Information:

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Office Policies of Bright Start Pediatrics

Consent for Treatment

By signing below, I authorize the employees of Bright Start Pediatrics to perform appropriate assessment and treatment of my child, as this office deems medically necessary.

Pharmacy / Prescription Information

I grant permission for Bright Start Pediatrics to access my child's prescription history from any pharmacy we currently use or have used in the past.

Financial Policy

Controlling medical costs is a concern for all of us. Bright Start Pediatrics will make every effort to keep costs down, while maintaining the highest, appropriate standards of medical care and service.

To help ensure that payment administration is done efficiently, we expect our patients to pay any co-payment obligations required by their health insurance plan on the date of service. It is the parents'/guardians' responsibility to know their cop-pay (or %) due at the time of the appointment. *If you fail to pay for your co-payment within one business day, a late fee of $15.00 will be assessed to your account.* A service fee of $25.00 will be assessed for a returned check. These fees will not be submitted to any insurance carrier and are payable prior to scheduling further non-urgent appointments within our practice.

By signing below, I recognize and fully understand that I am financially responsible for all services rendered by Bright Start Pediatrics. Furthermore, I agree to pay all co-payments on the date of service and any outstanding family balances. I understand that whichever parent brings our minor child in for services is responsible for payment of the services rendered, regardless of any divorce decree.

No-Show / Missed Appointments

The providers at Bright Start Pediatrics understand that a patient may, on occasion, miss their appointment due to unforeseen circumstances. We ask that when this occurs, you notify our office at least 24 hours prior to the appointment. In the event that you miss a scheduled appointment, it will be recorded in your child's record. After the first time, a phone call will be placed to reschedule the appointment and review our policy. Subsequent offenses will be followed with a letter and there will be a $50 service charge. This fee will not be submitted to any insurance carrier and is payable prior to scheduling further non-urgent appointments within our practice. If there continues to be a problem with missed appointments, the accounts of your child and his/her siblings may be changed to an INACTIVE status with the possibility of being discharged from the practice. (If a child is discharged from the practice for any reason, we will continue to provide 30 days of emergency-only service while you are seeking another provider.) Please help us to serve you better by keeping your appointments!

OVER

Medical Leave / FMLA Form Completion and/or Revision Policy

There is a $15 fee for the completion of each medical leave/FMLA form. This fee is payable when you submit the paperwork to the office for completion. Please allow 5 business days for completion. The staff will notify the individual when the form has been completed and is ready for pickup. If you would like the paperwork faxed or mailed to another facility/person, you will also need to complete a medical record release form with our office. Please ask the receptionist for the release form or download it from our website: www.brightstart-pediatrics.com.

Parent / Guardian Acknowledgement

The information I have provider to Bright Start Pediatrics is accurate and truthful. I have read and understand the policies set forth by Bright Start Pediatrics.

Patient Name	Date of Birth
Patient Name	Date of Birth
Patient Name	Date of Birth
Patient Name	Date of Birth
Patient Name	Date of Birth
Parent's / Guardian's Signature	**Date**

Effective November 1, 2014

Bright Start Pediatrics
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have questions about this notice, please contact our Privacy Contact who is Amy Beck, M.D.

Your medical information is personal. We are committed to protecting your medical information. We created a record of the care and services you received at the Practice. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the Practice whether made by your personal physician or one of the office's employees.

This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

Bright Start Pediatrics is required by law to:

1. Make sure that medical information that identifies you is kept private;
2. Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
3. Follow the terms of the Notice that is currently in effect.

How this Office May Use and Disclose Your Medical Information:

The following describes the different ways that your medical information may be used or disclosed by the Practice. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories:

For Treatment: We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, physician assistants, nurse practitioners, nurse midwives, nurses, technicians and other office personnel who are involved in providing you medical treatment.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at this practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

To Individuals Involved in Your Care or the Payment of Your Care: We may disclose medical information about you to a family member or close friend involved in your medical care. We may also give information to someone who is involved with payments or helps pay for your

care. Additionally, we may disclose information for notification purposes such as your location or general condition.

For Health Care Operations: We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run our office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the Practice should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, physician assistants, nurse practitioners, nurse midwives, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Practice.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Worker's Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Health Oversight Activities: We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections, and licensure renewals, etc.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

Law Enforcement: We may release medical information about you if required by law when asked to do so by a law enforcement official.

Coroners and Medical Examiners: We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Other Uses of Medical Information:

Most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI require your written authorization. Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. In the event of a breach of your unsecured PHI, you have the right to be notified of the breach. This notification will be sent via first class mail.

Your Rights Regarding Your Medical Information:

You have the following rights regarding the medical information Bright Start Pediatrics maintains about you:

Right to Inspect and Copy: You have the right to inspect and obtain an electronic or hard copy of your medical information with the exception of any psychotherapy notes.

To inspect and obtain a copy of your medical information, you must submit your request in writing to Amy Beck, M.D. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain copies of your medical information in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. For information regarding such a review, contact Dr. Amy Beck.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice.

To request an amendment, your request must be made in writing and submitted to Amy Beck, M.D. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a. Was not created by us;
b. Is not part of the medical information kept by this office;
c. Is not part of the information which you would be permitted to inspect and copy; or
d. Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of non-routine disclosures." This is a list of the disclosures this office has made of your medical information.

To request this accounting of disclosures, you must submit your request in writing to Amy Beck M.D. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure we make of your medical information.

We are not required to agree to unreasonable requests for a restriction. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

The practice will honor any request for restrictions of disclosures to a health plan for payment or health care operation purposes, if the PHI relates solely to a health care item or service for which you have paid for in full.

To request restrictions, you must make your request in writing to Amy Beck M.D.

Right to Request Confidential Communications: You have the right to request that we communicate with you only in a certain manner. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Amy Beck M.D. We will accommodate all reasonable requests.

Right to a Copy of This Notice: You have the right to a paper or electronic copy of this Notice. If you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

To obtain a paper copy of this Notice, contact Amy Beck M.D.

Revisions to This Notice:

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of any revised Notice at the Practice. *Any revised Notice will contain the effective date on the first page of the notice in the upper right-hand corner.* In addition, each time you visit the Practice we will offer you a copy of the current Notice in effect.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Amy Beck, M.D. at (269) 818-0070. All complaints must be submitted in writing. Our privacy officer will review all patient complaints and, if appropriate, conduct an investigation to develop the necessary information regarding the complaint. The results of the privacy officer's determination will be communicated to the patient in writing within (15) fifteen days of receiving the written complaint. If any measures will be taken by the Practice to mitigate any improper uses or disclosures of protected health information, this will also be communicated in the above written communication to the patient.

THIS OFFICE WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

Bright Start Pediatrics - The Patient/Family/Provider Relationship

Healthcare visits for children, adolescents and their families are often more than simply updating immunizations, having ears or eyes examined or treating the physical complaints of a recent illness. Each visit is an opportunity for parents, their children and ALL of the providers of this office (doctors, nurse practitioner, nurses, office staff) to work together to assure that the patient receives quality healthcare and that we are offering support and guidance to the family for raising a happy, healthy, well-balanced child. This enhanced aspect of the provider-patient relationship is called "family-centered" care as we are trying to provide a "patient-centered-medical-home" for you and your child. As with any healthy relationship, there are suggested guidelines for both partners. The key to a successful partnership is as follows:

We trust you and your children to:

Provide us with all information you have regarding your child's health and illnesses

Work together in the best interest of the child

Share with us your needs and concerns as your child grows

Keep scheduled visits – maintain routine yearly visits (more often birth-3yr)

Call your doctor BEFORE seeking after-hours care (unless truly a medical EMERGENCY)

Administer all medicine as prescribed and follow the advice of the provider

Learn about your insurance so you know what is a covered benefit and your co-pay amounts

Pay your share of the visit fee (co-pays) when your child is seen in the office

Respect us as individuals with skills and expertise in helping your child grow & learn

As we provide a "Medical Home" for your child's care, our goal is to:

Support the family as the "constant" in the child's life, knowing all families are DIFFERENT

Explain diseases, treatment and test results in an easy-to-understand way

Respect your privacy – your family's information will not be shared unless you give us permission

Have a doctor/provider on-call 24 hours/day, 7 days/week

Work together as partners to make health care decisions

Refer patients to trusted experts when necessary or requested

Provide a dedicated "care team" to service your child's needs in an efficient & FRIENDLY manner

Assess and accurately document the development (physical & psychological) of your child

Respect you and your child as partners in helping your child grow, learn and succeed!

Amy Beck, MD --- Dawn Rosser, MD --- Kathy Carlson, NP