926 13th Ave S, ♥ Great Falls, MT 59405
Phone (406) 770-3000 ♥ Fax (406) 770-3146
Hours: Monday-Thursday 8am-5pm

Newborn Letter

If you are the parent of a newborn, **congratulations** on this wonderful blessing for your family. If you are new to the practice or an existing patient of ours with an older child or children, again we hope to live up to your expectations as their primary care at Premier Care Pediatrics. We understand that you have a lot going on with the new addition to your family and we wanted to help you check one thing off your list.

To have your hospital and doctor's claims processed properly, you will need to notify your insurance of the baby's arrival as soon as possible. They allow a specific amount of time during which you will be able to add the baby to your policy, otherwise you may have to wait for the open enrollment. It is crucial for the baby's coverage to start from the baby's date of birth; make sure that the insurance policy is backdated to that day. Most insurance companies will require baby's social security number and the birth certificate. Please make sure that you have those documents available to prevent any issues with adding the baby to your insurance coverage.

Please understand that it is recommended to have your baby added to your plan by the time of their two (2) month checkup. If your child is not covered by their two-month checkup and we cannot verify that their coverage is active, you may have to pay out of pocket for that visit on the day of the appointment. In addition, you would be responsible for any previous balances accrued on the account.

New patient paperwork and parent/provider agreement may be printed below and brought in at the first appointment. We hope that this is a smooth transition for you and your baby, and we are looking forward to seeing you for years to come.

Best Regards,

Dr. Michael Garver and the staff at Premier Care Pediatrics

NEW PATIENT REGISTRATION
(PLEASE PRINT CLEARLY)

*TODAY'S DATE*____________________ How did you hear of us?____________________________

Patient

Patient's First Name _______________________ M.I.______ Last Name ______________________________

Date of Birth _________________________ Gender ☐ MALE ☐ FEMALE

Address: ____

City _______________________________________ State _____________________ Zip________________

Home Phone ____________________________ Alternative/Message Phone ____________________________

RACE (please circle): American Indian/Alaskan Native Asian African American/Black Caucasian/White
Native Hawaiian/Pacific Islander Other (Multi-racial) Unknown Declined

ETHNICITY (please circle): Hispanic/Latino Not Hispanic/Latino Other ___________________

Preferred Language __________________________ **Preferred Pharmacy** _____________________________

Who does the child reside with? ☐ Father ☐ Mother ☐ Both ☐ Other _________ ______________________

Who has legal custody of the child? ☐ Father ☐ Mother ☐ Both ☐ Other ____________________________

Who is responsible for the medical bills? ☐ Father ☐ Mother ☐ Both ☐ Other _________________________

Health Insurance

******PLEASE PRESENT INSURANCE CARD(S)******

PRIMARY INSURANCE ____

ID#____GROUP #_____________________________

Policy Holder's Name____ Date of Birth_____________________

Policy Holder's Address (if different from patient) ____

City _______________________________________ State _____________________ Zip________________

SECONDARY INSURANCE ____

ID#____GROUP #_____________________________

Policy Holder's Name ______________________________________Date of Birth ____________________

Policy Holder's Address (if different from patient) ____

City _______________________________________ State _____________________ Zip________________

1st Parent/Guardian

First Name _______________ M.I. _____ Last Name ____________________Maiden Name ________________

Social Security Number ______________________________________ Date of Birth _______________________

Address (if different from patient) ____

City _________________________ State ________ Zip _________ Relationship to patient ___________________

Home Phone ___________________________________ Cell Phone ______________________________________

Email ____ Marital Status ________________________________

Employer ____ Work Phone ______________________________

Employer Address ________________________________City __________________ State _______ Zip _______

2nd Parent/Guardian

First Name _____________ M.I. _______ Last Name ___________________ Maiden Name___________________

Social Security Number _______________________________________ Date of Birth ________________________

Address (if different from patient) ____

City _________________________ State __________ Zip ________ Relationship to patient ___________________

Home Phone ___________________________________ Cell Phone ______________________________________

Email ____ Marital Status _______________________________

Employer ____ Work Phone ____________________________

Employer Address ________________________________City _____________________ State _______ Zip ______

Contact (not living with you)

First Name ____________________________ M.I. _______ Last Name ___________________________________

Address ____City ______________________State _______ Zip ______

Phone Number ____ Relationship to patient ______________________

Parental Medical Release

The following named person(s) shall be authorized to bring my child to medical appointments **in my absence**. I agree to pay for all services provided to my child in my absence. Please mark box if you authorize them to receive HIPAA protected information.

Full Name/Relationship to patient: ______________________________________ Phone __________________ ☐

Full Name/Relationship to patient: ______________________________________ Phone __________________ ☐

Full Name/Relationship to patient: ______________________________________ Phone __________________ ☐

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PARENT(GUARANTOR)/PROVIDER AGREEMENT

*Please read the following items **carefully** and **thoroughly**. It is your responsibility to know the details of your insurance policy.*

FINANCIAL AGREEMENT*

- ✓ **INSURANCE CARDS MUST BE PRESENT AT EVERY APPOINTMENT.**
- ✓ Insurance eligibility will be verified prior to the appointment. ***IF INSURANCE IS FOUND TO BE INACTIVE***, verification from your insurance carrier or case worker will be required. If you are unable to obtain this, you will be considered SELF PAY and will be required to pay at time of service, or you may reschedule your appointment.
- ✓ **COPAYS** are due at the time of service prior to your child being seen by the physician.
- ✓ Payment in **FULL** is due when you receive your billing statement. If you are unable to pay your balance in full, please contact our patient account specialist (located in our office).
- ✓ **PENDING STATUS**. Newborns whose insurance is in a pending status will have 60 days before status will be changed over to SELF PAY. After this time, verification of coverage will be required or payment at the time of service will be expected. Should the insurance become active and retroactive payments are received, a refund will be issued.
- ✓ **NO INSURANCE.** We offer a 15% discount for *payment in full at the time of services.*
- ✓ Balances that remain unpaid at 120 days may be referred to a collection agency. I understand that in the event any unpaid balance is placed for collections within any third-party collection agency a fee of **50%** of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and other fees stated elsewhere. The authorized fee of **50%** and the additional costs and charges listed above represent the actual costs incurred by Premier Care Pediatrics to collect amounts owed under this agreement and corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.
- ✓ Refunds**:** If a refund is due and there are no outstanding balances, we will attempt to provide you a refund within 30 days.

POLICIES

- ✓ **LATE ARRIVALS, MISSED APPOINTMENTS, OR LATE CANCELLATIONS:** If you are more than **15 minutes late** for your appointment, you will be required to reschedule. Reminder phone calls are a **courtesy** only. It is your responsibility to keep track of your appointment times. If you are unable to keep your child's appointment, please be respectful and call to cancel or reschedule so that another patient may have the opportunity to utilize that opening.
- ✓ **MINOR CHILDREN:** All children under 18 must be accompanied by an authorized adult/guarantor listed in the patient's account. Exceptions with written documentation from parent/guardian assuming responsibility prior to appointment may be allowed. A parent/guardian must be present for Behavioral Health appointments and medication follow ups.
- ✓ **PRESCRIPTIONS/MEDICATIONS:** Antibiotics **will not** be called to a pharmacy without having seen your child. **Allow 48 hours** for us to complete prescription refill requests. Refills **cannot be filled earlier than 3 days from the previous month's refill**. We **require** regular visits every six (6) months for re-evaluation of chronic or recurrent conditions, including but not limited to asthma and ADHD.
- ✓ **MEDICAL RECORDS:** Requests for medical records and/or immunizations requires a **minimum of 3 business days to process**. If medical records are not being faxed to another provider for a referral, we will need a Release of Information (ROI) signed.
- ✓ **IMMUNIZATIONS:** We firmly believe that vaccinating is a key element to your child's health in the prevention of serious life-threatening illnesses to them and to others in the community. We follow the recommendations of the American Academy of Pediatrics (AAP), the Advisory Committee on Immunization Practices (ACIP), and the vaccine schedule published by the CDC. Vaccine Information Sheets are available in the office. Any family choosing not to vaccinate will be asked to find a new provider.
- ✓ **BEHAVIOR:** You, your family members, your friends, and any other accompanying persons are required to treat all staff at Premier Care Pediatrics with the utmost respect. **Disrespectful behavior, whether on the phone or in person, will NOT be tolerated. Posting of demeaning, disparaging, or malicious comments on social media will not be tolerated. These are considered serious offenses and will result in prompt discharge of your child/children from the practice.**
- ✓ **DISCHARGE FROM PRACTICE:** Failure to pay your bill or follow payment plan, failure to comply with provider's recommended treatment plan, 2 or more No Shows (per family), no showing for your initial visit, **disrespectful behavior**, and **posting of demeaning, disparaging, or malicious social media comments** are grounds for discharge from our practice. You will be notified by certified mail and will need to obtain a new provider for medical care. The provider, as per legal obligation, will ONLY treat on an emergency basis for 30 days. You will still be responsible for any balance owing on your account.
- ✓ **POLICY CHANGES:** This policy is effective *September 15, 2020* and may be revised as needed.

I verify that I have read and understand all Premier Care Pediatrics current policies and agree to abide by them.

PARENT/GUARANTOR'S SIGNATURE:____ DATE:___________________________

PARENT/GUARANTOR'S PRINTED NAME:____

**Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.*

Disclosures and Consents

ASSIGNMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Premier Care Pediatrics for services rendered to my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that my insurance carrier has determined should be payable to Premier Care Pediatrics.

MEDICAID/TRICARE INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's records that these programs may request. I hereby direct that payment of my dependent's authorized benefits be made directly to Premier Care Pediatrics on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:
I certify that I have received and read a copy Premier Care Pediatrics' Notice of Privacy Practices. I hereby authorize Premier Care Pediatrics to release any of my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO RELEASE IMMUNIZATION INFORMATION:
I authorize Premier Care Pediatrics and a public health agency to collect and enter my child's immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS). The IIS is a confidential computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care provider to assist in my child's medical care and treatment. In addition, information may be released to child care facilities and schools
in which my child is enrolled to comply with the state immunization requirements. I understand that I have the right to rescind this authorization at time by notifying Premier Care Pediatrics to that effect in writing.

AUTHORIZATION TO MAIL, CALL, TEXT, OR E-MAIL:
I certify that I understand the privacy risks of the mail, phone calls, texts, and e-mails. I hereby authorize Premier Care Pediatrics Representative or my physician to mail, call, text, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, billing notifications, referral arrangements, laboratory results, and surveys. I understand that I have the right to rescind this authorization at any time by notifying Premier Care Pediatrics to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services from another facility.
I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my physician or his or her designee at Premier Care Pediatrics.

PARENT/GUARANTOR'S SIGNATURE ____ **DATE:** _________________

PREMIER CARE PEDIATRICS

NOTICE OF PRIVACY PRACTICES

AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INUSRANCE PORTABLILITY AND ACCOUNTABLITY ACT OF 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in you IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

PREMIER CARE PEDIATRICS
926 13th Ave S
GREAT FALLS, MT 59405
(406)770-3000

C. WE MAY USE AND DISCLOSE YOUR IIHI IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI.

1. TREATMENT. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses- may use or disclose your IIHI in order to treat you of or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. PAYMENT. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entitles to assist in their billing and collection efforts.
3. HEALTH CARE OPERATIONS. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may us you IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entitles to assist in their health care operations.
4. APPOINTMENT REMINDERS. Our practice may use and disclose your IIHI to contact you and remind or reschedule your appointment.
5. TREATMENT OPTIONS. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. HEALTH RELATED BENEFITS AND SERVICES. Our practice may use and disclose your IIHI to inform you of health related benefits or services that may be of interest to you.
7. RELEASE OF INFORMATION TO FAMILY/FRIENDS. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assist in taking care of you. For example, a parent or guardian may ask a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to the child's medical information.
8. DISCLOSURE REQUIRED BY LAW. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES;

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. PUBLIC HEALTH RISKS. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. HEALTH OVERSIGHT ACTIVITIES. Our practice may disclose your IIHI to health oversight agency for activates authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil right laws and the health care system in general.
3. LAWSUITS AND SIMILAR PROCEEDINGS. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. LAW ENFORCEMENT. We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death, we believe has resulted from criminal conduct
   - Regarding criminal conduct at our office.
   - In response to a warrant, summons, court order, subpoena, or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. DECEASED PATIENTS. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may release information in order for funeral directors to perform their job.
6. ORGAN AND TISSUE DONATION. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. SERIOUS THREATS TO HEALTH OF SAFETY. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
8. MILITARY. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. NATIONAL SECURITY. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
10. INMATES. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
11. WORKERS COMPENSATION. Our practice may release your IIHI for worker's compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. CONFIDENTIAL COMMUNICATIONS. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. In order to request a type of confidential communication, you must make a written request to Premier Care Pediatrics (406)770-3000 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. REQUESTING RESTRICTIONS. You have the right to request a restriction in our use or disclosure of you IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care of the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Premier Care Pediatrics (406)770-3000. Your request must describe in a clear and concise fashion:
   (a) the information you wish restricted;
   (b) whether you are requesting to limit our practice's use, disclosure or both; and
   (c) to whom you want the limits to apply
3. INSPECTION AND COPIES. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about yourself, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Premier Care Pediatrics, in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and /or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. AMENDMENT. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request and amendment, your request must be made in writing and submit to Premier Care Pediatrics (406) 770-3000. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. ACCOUNTING OF DISCLOSURES. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment, or non-operation purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse: or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Premier Care Pediatrics. All requests for an " accounting of disclosures" must state a time period, which may not be longer than (6) years from the date of disclosure and may not include dates before April 1, 2007. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. RIGHT TO A PAPER COPY OF THIS NOTICE. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this notice contact Premier Care Pediatrics.
7. RIGHT TO FILE A COMPLAINT. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of Department of Health and Human Services. To file a complaint with our practice, contact Premier Care Pediatrics (406) 770-3000. All complaints must be submitted in writing. **YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT**
8. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES. Our practice will obtain your written authorization for uses and disclosure that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact Premier Care Pediatrics (406)770-3000

Thank You

Thank you for choosing Premier Care Pediatrics for your child's health care. Our practice and philosophy is centered on providing your family with the most comprehensive and personalized care available. With compassionate caregivers that are sensitive to your needs, we are moving into the future to create a practice unique to this area. Our staff has dedicated their energy to ensure that families have a positive experience and leave feeling that "Your family comes first." Our success is derived from a child and family friendly environment and a creative staff that enjoys working well together. Our provider, Dr. Garver, along with our staff truly care about the well-being of each of our patients and strive to provide the highest level of medical care possible. Our concept and philosophy are not new ones. This office belongs to each and every one of you and we value your child a patient. Your comments and input are greatly appreciated. Again, thank you for choosing us to meet your child's health care needs.

Sincerely,

Michael Garver, MD, FAAP

Premier Care Pediatric Staff