New Patient Packet Babies < 1 year

Welcome to Oberlin Pediatrics. We look forward to caring for your child and welcoming you into the Oberlin family.

Complete the following pages ***at least one week*** prior to your appointment and submit it in person, by mail or upload through the portal.

- Child's past Medical history, Family history and Social history information
- Submit a copy of child's Immunization Records
- Family Demographic Form
- Insurance Questionnaire
- Notice of Privacy Practices (HIPAA)
- Vaccine Policy
- Financial Policy
- Family Behavior Policy

If transferring from another practice

Name of previous Pediatric practice:
Reason for transfer: ____

Authorization to Use/Release/Disclose Health Information

I authorize the transfer of copies of all Medical Records from previous Pediatric Practice (or other medical facilities) to Oberlin Road Pediatrics. I hereby authorize the use, release and/or disclosure of my health information as described below. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy regulations.

Patient Name: ______________________ Date of Birth: _________________

Organizations/Persons Providing the Information:
Name:____
Address:____
____
Phone:___________________ Fax:________________

Transferring to:
Oberlin Road Pediatrics
1321-A Oberlin Road
Raleigh, NC 27608
Ph: 919-828-4747
F: 919-828-7563

SIGNATURE: _________________________________ DATE:_______________
Printed name:_________________________________

Medical History for Babies < 1 year old

Patient's Name: ____________________ Date of Birth: _________________
Race: ______________________ Ethnicity: ___________________
Gender: ____________________

Pregnancy/Neonatal Period

Is the child yours by ❒ birth ❒ adoption ❒ surrogacy ❒stepchild ❒ other______________

If adopted: At what age? __ From what country? ______________________

Prenatal History (for the birth mother)

Did you have any complications with the pregnancy? ❒ NO ❒ YES___________________________
Was conception or sustaining pregnancies a problem? ❒ NO ❒YES
Did you have any infections or illnesses during pregnancy? ❒ NO ❒ YES___________________________
Did you have any abnormal prenatal labs or ultrasounds? ❒ NO ❒ YES___________________________
Were you taking any prescription medicines? ❒ YES__________________________ ❒NO
Were there prenatal exposures to: ❒ Tobacco/Nicotine ❒ Alcohol ❒ other________________
What vaccines did you receive during pregnancy: ❒ Flu ❒ DTaP ❒ RSV

Newborn/Infant Medical History

Was the child premature? ❒No (37+ weeks) ❒ Yes, born at ________weeks
Birth weight: ________________
Did the baby go home on the same day as the mom? ❒ YES ❒NO
Any problems in the newborn period: ❒ NO ❒ YES___________________________
Hearing screen in the hospital: ❒ Normal ❒ Needs further screening

Has your child ever been treated for or diagnosed with:

- ❒ Chronic poor feeding/growth concerns
- ❒ Eczema or chronic skin problems
- ❒ Recurrent wheezing
- ❒ Food allergy or intolerance
- ❒ Recurrent ear infections
- ❒ Cardiac concerns
- ❒ Pneumonia
- ❒ Urinary tract infection/Kidney problems
- ❒ Movement or developmental delays
- ❒ Other Chronic/recurrent medical conditions:____
____

Hospitalized overnight in the hospital, other than at birth? _____________________________
Previous surgeries and dates: ____
Previous Pediatrician, and date (or age) of last check up: ____
Please list any specialist(s) your child is currently seeing and reason:

____

Medications

ALLERGIES to Medicines/ vaccines (list and describe reaction):

____

Current routine prescription medications and dose:

____

Routine over-the-counter medications:

____

Routine vitamins or supplements:

____

Family History

Do either of the child's parents or siblings (brothers or sisters) have:

Condition	**Father**	**Mother**	**Siblings**	**Comment:**
Asthma/Wheezing	❒	❒	❒	______________________
Food Allergies	❒	❒	❒	______________________
Environmental Allergies	❒	❒	❒	______________________
Eczema	❒	❒	❒	______________________
Blood Disorders	❒	❒	❒	______________________
Cancer	❒	❒	❒	______________________
Hearing Loss/deafness	❒	❒	❒	______________________
Heart Attack/Disease	❒	❒	❒	______________________
High Cholesterol	❒	❒	❒	______________________
High Blood Pressure	❒	❒	❒	______________________
Stroke at age <55	❒	❒	❒	______________________
Diabetes (type 1 or 2)	❒	❒	❒	______________________
Endocrine Disease	❒	❒	❒	______________________
Autoimmune Disorder	❒	❒	❒	______________________
Celiac	❒	❒	❒	______________________
Migraines	❒	❒	❒	______________________
Depression/Anxiety	❒	❒	❒	______________________
Alcohol or Drug Abuse	❒	❒	❒	______________________
ADHD/ADD	❒	❒	❒	______________________
Learning difficulties/Dyslexia	❒	❒	❒	______________________

Other genetically transmitted conditions that are important to know:

____

Social History:

Who lives in the child's home? ❒Mom (s) ❒Dad (s) ❒Stepparent ❒Siblings (#____) ❒ Grandparent(s) ❒Other____________

Does your child live in multiple households? ❒Yes ❒No

Daytime care: ❒ At home ❒Preschool/daycare ❒Other_______________

Smoke Exposure at home ❒None ❒Tobacco or Vape

Home water source: ❒City Water ❒Well Water ❒Other?______________

Language(s) spoken at home ❒English ❒Spanish ❒ ___________________

Any special cultural or religious practices that are important for us to know about? ___________________________

FAMILY CONTACT INFORMATION

PARENTS' INFORMATION:

Full Name:_________________________________ Employer Name:_________________________________
DOB:_________________________________ Occupation:_________________________________
Address:_________________________________
Cell Phone:_________________________________ Home Phone: :_________________________________
Email address: _______________________________ Gender M/F ____

Full Name:_________________________________ Employer Name:_________________________________
DOB:_________________________________ Occupation:_________________________________
Address: ❒Same as above ❒___________________________________
Cell Phone:_________________________________ Home Phone: :_________________________________
Email address: _______________________________ Gender M/F ____

Other siblings that are (or will be) Oberlin patients:

_______________________________ _________________________________
Name: DOB: Name: DOB:

_______________________________ _________________________________
Name: DOB: Name: DOB:

I authorize my child's physician, nurse, or other Oberlin Pediatrics employee to leave messages pertaining to my child/children at the phone numbers I have listed above.

In the absence of the parent/legal guardian, I give the following person(s) permission to seek treatment, obtain any prescriptions or other medical forms, for my child from Oberlin Pediatrics. I also realize that the person listed on this form or the person with my child may have access to pertinent protected health information if medically necessary. This authorization will be valid until otherwise rescinded.

Name:____________________________ Phone #: __________________ Relationship:______________________
Name:____________________________ Phone #: __________________ Relationship:______________________

Insurance Coverage: In the first 30 days of life: ❒Father ❒Mother ❒Other ❒N/A
After first 30 days: ❒Father ❒Mother ❒Other

Custody and Medical Decision Making: If there is any situation OTHER than BOTH parents have custody and medical decision making, please provide us a copy of your legal arrangements.

SIGNATURE: _________________________________ DATE:_______________
Printed name:_________________________________

INSURANCE FORM

Primary Insurance Company Name: ____

Effective Date of Insurance: _____/________/_________

Name of Policy Holder: ____ DOB:_____________________________

CHILDREN COVERED ON THIS POLICY:

___________________________	___________________________	______________________________
Name: DOB:	Name: DOB:	Name: DOB:
___________________________	___________________________	______________________________
Name: DOB:	Name: DOB:	Name: DOB:

Previous Insurance Company Name: ____

Termination Date of this Insurance: ____

Signature: ____

Today's Date ______/________/________

Do you have **Secondary Insurance** Yes ☐ No ☐

If **YES** please complete:

Name of Secondary Insurance: ____

Effective Date: ________/__________/__________

Secondary Insurance Policy Holder's Name: ________________________________DOB ______________________

If you have changes in your insurance, it is important that you update this information with us as soon as possible. Thank you.

NOTICE of PRIVACY PRACTICES(HIPAA)

I have received a copy of the HIPAA rules and regulations to review for my knowledge and use. I have the right to request a copy for my own use.

Patient Name: ____ **Date:** _____________

Signature: ____

If signature is not that of the Patient, indicate the relationship of person signing for the Patient (e.g. Parent, Family Member, Guardian, Close Relative or Guarantor):

____

If Patient or Patient's personal representative does not sign, indicate the reasons why signature could not be obtained.

____

____

Name of Practice staff Member: ____
Date: _________________________

Vaccine Policy

The physicians and staff of Oberlin Road Pediatrics fully support the efficacy and safety of vaccines. We follow the American Academy of Pediatrics (AAP) standardized schedule for implementation of vaccines, and the North Carolina State Law as the MINIMUM requirement for vaccine administration for our patients. Oberlin Road Pediatrics expects our patients to be immunized on time, starting with the Hepatitis B vaccine in the neonatal period.

If you are transferring your child into our practice from another medical provider, we will review the child's immunization records. If we determine that your child is significantly behind on shots, you will be asked to schedule a vaccine consultation with one of our physicians before we will see your child as a patient. We will work with new families to comply with vaccine recommendations and get back on track. However, if a requested vaccine consultation does not occur or if you are not willing to comply with NC vaccination laws, then Oberlin Road Pediatrics is not the right practice for your family, and we will not accept the child as a new patient.

We are happy to discuss your questions about vaccines during Well Child appointments. If there are extensive concerns or questions, parents will need to set up a separate vaccine consultation appointment. It is Important to understand that this visit may not be covered by Insurance and parents will be responsible for paying for this consultation at the time of service, which may range in cost from $100-$200 depending on the amount of time spent with the physician.

Signature of Parent/Guardian: ______________________________ Date: __________________

Vaccine Consent Form: By signing this consent, you are giving us permission at this, and future appoints to vaccinate your child, you will be offered a Vaccine Information Statement (VIS) explaining each vaccine and information about vaccines.

I, parent/guardian of _________________ have read the vaccine policy and give permission for age-
(Child's Name)
appropriate immunizations to be administered.

Signature of Parent/Guardian: _______________________________ Date: __________________

Revised 07/22/2012

Vitamin K Policy

Vitamin K is needed to help blood make healthy clots. Bleeding from not having enough vitamin K can result in profoundly serious complications, such as liver dysfunction, neonatal strokes or even death. Babies cannot absorb enough vitamin K from either oral medication or from breastmilk. An intramuscular injection of vitamin K has been the standard of care since 1961 because it is the safest way to ensure that we prevent neonatal stroke from Vitamin K deficiency.

I certify that I have followed the neonatologist's or pediatrician's recommendation, and my baby has received vitamin K in the hospital. If for any reason my baby has not already received IM vitamin K, this will be done on the day of the initial visit, which will require a return visit to the hospital. Refusal to do so signifies a significant break in the physician-patient relationship and ORP will not schedule any further appointments.

Signature of Parent/Guardian: ______________________________ Date: __________________

Financial Policy

Thank you for choosing Oberlin Road Pediatrics as your child's medical home.
Our goal is great quality care, with open communication and clarity about financial responsibility.

Initial:

___ **Insurance**: We participate with most insurance plans. Your insurance coverage and benefits are a contract between you and your insurance company.
Please provide a copy of your insurance card at each visit.

___ **Services Not Covered by Insurance:** It is your responsibility to check with your insurance company to determine covered benefits. The patient/guarantor is responsible for 100% of charges the insurance company chooses not to cover, including but not limited to co-payments, deductibles, vaccines, developmental screenings, and after-hour/weekend appointment charges.

___ **Well Child visit services**: Well Child checks are preventive care services meant to evaluate the child's growth, development, discuss preventative care, and review and administer vaccinations. If you have additional concerns that you would like to address such as fever, asthma, ear infections, initiating/changing a medication, ADHD etc., or if your child is medically complex, your insurance company may bill you a second co-pay or apply this portion of your visit to your deductible. The physicians at ORP code accurately and by the Medicaid rules that govern all insurance plans, so we may bill for both a Well visit and a Sick/Medical concern in the same visit. This cost for the additional concerns may go patient responsibility.

___ **Credit Card on File Policy:** We participate with CardPointe, a secure Payment Processing Platform such as the ones used for online retail stores. The stored credit card can be used to pay co-pays and charges at future visits. This service is secure, encrypted, and our staff does not have knowledge of your credit card number.
Circumstances when your card would be charged by ORP include but are not limited to:
- Co-pays and insurance deductibles
- Missed or canceled appointments without appropriate notice (see below)
- Any non-covered services and/or denial of services allocated to patient responsibility
- Any amount not paid by your insurance 90 days after a corrected claim has been filed

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.
If your balance due is larger than $200.00, we will provide a courtesy call and email to let you know we will be charging your card on file or determine if you need to establish a payment plan.

___ **For patients who don't have insurance or are not using insurance:** Per federal CMS rules, you have the right to request a Good Faith Estimate for the total cost of any non-emergency items and services. This includes related costs like medical tests and office fees. This is an estimate, not a bill. Please ask for a Good Faith Estimate at the time of scheduling your visit, and you will receive this in writing at least 1 business day before your appointment. For more information, go to cms.gov.
We offer a 25% discount to self-pay patients when paid in full the day of the visit.

___ **Financial Hardship**: Should you have extraordinary financial pressures; we will assist you with a payment plan. This plan will need to be IN WRITING with our billing department prior to scheduling future visits. No balance over $500.00 can be carried on a family account unless a payment plan has been signed and the arrangement is being followed. The balance should be paid off in the next 12 months.

___ **Missed Appointments**: There is a $50 no-show fee that will be charged to the credit card on file.
Cancellation policy: Speak to an ORP employee at least 24 hours in advance for Well Child Checks or Medicine/Behavioral consults or Medicine recheck visits, or at least 4 hours for office acute care visits or vaccine appointments.
After 3 missed appointments, we reserved the right to dismiss the family from the office.

___ **Form and letter fee** (daycare forms, school forms, camp, sports, allergy, individual school, or travel letters, etc.): Effective 1/1/2023, there will be a $10 fee (per child) for forms that are completed outside of a Well Child scheduled visit. The office spends about 600+ hours a year completing forms outside of the child's visit. Most are completed in a timely way, but any form that needs "RUSH" completion of < 3 business days will have a charge of $30.
Individual letters from the physician will incur a fee of $10/letter. Letters to return to activities or school excuses are free. Forms that can be completed during the scope of the visit are free.

___ **Copying medical records**: With your written consent, we will provide you with a copy of your child's medical record for a fee of $20 per child.

___ **After-hour phone nurse triage:** After 8 pm (5 pm on Fridays) and on holidays, our phones transfer to an answering service. If you need medical triage advice, the call will be transferred to the Wake Med Nurse Triage services. A registered nurse will answer, address urgent concerns, and can page the on-call MD if needed. There is a $22 charge for calls that need the Wake Med nurse triage service, and this will be billed directly to you. We will waive this free for calls regarding newborns <90 days old, or calls where the patient is instructed to go to the Emergency Room based on their severity of illness.

___ **Service charges:** Keeping a credit card on file prevents most service charges. Service charges are only accrued if there are late payments, inaccurate insurance information, or failure to pay bills.
A $15 administrative fee will be charged if the co-pay is not received within 48 hours of service.
A $35 administrative service charge will be added for:
- Re-filing of insurance due to incomplete or incorrect information given at the time of service, including if the insurance has been terminated.
- Administrative fee associated with accounts turned over to collection agencies.
- Returned checks.

Any amount not covered by the patient's insurance including applicable deductibles, additional copays, etc. will be due 30 days from the time of the service. Late payments will incur an additional $10 per month billing fee.
Accounts will be turned over to a collection agency if past due 90 days or more. Failure to pay the balance may result in discharge from the practice.
The family is responsible for all collection costs involved with the collection of your account including court costs, reasonable attorney fees, and all other expenses incurred with collection if there is a default on any unpaid balance.

Signature: ________________________________ Date: ______________________________
Printed name: ____
Name of Guarantor of child's Insurance: ____

Revised 1/1/2023

Family Behavior Policy

Patient Name: ____________________________________

This practice is a family-friendly pediatric office caring for impressionable young children and their families. Although occurrences are rare, Oberlin Road Pediatrics feels strongly that our patients, their families, AND our staff deserve to be protected from verbal abuse and aggressive behavior. We all need to respect each other and to "follow the golden rule".

For this reason, we have developed and strictly enforce a "No Tolerance Policy" for abusive conduct, "cussing", crude graphics or language on clothing, threatening or aggressive behavior, and larceny. These restrictions apply to any such actions toward patients, other family members and visitors, and Oberlin Road Pediatrics staff. Furthermore, these rules shall also apply to telephone calls and written communications to our office staff and clinicians. We expect a civil and harmonious environment for our pediatric patients, families, and staff.

Please sign below that you understand, agree to, and will abide by this policy. As a "No Tolerance Policy", there will be no further warnings, second chances, or exceptions. Violations will result in immediate transfer of care to another health care provider of your choice. Failure to sign this contract will result in discharge from the practice.

While we understand that disagreements may occasionally occur, these need to be resolved in a civil manner. Depending on the degree of infraction, we reserve the right to involve Child Protective Services, law enforcement, and other appropriate agencies should we deem necessary. We may press charges at our discretion.

Thank you for your interest in making the Oberlin Road Pediatrics office and grounds a wholesome and safe, family-friendly environment.

Signature: ____Relationship: _______________

Printed name: ____Date: ______________________