New Patient Packet

Welcome to Oberlin Pediatrics. We look forward to caring for your child and welcoming you in to the Oberlin family. We are accepting new patients that are 16 years old and younger.

Complete the following packet and submit it in person, by mail or email it to newpatientrequest@orpkids.com.

- Child's past medical history, Family history and social history information
- Submit a copy of child's Immunization Records
- Family Contact Information
- 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: _____

It is your responsibility to request your child's medical records. Please fill out a medical release of information form from your previous pediatrician's office. They can fax or mail the medical records to us directly.

Mailing address: 1321A Oberlin Road Raleigh NC 27608 **Fax number:** 919-828-6765

OBERLIN PEDIATRICS

Medical History for Child

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? _____

This section only needs to be completed if the child is 1 year old or under:

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? _____

OBERLIN PEDIATRICS

FAMILY CONTACT INFORMATION

PARENTS' INFORMATION:

Full Name:_____ Employer Name:_____
DOB:_____ Occupation:_____
Address:_____
City:_____ State:_____ Zip Code:_____
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:

How did you hear about us? ❒Website ❒Print Advertisement ❒Social Media ❒Friends/Family ❒ Internet Search

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:_____

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

SIGNATURE: _____ DATE:_____
Printed name: _____

OBERLIN PEDIATRICS

INSURANCE QUESTIONNAIRE

Primary Insurance Company Name: _____

Effective Date of Insurance: _____/_____/_____

Name of Policy Holder: _____ DOB:_____

Insurance ID Number: _____ Group Number: _____

CHILDREN COVERED ON THIS POLICY:

_____ _____

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 _____

Insurance ID Number: _____ Group Number: _____

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

OBERLIN PEDIATRICS

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:**

Revised 1/4/2017

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: _____

OBERLIN PEDIATRICS

THIS POLICY ONLY NEEDS TO BE SIGNED IF YOUR CHILD IS UNDER 1 YEAR OLD.

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: _____

Revised 07/22/2012

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 additional 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.

____ **Portal/Phone/Telemedicine Visits**: We are implementing a policy regarding charges for certain virtual visits such as patient portal messages and phone calls to ensure we can continue to provide high quality, timely care for our patients without requiring in person office visits when circumstances allow.

This would include any in-depth medical decision-making questions and concerns or take longer than 5 minutes to address such as:

- New symptoms or concerns not previously discussed
- Requests for changes to medications and treatment plans
- Inquires related to chronic conditions or follow-up care

We will bill your insurance for these visits, and you may be responsible for a copay or deductible.
Please note that most routine inquiries, such as requesting refills, will continue to be free of charge.

___ **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 Oberlin Road Pediatrics 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. Any amount not covered by the patient's insurance including applicable deductibles, additional copay, etc. will be due 30 days from the time of service.

We will send a courtesy email that your statement is ready, and we will run the card on file for the balance due three weeks after the statement is run. If you have questions about your balance or would like to use another form of payment, reach out to our office and speak to the billing department.

___ **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. New patients to our practice who consecutively miss their first appointment twice in a row will not be rescheduled and will need to seek care elsewhere.

___ **Form and letter fee** (daycare forms, school forms, camp, sports, allergy, individual school, or travel letters, etc.): There will be a $10 fee (per child, per form) for forms that are completed outside of a Well Child scheduled 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 charge 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.
- 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.

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.

Signed: _____ Date: _____

Printed name: _____

Name of Guarantor of child's Insurance: _____

Revised 4/2025

OBERLIN PEDIATRICS

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 are very aware that families under physical and emotional stress might not be on their best behavior. However, we all need to respect each other and to "follow the golden rule".

We understand that disagreements may occasionally occur, and we encourage you to discuss these matters with us in a civil manner. We encourage constructive criticism. As we only improve when we know we are doing things wrong.

However, when discussions/conversations become overheated or rude, we have a "Three Strikes you are out" policy. This behavior will be documented in the family's chart, and the parents will receive a letter with each infraction. If a third letter is sent, then the family is dismissed from our practice.

In addition, we have a "No Tolerance" policy when behavior becomes abusive, threatening, or aggressive. This behavior will be documented in the family's chart and will result in immediate dismissal.

Failure to sign this contract will result in discharge from the practice.

Depending on the degree of infraction, we reserve the right to involve Child Protective Services, law enforcement, and other appropriate agencies should we dem them necessary.

Lastly, we ask that families refrain from wearing crude graphics and language on clothing and using offensive language.

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: _____