KIDS CARE PEDIATRICS
101 Kellie Drive
Smithfield, NC 27577

Policies and Procedures

Welcome to Kids Care Pediatrics! Our mission is to provide quality, caring pediatric health care to your children from birth through age 18. Our goal is to help the children and families in our neighboring communities live healthier and happier lives. We cannot accomplish this goal alone and hope that you will work with us to ensure your child reaches his or her full potential. A large part of your role includes bringing your child in for their regularly scheduled exams and for any recommended follow ups after illnesses. Another important part of your role is to make the provider aware of any major changes in your family that may affect your child's health. Some of these changes include marital problems, divorce, job loss or another family member's illness.

We reserve the right to refuse care to any patient. The staff of Kids Care Pediatrics is trained to treat every parent and patient with respect. In turn, we request the same from you and your child. Behavior such as abusive and/or vulgar language, kicking, spitting or biting will not be tolerated. Clothing with words, terms or pictures that may be offensive are unacceptable and you will be asked to leave or not wear such clothing again on our premises. Your child's compliance is important. In the event one of our staff feels in danger from a patient or parent's behavior, the treatment plan will not continue.

Vaccines and Alternative Schedules We promote and follow the CDC and AAP Guidelines for Immunizations. ***We do not use alternative vaccine schedules***

APPOINTMENTS

Our office hours are **by appointment only**. We ask that you keep all scheduled appointments or provide 24 hours notice so that we may give another child the opportunity to be seen. You will be given 48 hours notice of your child's appointment. If you miss an appointment, a $10.00 charge may apply if 24 hours notice is not given. If you are **10 minutes** or more late, we may be unable to see you in order to stay on schedule with other patients; therefore, we ask the staff to check with us on late arrivals to make sure you can still be seen or if you will need to reschedule. Our providers make every effort to keep the office running on time. There may be times however, when they fall behind their schedule, especially during the winter when there are many children who need appointments. In the event of an emergency, we will make every effort to contact you to reschedule your child's appointment to a time convenient for you. We appreciate your patience and understanding at these times. Please call our office for same day sick appointments and one of our telephone triage nurses will return your call to schedule an appointment or give advice on how to treat your child should they not need an appointment. After our regular business hours, including holidays and weekends, WakeMed nurses provide telephone advice to our patients.

SIBLING APPOINTMENTS

We appreciate the opportunity to serve all your children. However, it is important that every patient needing medical advice or care have a scheduled appointment. Request for an additional patient appointment should be scheduled prior to your interaction with a nurse or doctor.

FORMS AND MEDICATION REFILLS

Any school, daycare, or medication forms you would like to be filled out, need to be faxed to 919-938-3795 or emailed to info@kids-care-pediatrics.com. Please have your portion of the form filled out. We require 48-hours for processing this type of paperwork. If you child needs a refill on medication other than a controlled substance, please call your pharmacy and have them send us a refill request. Any controlled substance prescriptions can be requested on line at info@kids-care-pediatrics.com. We ask you to give us 48 hours to process these requests.

I have read and understand these terms and agree to them.

Signature_____ Patient Name/Relationship_____ Date_____

KIDS CARE PEDIATRICS

PLEASE COMPLETE THE FOLLOWING INFORMATION:

PATIENT NAME_____
LAST FIRST MIDDLE
Address_____City_____State_____Zip_____

Date of Birth_____ Gender (circle) Male Female

Race:
(check one) □ American Indian/Alaskan Native □ Asian □ Black/African American
□ Native Hawaiian or other Pacific Islander □ White □ Declines to Respond
Ethnicity:
(check one) □Hispanic or Latino □ Not Hispanic or Latino □ Declines to Respond

Preferred Language:_____ **Email**_____
Parent or
Legal Guardian_____ Relationship_____

PARENTS INFORMATION
Mother's Full name: _____DOB_____

Marital Status: □Single □Married □Divorced □Separated □Widowed

Home Phone_____ Alternate Phone _____
Work/Cell
Drivers License #_____ Place of Employment_____

Address_____City_____State_____Zip_____

Father's Full Name_____DOB_____

Marital Status: □Single □Married □Divorced □Separated □Widowed

Home Phone_____ Alternate Phone _____
Work/Cell
Drivers License #_____ Place of Employment_____

EMERGENCY CONTACT (other than parent)

Name_____ Relationship to Patient_____

Home Phone _____ Phone Number(s)_____

Address: _____ City_____ State_____ Zip_____

TO ALL PARENTS OF NEWBORNS: You only have 30 days to add your newborn, do not wait for their social security number to contact your insurance company!!

Please bring your insurance card to each visit. Copays and deductibles are due at each visit.

INSURANCE INFORMATION

PRIMARY

Subscriber Name_____ Date of Birth_____

Insurance Co. Name_____ Policy No._____ Group No. _____
Please present insurance card

Tricare/Humana Sponsor SSN_____ChampVa Patient SSN_____

ASSIGNMENT AND RELEASE

By my signature below, I hereby authorize Kids Care Pediatrics to disclose my child's medical information so that the practice may seek payment from third parties for such treatment and carry on the practice's health care operations. I also authorize Kids Care Pediatrics to disclose my child's medical information to insurer's and providers outside of the practice when necessary so that these providers may treat my child, seek payment for that treatment and for the purpose of their health care operations. I also authorize Kids Care Pediatrics to disclose my child's medical information on my home answering machine or voice mail._____(INITIALS) I understand that I am responsible for all charges, regardless of insurance coverage, for this service date as well as all future service dates not covered by insurance. We will assist you in receiving reimbursement as much as possible but you are responsible for your bill. We accept MasterCard, Visa and American Express for your convenience. There will be a $25.00 service fee for any returned checks and we will accept cash only at any subsequent visits.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

Persons Authorized to Request Medical Treatment for your Child

In accordance with Privacy Rules set forth by the federal government's Health Insurance Portability and Accountability Act (HIPAA), Kids Care pediatrics may disclose your child's protected Health information only within specific guidelines. Permission for evaluation and treatment is granted whether child is presented by parent, other family member, unrelated third party or unaccompanied. Please indicate below the names and relationship to your child of individuals to whom Kids Care Pediatrics may discuss your child's medical information. If anyone other than the parent/guardian/representative of those individuals listed below brings the child in for care, HIPAA, by law, allows us to assume that this individual is authorized to receive health information about your child and we will release only the minimum amount of information needed to enable that individual to appropriately care for the child and to relay the information to the parent

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

ASSIGNMENT AND RELEASE

I agree to be responsible for all charges incurred in connection with medical care provided to my child.

Signature_____ Date_____

Printed Name_____ Relationship to Child_____

MEDICAL RECORDS REQUEST

KIDS CARE PEDIATRICS

101 Kellie Drive Smithfield, NC 27577
Phone 919-938-3749 Fax 919-938-3795
info@kids-care-pediatrics.com

Release From:

_____

_____

_____

Phone_____ Fax_____

Release to:

_____

_____

_____

Phone_____Fax_____

Patient **Date of Birth** **Phone Number**

_____

ADDRESS_____ _____

Purpose of Disclosure:
_____Transferring to another provider _____Physician/Staff Request
_____Patient/Parent Request _____ Moving/address:_____
Other_____

Fax shot record to 919-938-3795 as soon as possible. Please mail/release medical records for treatment of the above named individual.

_____
SIGNATURE OF LEGAL REPRESENTATIVE AND RELATIONSHIP TO PATIENT DATE

_____
SIGNATURE OF WITNESS

_____ Copy of Complete Medical Records From Date_____ to Date_____ _____
Copy of Last 2 years including last physical

MY SIGNATURE ABOVE INDICATES THAT I UNDERSTAND WHAT INFORMATION WILL BE RELEASED AND THE NEED FOR THE INFORMATION. I FURTHER UNDERSTAND THE INFORMATION BEING RELEASED MAY INCLUDE INFORMATION REGARDING DRUG AND ALCOHOL ABUSE, AIDS/HIV, STD OR TB. IN ADDITION INFORMATION RELATED TO DRUG AND ALCOHOL ABUSE IN MY RECORDS IS PROTECTED UNDER FEDERAL REGULATIONS AND CANNONT BE RELEASED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED IN THE 42 CODE OF FEDERAL REGULATIONS PART 2. THIS CONSENT WILL EXPIRE_____ (SPECIFIC DATE OR CONDITION) NOT MORE THAN 365 DAYS FROM THE DATE OF SIGNATURE. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, VERBALLY OR IN WRITING AT ANY TIME BUT THAT IT WILL REMAIN VALID TO THE EXTEND RELEASE BASED ON THIS CONSENT HAS ALREADY OCCURED. THE INFORMATION CONTAINED HEREIN IS PROTECTED HEALTH INFORMATION OR IS OTHERWISE PRIVILIGED AND IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR COMPANY LISTED. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT OR THE EMPLOYEE OR AGENT RESPONSIBLE TO DELIVER IT TO THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPY OF THIS COMMUNICATION IS STRICTLYPROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFYUS IMMEDIATELY AT **919-938-3749.**OFFICE USE ONLY:
DATE MAILED/FAXED_____ Initial_____

Consent to the Use and Disclosure of Health Information for Treatment Payment of Healthcare Operations.

I understand that as part of my healthcare, Kids Care Pediatrics originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- **A basis for planning my care and treatment**
- **A means of communication among the many health professionals who contribute to my care**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third party payer can verify that services billed were actually provided**
- **And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.**

I have been provided with a *Notice of Information Practices* that provides a complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and I will be informed of any changes upon my next visit. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information.**

_____ **Childs Name**

_____ _____

Signature of Patient, Parent or Legal Representative **Date**

_____

Relationship to Patient

_____

_____ _____ _____

KIDS CARE PEDIATRICS **Title** **Date**

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VACCINE POLICY

We at Kids Care Pediatrics are dedicated to providing the best care that we can for our patients. We feel to do this effectively we must enter into a partnership based on mutual trust with the parents or guardians of our patients so that together we can achieve this goal. Recently, there has been a trend of unjustified fear of side effects from vaccines by well-meaning parents. We believe that immunizations are one of the most important health interventions a parent can do on behalf of their children, and we want all of our patients to benefit from this modern lifesaving tool. While we recognize and respect the parents' role as the ultimate decision maker for their child's healthcare, we believe strongly that we are obligated to deliver the best and safest healthcare possible for our patients and our community. We feel professionally uncomfortable caring for children who will not receive a minimal set of vaccinations. These preventable diseases can and do cause severe illness, brain damage and death. Although we strongly support all recommended vaccines, there are four series that we must insist that our patients receive in a timely manner to remain a patient in our practice.

North Carolina requires: Diptheria, Tetanus and Acellular Pertussis (DTaP); Hemophilus Influenza Type B (Hib); Measles, Mumps and Rubella (MMR); Pneumoccocal Conjugate Vaccine (Prevnar); IPV; Varicella; Meningoccal (Meningitis); Hepatitis B and Tdap. While we believe that vaccines are very safe, and clearly safer than not having vaccines, we recognize that there are risks associated with all interventions and therapies.

We hope that you take the time to read quality papers and internet sites about the benefits of vaccines. The best internet site for vaccine education can be found at www.vaccine.chop.edu, which is hosted by one of the finest children's hospitals in the country, The Children's Hospital of Philadelphia. The federal government also maintains an informative site at the CDC web site: www.cdc.gov/vaccines, the North Carolina site is Immunizenc.gov.

We hope that you will review the accurate information about immunizations here as well as on respected internet sites and consider allowing your child(ren) to receive this important protection. These and all other childhood vaccines are available through our office. As a group practice, we feel we must implement a consistent policy in regard to Parental Refusal of Immunizations. Refusal of these vaccinations indicates a significant difference of philosophy of care and it would be best that we terminate our doctor-patient relationship. It is our hope that no patient is discharged from our practice due to vaccine refusal.

If you cannot meet us halfway and obtain at least the required vaccine series, we will with great reluctance send a letter to you discharging your child(ren) from our care. If your child requires medical care within the following 30 days we will provide that care. After that period our obligation ends. When you have chosen another pediatrician, we will then forward your medical records to this new provider.

Some of us are old enough to have practiced pediatrics without Hib, Prevnar and the newer DTaP. In those days many of our journals were filled with articles describing which antibiotics work best for meningitis and whether or not we could use steroids to preserve hearing in the patients who survived. We became good at managing patients with acute meningitis as well as the complications that followed meningitis – seizures and CSF shunts. These articles and patients are quite rare now because meningitis is rare. We do not want to practice pediatrics like that again!

Unfortunately, there seems to be an increasing frequency of parents refusing all vaccinations nationally. This places children in unnecessary and potentially severe risk, and we feel obligated to do everything we can to reduce the number of children needlessly exposed. It is to this group that this letter speaks. It is our hope that the majority of families with ill-founded fears of vaccines will reconsider and obtain for their children all recommended vaccines. If not, and you are unwilling to obtain at least the minimal vaccinations we require to remain a patient with us, we ask that you find another doctor's office to care for your children. If you would like to stay with us, please schedule a visit in the next week to begin the vaccination series.

_____ _____

Parent/Guardian Date