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. We are committed to treating every parent and patient with the utmost respect. 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 we hope you will work with us to ensure your child reaches his or her full potential. Part of your role includes bringing your child in for regularly scheduled exams and any recommended follow-ups after illnesses. Another essential part of your role is to make the provider aware of any significant 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. In turn, we request the same respect 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 is unacceptable, and you will be asked to leave or not wear such clothing again on our premises. Your child's compliance is essential. If one of our staff members feels in danger from a patient's 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 allow another child 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 later, we may be unable to see you stay on schedule with other patients; therefore, we ask the staff to check with us on late arrivals to ensure you can still be seen or if you need to reschedule. Our providers make every effort to keep the office running on time. There may be times when they fall behind schedule, especially during the winter when many children need appointments. In 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. WakeMed nurses provide telephone advice to our patients after regular business hours, including holidays and weekends.

SIBLING APPOINTMENTS

We appreciate the opportunity to serve all your children. However, every patient needing medical advice or care must have a scheduled appointment. Requests for additional patient appointments should be made before your interaction with a nurse or doctor.

FORMS AND MEDICATION REFILLS Any school, daycare, or medication forms you would like to be filled out must 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 to process this type of paperwork. If your 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 online at **info@kids-care-pediatrics.com.** Please give us 48 hours to process these requests. I have read and understand these terms and agree to them.

Signature_____Patient Name/Relationship_____Date_____

PAITENT INTAKE FORM
KIDS CARE PEDIATRICS
101 Kellie Drive, Smithfield, NC 27577
Phone 919-938-3749
Fax 919-938-3795
info@kids-care-pediatrics.com

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_____
Address_____City_____State_____Zip_____

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 your insurance card

Tricare/Humana Sponsor SSN_____ChampVa Patient SSN_____

ASSIGNMENT AND RELEASE

By my signature below, I authorize Kids Care Pediatrics to disclose my child's medical information so that the practice may seek third-party payment for such treatment and carry on the practice's healthcare operations. I also authorize Kids Care Pediatrics to disclose my child's medical information to insurers and providers outside of the practice when necessary so that these providers may treat my child and seek payment for that treatment and for the purpose of their healthcare operations. I also authorize Kids Care Pediatrics to disclose my child's medical information on my home answering machine or voicemail._____**(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 returned checks, and we will accept cash only at 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 the child is presented by a 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. We will release only the minimum amount of information needed to enable that individual to care for the child appropriately and to relay the information to the parent.

_____ Relationship_____
_____ Relationship_____
_____ Relationship_____

ASSIGNMENT AND RELEASE

I agree to be responsible for all charges incurred concerning medical care provided to my child.

Signature_____ Printed Name_____

Date_____ Relationship to Child_____

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

Patients Name _____ Date of Birth_____

Does your child have Illnesses we need to know about?
(Example) Diabetes, Autism, Autoimmune Diseases, Heart conditions, etc., and are followed by specialists?_____
_____
_____
_____
_____

Has your child had any surgeries?
_____
_____
_____

Are they currently on any medications? (What are the name(s) and dosages, and how often are they taken?
_____
_____
_____

Is there anything you would like us to know about your 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: Release to:

_____ _____

_____ _____

_____ _____

Phone_____ Fax_____ 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 the record to 919-938-3795 as soon as possible. Please mail/release medical records for the 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 the 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. IT CANNOT 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 EXTENDED RELEASE BASED ON THIS CONSENT HAS ALREADY OCCURRED. THE INFORMATION CONTAINED HEREIN IS PROTECTED HEALTH INFORMATION OR IS OTHERWISE PRIVILEGED 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 FOR DELIVERING IT TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US 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 LegalRepresentative Date

_____

Relationship to Patient

_____ _____

KIDS CARE PEDIATRICS Title Date

VACCINE POLICY

Kids Care Pediatrics is dedicated to providing our patients with the best care possible. We must enter into a partnership based on mutual trust with our patient's parents or guardians to achieve this goal. Recently, there has been a trend of unjustified fear of side effects from vaccines by well-meaning parents. Immunizations are one of the most essential health interventions a parent can do for their children, and we want all of our patients to benefit from this modern lifesaving tool. While we recognize and respect the parent's role as the ultimate decision-makers for their child's healthcare, we believe strongly that we must 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 promptly 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; Meningococcal (Meningitis); Hepatitis B and Tdap.** We believe that vaccines are very safe and safer than not having vaccines, and we recognize that there are risks associated with all interventions and therapies. We hope 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 website: **www.cdc.gov/vaccines**. The North Carolina site is **Immunizenc.gov.** We hope you will review the accurate information about immunizations here and on respected internet sites and consider allowing your child(ren) to receive this vital protection. These and all other childhood vaccines are available through our office. As a group practice, we must implement a consistent **Parental Refusal of Immunizations policy**. Refusal of these vaccinations indicates a significant difference in philosophy of care, and it would be best to terminate our doctor-patient relationship. We hope 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 needs medical care within the following 30 days, we will provide that care. After that period, our obligation ends. We will forward your medical records to this new provider when you choose another pediatrician.* 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 worked 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 is an increasing frequency of parents refusing all vaccinations nationally. This places children at 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. We hope that most families with ill-founded fears of vaccines will reconsider and obtain all recommended vaccines for their children. If not, and you are unwilling to receive 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 next week to begin the vaccination series.

_____ _____

Parent/Guardian **Date**