

Oberlin Road Pediatrics “Newborn First Visit Packet”

Newborn Questionnaire Form

RSV Risk Assessment Form

Insurance Questionnaire Form

Family Registration Form

Acknowledge Receipt: Notice of Privacy Practices

Vaccine Policy

Oberlin Road Pediatrics Financial Policy

Family Behavior Policy

New Born First Visit Packet last updated

1/30/2023

Please fill out the forms and bring with you to your First Visit.

New Born Questionnaire Form

Updated 01-04-2017

New Born Questionnaire 1 of 2

We at Oberlin Road Pediatrics welcome you. We thank you for considering Oberlin Road Pediatrics for your child's primary care. Prior to your first appointment with us we request the following items to be completed on your part:

1. We ask that you please read over our "Vaccination" / "No Show Policy" attached & online @ www.oberlinroadpediatrics.com.

Please sign the following Practice Policy statements below:

I have read and agree with Oberlin Road Pediatrics' Vaccination Policy _____
 (Signature) (Date)

I have read and agree with Oberlin Road Pediatrics' No Show Policy _____
 (Signature) (Date)

Please fill out the following questionnaire.

Child's Name: _____ DOB: ___/___/___ Sex: Male Female Today's Date: ___/___/___

Do you have any concerns, questions, or problems that you would like to discuss today?

Prenatal History:

Did you have any illnesses during pregnancy? Yes No If yes, what? _____ Gestational Diabetes Yes No Pre-eclampsia Yes No Low amniotic fluid Yes No Excess amniotic fluid Yes No	Were you taking any prescription medications? Yes No If yes, what? _____ Group B Strep Pos Neg. Prenatal Exposure to any other substances: Yes No <input type="checkbox"/> Over The Counter meds <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Other _____
Did you have any abnormal prenatal ultrasounds or labs? Yes No If yes, what? _____	

Family History: (Please provide the specific type of cancer, thyroid disease, allergy and mental illness in the space provided.)

Has anyone in your child's family had: Include "Mom, Dad, brother, sister, maternal & paternal grandparents" (Example: MGM, MGF, PGM, PGF)

Illness		Relationship to child	Illness		Relationship to child
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Attack age <55	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes Type I	<input type="checkbox"/> Yes <input type="checkbox"/> No		Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No		Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke at age <55	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergic Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No		Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No		AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No		Genetic Syndromes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Social History:

Parent 1 Occupation: _____ Parent 2 Occupation _____

- Do you live in a: house apartment other?
 Do you have city water well water other?
 Do you have a working smoke detector on each floor? Yes No
 Is your home free of tobacco smoke? Yes No
 Do you have Pets? Yes No What Kind? _____

Adoption? yes no What Country Adopted From? _____ Age at adoption _____

List names and age of persons living with patient?

NAME	AGE	NAME	AGE

For Office Use Only

**RESPIRATORY SYNCYTIAL VIRUS
(RSV) RISK ASSESSMENT**

- History of BPD-less than 2 yr old w/BPD under treatment now or has received medical intervention for BPD within the last 6 months (oxygen, diuretic, bronchodilator, steroids)
- History of Preterm Infant – 28 wk. gestation or less and < 12 mo old by Nov 1
- History of Preterm Infant-29 – 32 wk gestation and 6 mo old or less by Nov. 1
- History of Preterm Infant – 32 – 35 wk gestation, 2 or more risk factors: school age, sibling, daycare, smoker in home, airway abnormality, neuromuscular disease

- History of Congenital Heart Disease and < 2 yr old with significant heart disease
- Recommended Palivizumab (Synagis)
- No risk factors for RSV – no further evaluation or treatment is indicated

BLOOD PRESSURE RISK ASSESSMENT

- History of prematurity
- Very low birth weight
- Stay in NICU?
- History congenital heart disease (repaired or unrepaired)?
- Abnormal prenatal ultrasound of infant’s kidneys

RSV RISK ASSESSMENT

PATIENT'S NAME _____ DATE _____

DOB _____ GESTATIONAL AGE _____ weeks; BIRTH WT _____ (lb/oz)

1. Will patient be less than 2 years old at the start of RSV season (Nov-Apr):	Yes ___ No ___
2. Does patient have Chronic Lung Disease, Hemodynamically significant Congenital Heart Disease, or other serious conditions that compromise pulmonary or immune Function (other than prematurity)?	Yes ___ No ___
3. Was patient born prematurely (< 35 weeks) - (see below)	Yes ___ No ___
<= 28 Weeks Gestational Age - Less than 1 year old at the start of RSV season:	Yes ___ No ___
29-32 Weeks Gestational Age - Less than 6 months old at the start of RSV season:	Yes ___ No ___
32-35 Weeks Gestational Age - Less than 6 months old at the start of RSV season with additional Risk Factors:	Yes ___ No ___

(Check All that apply)

- Daycare attendance (Definition: >= 2 unrelated Children for >=4 hr/week)
- School-age siblings
- Exposure to environmental air pollutants
- Severe neuromuscular disease
- Congenital abnormalities of the airways
- Low birth weight (< 2500 g)
- Multiple birth
- Exposure to environmental tobacco smoke
- Crowded living conditions
- Family history of wheezing
- Young chronological age (<= 12 weeks)



Oberlin Road Pediatrics

1321 Oberlin Road
Raleigh NC 27608
Phone 919.828.4747 - Fax 919 828 6765

INSURANCE QUESTIONNAIRE

New 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.

Revised: 03/10/2020

PARENTS'S INFORMATION

Gender

M/F ___

Full Name _____

Employer Name _____

DOB _____

Occupation _____

Address _____

Work Phone _____

City/County/State/Zip _____

Home Phone _____

email address: _____

Mobile Phone _____

PARENTS'S INFORMATION

Gender

M/F ___

Full Name _____

Employer Name _____

DOB _____

Occupation _____

Address _____

Work Phone _____

City/County/State/Zip _____

Home Phone _____

email address: _____

Mobile Phone _____

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

PATIENT INFORMATION

(LIST ALL CHILDREN)

Full Name _____

DOB _____

M/F _____

RACE / ETHNICITY R DECLINED

LANGUAGE PREFERRED _____

Has Insurance coverage: Father _____ Mother _____ Who has custody? Father _____ Mother _____ Both _____ Other _____

Marital Status (circle one) Single Married Separated Divorced Widowed

Primary Care Provider of choice _____

In Emergency Notify _____ Relationship _____ Phone _____

(Someone Other than Parent)

SIGNATURE: _____

DATE: _____

(Parent or Guardian **Must Sign** if Patient is a Minor)

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 Road Pediatrics, PA. 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 _____

Employee completion _____ Date _____

Acknowledgement of Receipt - NOTICE of PRIVACY PRACTICES

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: _____

Updated July 22, 2012

Oberlin Road Pediatrics 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 \$15 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.

Signed: _____

Date: _____

Printed name: _____

Name of Guarantor of child's Insurance: _____

Oberlin Road 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 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.

Signed: _____ Relationship: _____

Printed name _____ Date: _____