Oberlin Road Pediatrics
"New Patient First Visit Packet"

New Patient Questionnaire Form

Patient Medical History Questionnaire

Insurance Questionnaire Form

Family Registration Form

Acknowledge Receipt: Notice of Privacy Practices

Vaccine Policy

Oberlin Road Pediatrics Patient Scheduling and Payment Policy

Revised 08 23 2019

Family Behavior Policy

New Patient First Visit Packet last updated
8/23/2019

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

ORP NEW PATIENT QUESTIONNAIRE

We at Oberlin Road Pediatrics welcome all new patients under the age of 17 and we thank you for considering Oberlin Road Pediatrics for your child's primary care. Prior to your first appointment with us we do require the following items to be completed on your part:

1. We ask that you 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 NOTE: WE MUST *RECEIVE THIS FORM* & *YOUR CHILD'S VACCINATION RECORD* BEFORE YOUR CHILD'S FIRST APPOINTMENT CAN BE SCHEDULED.

2. If transferring from another Pediatric Practice, please request Medical Records be sent to Oberlin Road Pediatrics. Please download and complete the Medical Release Forms located on our website under Forms.

   PLEASE NOTE: WE MUST RECEIVE YOUR PREVIOUS MEDICAL RECORDS 1 WEEK PRIOR TO YOUR FIRST SCHEDULED APPOINTMENT OR YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

3. To help us get to know your child better, please complete the following questionnaire and mail / fax to us @ (919) 828-6765.
   Child's Name(s) _____ DOB _____
   How did you hear of Oberlin Road Pediatrics? _____
   If referred to us – by whom? _____
   Tell us why you need a new Pediatric Practice? New Baby Y / N; New to the area Y / N; Second Opinion? Y / N;
   (If Yes to Second Opinion, please explain) _____
   Other Reason Y / N _____

   1. Are you transferring from another Pediatric Practice?- (If Yes -Please give name of practice and the reason for transfer)
      _____
      Other reasons: (please explain) _____
      _____
   2. Is your child or children up to date on immunizations? Y / N _____
      Is your child currently on any medication? Y / N If yes, please list names and dosages _____
      _____
   3. Does your child see any other specialist? (e.g. allergist, urologist, neurologist, etc.) Y / N If yes, please list: _____
   4. Does your child have any ongoing or past health problems? Are there any special medical needs? Please list: _____
      _____
   5. Parents' or Guardian's name: _____
      Address: _____
      Phone Number: _____
   6. Who has custody of child? _____? If any special arrangements are in place due to separation/divorce of parents, any foster care, adoption, etc – please provide necessary documentation indicating who has the right to bring minor to appointments.) Thank you.
   7. Name of Health Insurance Company _____
      Secondary Insurance? Y / N - If yes, name _____

ORP PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name of Patient _____ DOB ___/___/____ Sex □ M □ F Today's Date ___/___/___

Email Address _____

ALLERGIES

Is your child allergic to any medications? □ Yes □ No Epi-pen Prescribed for severe allergic reaction □ Yes □ No

Name of medication(s) and types(s) of reaction _____

Does your child have any environmental or food allergies? □ Yes □ No

Please list allergen and type of reaction _____

Has your child had a Serious Reaction to an Immunization? □ Yes □ No If yes, which immunization and type of reaction?

_____

PAST MEDICAL HISTORY

Check box if your child has or has had any of the following: (Circle the ADHD type please) □ **No Past Medical History:**

ADHD - □ Hyperactive ? □ Inattentive ? □ Combined ?	□ Yes □ No	Hearing problems	□ Yes □ No
Asthma	□ Yes □ No	Vision problems	□ Yes □ No
Frequent wheezing or coughing spell	□ Yes □ No	Teeth problems	□ Yes □ No
Urinary Tract Infections	□ Yes □ No	Diarrhea or Constipation	□ Yes □ No
Recurrent or Frequent Ear Infections	□ Yes □ No	Anemia	□ Yes □ No
Recurrent or Frequent Strep Throat	□ Yes □ No	Eczema, hives or skin conditions	□ Yes □ No
Heart Murmur	□ Yes □ No	Convulsions/central nervous system problems	□ Yes □ No

Other Medical Conditions?

_____

Surgery or Hospitalizations? Please describe _____

Serious Injuries? _____

Prematurity or complications at birth? □ Yes □ No Please describe _____

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	□ Yes □ No		Deafness	□ Yes □ No	
Heart Attack age <55	□ Yes □ No		Sickle Cell Anemia	□ Yes □ No	
Diabetes Type 1	□ Yes □ No		Seizures	□ Yes □ No	
Diabetes Type II	□ Yes □ No		Asthma	□ Yes □ No	
Stroke at age <55	□ Yes □ No		Tuberculosis	□ Yes □ No	
Cancer	□ Yes □ No		Mental Illness	□ Yes □ No	
Thyroid Disease	□ Yes □ No		Migraine Headaches	□ Yes □ No	
Allergic Disorders	□ Yes □ No		Cystic Fibrosis	□ Yes □ No	
SIDS	□ Yes □ No		Hemophilia	□ Yes □ No	
Obesity	□ Yes □ No		Hepatitis	□ Yes □ No	
Alcohol Abuse	□ Yes □ No		AIDS	□ Yes □ No	
Drug Abuse	□ Yes □ No		Genetic Syndromes	□ Yes □ No	
High Cholesterol	□ Yes □ No		Other	□ Yes □ No	

SOCIAL HISTORY / SAFETY / ENVIRONMENT

Do you live in a:	□ House	□ Apartment	□ Other?
Are your home and car free of tobacco smoke?	□ Yes	□ No	
Please inform us if you have any pets and if so what kind.	□ Yes	□ No	_____
Please inform us if your child is home schooled.	□ Yes	□ No	_____

Adoption

If your child has been adopted, please tell us what country your child was adopted from and at what age? _____

What **Medications** and **Dosages** is your child on?

MEDICATION	DOSAGE	TIMES A DAY

Name of person completing form _____ Signature _____

Relation to child _____ Date _____

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: Name: DOB: Name: DOB:

Previous Insurance Company Name: _____

Termination Date of this Insurance: _____

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

If **YES** please complete:

Name of Secondary Insurance: _____

Effective Date: _____/_____/_____

Secondary Insurance Policy Holder's Name: _____DOB _____

Signature: _____

Today's Date _____/_____/_____

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

Revised: 03/17/2019

Oberlin Road Pediatrics

"FAMILY REGISTRATION FORM"

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 /OR 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 _____

Oberlin Road Pediatrics

Acknowledgement of Receipt of NOTICE of PRIVACY PRACTICES

I have received a copy of the HIPAA roles 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
(Child's Name)
for age - appropriate immunizations to be administered.

Signature of Parent/Guardian: _____ Date : _____

Updated July 22, 2012

OBERLIN ROAD PEDIATRICS PATIENT SCHEDULING AND PAYMENT POLICY

Revised August 23, 2019

Thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing healthcare services to our patients.

INSURANCE: We participate with most insurance plans. Your insurance coverage and benefits are a contract between you and your insurance company. Each plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits.

We offer a discount for our "self-pay" patients IF they pay in full the day of service.

Our Hours:

Monday-Friday:

Regular office hours: 7:00 am – 5:00 pm
Walk-in clinic: 7:00 am - 8:30 am
Urgent Care sick visits by appointment only: 5:00 pm – 7:00 pm
Phone lines to our receptionists are open 8:00 am – 5:00 pm

Saturday: NO WALK-INs

Urgent Care sick visits **by appointment only: Call 919-828-4747 starting at 8:00 am.**
Appointments are scheduled in time order from 9:00 am up until 4:00 pm depending upon emergent care needs and time of year.

Sunday: NO WALK-INs

Urgent Care sick visits **by appointment only: CALL 919-828-4747 starting at 8:00 am.**
Appointments are scheduled in time order from 9:00 am up until 4:00 pm depending upon Emergent care needs and time of year.

Please note that any appointment after 5:00 pm weekdays and all weekend appointments will incur an extra charge. Your insurance company may or may not cover this charge.

The following are our financial guidelines relative to patient responsibility:

- Please provide a copy of your insurance card at each visit.
- **Payment is expected at the time of service. As of January 1st 2013 co-pays not received within 48 hours of service will be subject to a $15 administration fee.**
- As a courtesy to our patients we accept cash, check, money order, Visa, and MasterCard. **We no longer accept American Express.**

- **We cannot extend professional courtesy discounts**.

- **As of January 1st 2013, a service charge of $35 will be added for**: 1. Returned checks. 2. Re-filing of insurance due to incomplete or incorrect information given at the time of service, and including for example when your insurance has terminated. 3. Administrative fee associated with accounts turned over to collection agencies

- As of January 1st 2013, 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 balance may result in discharge from the practice.

- You will be 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.

- Should you have extraordinary financial pressures, we will assist you with a payment plan. Staring on January 1st 2013 this plan will need to be **IN WRITING** with our billing department prior to services being rendered. No balance over $500.00 can be carried on a family account, unless the above-mentioned payment plan has been signed and the arrangement is being followed.

- **Effective SEPTEMBER 1, 2019, the NO SHOW fee for missed appointments will be $50. IN ADDITION, cancellations under 24 hours for Well Child Checks/Complete Physical Exams OR notification less than 4 hours for office sick visits will incur a $50 fee as well.**

- **Effective SEPTEMBER 1, 2019, cancellations under 24 hours for Medicine Rechecks or Consults will incur a $50 fee. This also includes missed or cancelled flu shot/shot only appointments if missed or cancelled in less than the 4 hour window.**

- **For repetitive No-Shows in a family, the family will be dismissed.**

- **As of January 1st 2013 a "RUSH" fee of $30 will be assessed for any "FORM" requiring completion in less than 5 business days. This fee will be paid at the time the form is dropped off. Forms brought in at the time of the child's well child check/physical exam and those forms not needed in less than 5 business days will be FREE of charge.**

- **As of March 1st 2014 the "RUSH" fee will also be charged for any letter that you need for a physician to write for your child that is needed in less than 5 business days. This fee will be paid at the time the letter is requested.**

- We appreciate the opportunity to participate in your family's healthcare. If you have any questions regarding this policy, please let us know.

_____ _____

Parent / Guardian signature Date

Oberlin Road Pediatrics, PA 1321A Oberlin Road, Raleigh N.C. 27608 Phone # 919-828-4747 Fax # 919-828-6765

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: _____