Welcome to Washington Pediatrics

We are glad that you have chosen us to provide your child's primary care, and we are looking forward to working with your family.
Enclosed you will find our new patient information.
Please complete and submit each of the following documents to our office staff prior to or at the time of your first visit:

- ✓ **Vaccine Policy/schedule**
- ✓ **Office Policy Agreement**
- ✓ **Family Demographic:** This form provides your address and phone number, emergency contacts, and insurance information.
- ✓ **Health History Form:** Provides information about Family medical history.
- ✓ **General Consent Form**: Complete and submit if you anticipate that your child will be accompanied to his or her appointments by someone other than a parent or legal guardian.

It is also important that you contact your insurance company and notify that Washington Pediatrics will be serving as your child's primary care physician. Also, please be sure to bring your insurance card(s) and required co-payment (if any) to the appointment.

Once again, welcome to Washington Pediatrics. Should you have any questions, please do not hesitate to contact us at 252-946-4134

Warm Regards,
Washington Pediatrics Staff

Washington Pediatrics requires the following vaccinations, at a minimum, to remain a patient at our office. These vaccines are DTAP (Diphtheria, Pertussis or Whooping cough and Tetanus), Polio, Hib (Haemophilus influenza type B), Pneumococcal, MMR (measles, mumps rubella), Chickenpox (Varicella), Meningococcal ACWY (Men A), TDAP (Tetanus, Diphtheria, Pertussis). We enforce this policy to protect the wellbeing of all our patients who are medically unable to receive vaccinations.

If you are unwilling to accept these minimum vaccinations that we require you will be discharged from Washington Pediatrics. We follow the American Academy of Pediatrics immunization schedule without deviations. We do not support alternate Schedule.

Immunization Schedule/Las Vacunas de Rutina

Birth **-** Hepatitis B #1

1 month- Hepatitis B #2

2 months – DTaP #1, IPV #1, HIB #1, Pneumococcal #1, Rotateq#1

4 months – DTaP #2, IPV #2, HIB #2, Pneumococcal #2, Rotateq#2

6 months – DTaP #3, IPV #3, HIB #3, Pneumococcal #3, Rotateq#3

9 month – Hepatitis B #3

12 months- Pneumococcal #4, Hepatitis A #1

15 months – MMR#1, Varicella #1, DTap#4, HIB # 4, IPV#4

18 months- Hepatitis A #2

4 years–DTaP #5, IPV #5, MMR # 2, Varicella #2

9-14 years- Gardasil #1 & 2

15 -18 years - Gardasil # 1, 2 & 3 (if not given before age 15)

11- 18 years- TDAP, Meningococcal ACWY #1

16-18 years – Meningococcal ACWY #2 and Meningococcal B 1&2

Pentacel: DTaP, IPV, ActHib **Meningococcal ACWY** (Men A)

ProQuad/MMRV: MMR, Varicella **Meningoccoal B**

Kinrix/Quadracel: Dtap, IVP

**** Immunization Schedule is Subject to Change****

Office Policy Agreement

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our office policy allows for a good flow of communication and enables us to achieve our goal.
Please read each section carefully and initials. If you have any questions, do not hesitate to ask our staff.

Appointments:
1) We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice.
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.
5) If the child/patient is accompanied by anyone other than his or her Parent/Legal Guardian **we must have a signed Permission to Treat: Alternative Caregivers** form on file, completed by the Parent/Legal Guardian before the appointment.

Parent/Guardian Initials: ________

Insurance Plans:
1) It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designated is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan. Your Health Insurance Policy is a contract between you and your insurance company. It is important for you to be informed of the specifications of your insurance policy.

    a. It is your responsibility to understand what types of services or procedures are covered by your insurance policy.
    b. You are responsible for the payment of services or procedures that are not covered by your insurance policy.
    c. For children younger than 2 years, there is a limit as to the number of allowable visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.

4. It is your responsibility to know if a written referral or authorization is required to see specialists, or prior to a procedure. It is the responsibility of the policy holder to know what services are covered by their policy.
5. If we are not in network with your insurance company you will be responsible for any additional fees that may be applicable based on your insurance policy

Parent/Guardian Initials: ____________

Financial Responsibility:

We must emphasize that as pediatric providers, our relationship is with you and your child, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) Co-payments are due at the time of service.
3) Self-pay patients are expected to pay for services in FULL at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits.
6) If previous arrangements have not been made with our finance office, any account balance outstanding requires a payment to be made prior to visit.
7) We accept cash, checks, credit and debit.
8) A $25.00 fee will be charged for any checks returned for insufficient funds.

Parent/Guardian Initials: ________

Forms:

1) There is no charge for forms to be filled out during wellness checks, this is considered part of the visit. However, should you lose your school, daycare, camp, or sports forms We require 3-day turnaround time. Not including weekends.

Parent/Guardian Initials: ________

Transfer of Records:

1) If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice.
2) A copy of your complete record is available for a minimum of $10, and the exact dollar amount will be provided to you at your request. Please be advised that it may take up to 30 days to prepare the full medical record for shipping.
3) We provide records of your child for visits (including consultations from specialists) rendered here at Washington Pediatrics only. For any previous records, you must request them directly from your previous doctor(s).

Parent/Guardian Initials: ________

Prescription Refills:

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.
2) An appointment may be required before a refill can be processed, please understand these rules and regulations are in place with the best interest of your child's health in mind.

Parent/Guardian Initials: ________

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)____

Responsible Party Member's Name _________________________Relationship_____________

Responsible Party Member's Signature _______________________ Date _________________

On completion, we will provide you with a copy for your records.

PEDIATRIC PATIENT DEMOGRAPHICS

Patient Information :

Full Name (First, Middle, Last): ____

Nickname: _______________ Date of Birth: __________________ Age: __________ Gender: ☐Male☐ Female

Address: ____ City: ______________________________

State: _________ Zip Code: ________________

Email Address: ____

Which racial category does the patient most closely identify with? *(mark all that apply)*

- ☐ African American
- ☐ American Indian/ Alaska Native
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Middle Eastern
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ Other: ____________________ (please specify)

Ethnicity: What is the patient's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Family Information:

Primary Parent/Legal Guardian (Primary Insurance Policy Holder)

Full Name of Policy Holder (as it appears on insurance card): ____

Gender: ☐ Male ☐ Female Date of Birth: __________________ Relationship to Patient: ___________ Age: ___________

Phone #: ______________________ Employer: ________________________

Other Parent/Legal Guardian:

Full Name (First, Middle, Last): ____ Date of Birth: ___________

Gender: ☐Male ☐Female Relationship to Patient: ____________________ Age: ___________

Phone #: ____________________________

What is the patient's living situation if not with both biological parents?

*With whom does the patient reside? ___________________________

*If all guardians do not reside at the address listed above, please provide a secondary address for statements and information:

Address: ____

City: _____________________________ State: _________ Zip Code: ________________

Please list any of patient's siblings (under 18):

Name:	Date of Birth:

Birth History	☐ Do not know birth history	
Birth Weight:		
Birthplace (Hospital, City, State)		
Was the baby born prematurely?	How early was the baby born?	
Were there any prenatal or neonatal complications	No	Yes, Explain:
Was a NICU stay required	No	Yes, Explain:
Was the delivery	☐ Vaginal ☐ Cesarean	

General: DK= don't know	Yes	No	DK	Explain
Do you consider your child to be in good health?				
Does your child have any serious illnesses or medical conditions?				
Has your child had any surgery?				
Has your child ever been hospitalized?				
Is your child allergic to medicine or drugs?				
Do you feel your family has enough to eat?				
Please list if any tobacco, drug, or alcohol use in home?				

Biological Family History: DK = don't know	Yes	No	DK	Who and explain:
Asthma				
Heart Disease				
High Cholesterol				
High Blood Pressure				
Stroke				
Cancer				
Liver Diseases				
Kidney Diseases				
Diabetes				
Epilepsy/Convulsions				
Mental Illness/Depression				
Development Disabilities				
Immune Problems, HIV or AIDs				
Sickle cell Trait				
Sickle Cell Diseases				
Additional Family History:				
Additional Medical Concerns/Question:				

GENERAL CONSENT FORM

Patient Name: ________________________________ DOB _________________________

Consent for Medical Treatment of a Minor. I do hereby give permission for Washington Pediatrics and its physicians, nurse practitioners, physician assistants or their designee(s) to examine and treat my child as is necessary in their judgement. I voluntarily consent to procedures which include but may not be limited to diagnostic evaluation, medical or surgical treatment, or other forms of necessary treatment. I also acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as the result of treatments, procedures, or examinations by Washington Pediatrics. I further understand that all options will be discussed prior to the administration of such treatments, procedures, or examinations.

Parent/Guardian Initials: ________

Notice of Privacy Practices. I acknowledge that Washington Pediatrics provided me with a written copy of their Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Parent/Guardian Initials: ________

Financial Policies and Responsibility, Insurance Authorization, & Assignment of Benefits. I authorize Washington Pediatrics to release to my carrier and /or their agents any information necessary to determine benefits payable for related services. I also authorize the payment of medical benefits directly to Washington Pediatrics. I understand I am financially responsible for all charges, whether or not paid by insurance.

Parent/Guardian Initials: ________

Communication Authorization. I authorize Washington Pediatrics to contact me regarding personal health information (including, but not limited to lab and other test results). By providing contact information, I authorize Washington Pediatrics to use the contact information I have provided to communicate with me and place calls; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me. I further understand that Washington Pediatrics may also contact through my secure patient portal account. If the office is unable to contact me, I authorize them to send a notice to my home address.

Primary Ph #: ________________________________ Secondary Ph #: ________________________________
Contact Name: ________________________________ Contact Name: ________________________________

By signing below, I acknowledge that I have read, understand, and agree to abide by the statements contained in this document for the above-listed patient.

____

Parent/Guardian Signature Relationship to Patient

____

Parent/Guardian Printed Name Date

Updated 2024

Permission to Treat: Alternate Caregivers. In my absence, I hereby give my consent to the following individuals to consent to medical treatment for the patient. I understand the caregiver will be required to show a photo ID, have current insurance information and payment due for each visit. I understand it is my responsibility to notify Washington Pediatrics in writing should the alternate caregiver contact(s) change. I also understand that this consent will expire one year from the signature date and to keep alternate caregivers on account, I must update their information annually.

Below, list the Alternate Caregivers who might bring the patient to the office in the event the primary caregivers (parent/legal guardian) are unable. For example, an extended family member, stepparent, nanny, family friend, etc.

Name: ______________________________________DOB: ___________________Relationship: ______________

Name: ______________________________________DOB: ___________________Relationship: ______________

Name: ______________________________________DOB: ___________________Relationship: ______________

By signing below, I acknowledge that I have read, understand, and agree to abide by the statements contained in this document for the above-listed patient.

____

Parent/Guardian Signature Relationship to Patient

____

Parent/Guardian Printed Name Date