MACK PEDIATRICS

3721 Lynn Road, Suite 104 Raleigh, NC 27613 Office: 919 825-3600 Fax: 984 200-6001

Acknowledgment of Receipt - Notice of Privacy Practices

Please complete one form per child

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: _____ Date of Birth:____/____/_____

Person signing for patient: _____

Signature: _____

Relationship to patient: _____

If Patient or Patient's personal representative does not sign, indicate below the reasons why signature could not be obtained:

Name of practice staff member:_____Date:____/____/_____

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Authorization to Use/Release/Disclose Health Information

This form is for babies not seen by Dr. Mack at the hospital or birthing center.
Please complete one form per child.

Please Note: We can serve the patient better if we receive your previous Medical Records prior to your first scheduled appointment.

I hereby authorize the use, release and/or disclosure of my health information as described below.
Patient Name:_____ Date of Birth:____/____/_____

Organization(s) Providing the Information:	Organization Receiving the Information:
Name (i.e. Weebe Birth Ctr):_____	Mack Pediatrics
Street:_____	3721 Lynn Road, Suite 104
City/State/Zipcode: _____	Raleigh, NC 27613
Phone_____ Fax_____	Phone 919-825-3600 Fax 984-200-6001

I authorize this information to be sent to Mack Pediatrics at the above address:

X Complete Medical Records (including newborn H&P, discharge summary, immunizations, and test/screening results)

- I have the right to revoke this Authorization, in writing, at any time by notifying Mack Pediatrics. Such revocation will not apply to information that has already been disclosed in reliance of this Authorization.
- I have the right not to sign this Authorization. Mack Pediatrics will not condition treatments, payment for services or enrollment or eligibility for benefit on whether I sign this Authorization.
- The Organization Providing the Information may deny in writing your request to inspect and/or copy your records in limited circumstances. You may request a review of the denial in writing. Another licensed health care professional, chosen by them, will conduct a review of the denial.
- I have read and understand this Authorization, have had the opportunity to have my questions answered, have signed this Authorization freely and, if requested have received a copy of it.
- This Authorization expires one year after the date below unless otherwise specified:_____

Signature: _____Name:_____ Date ____/____/_____
Relationship to Child:_____

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Newborn Questionnaire

We at Mack Pediatrics welcome you and thank you for selecting our clinic for your child's primary care. Please complete this newborn information packet prior to your first appointment at Mack Pediatrics.

Name of patient (baby)_____
Date of Birth:____/____/_____ Gender:_____ Today's date:____/____/_____

Do you have any concerns today? If so, please detail below:

Prenatal and perinatal history:
1. How many weeks of gestation pregnant was mother at time of baby's delivery?_____
2. Was this a pregnancy of twins, triplets, etc? No__ Yes___ If yes, how many babies?_____
3. What was the birth mother's Group B Strep status? _____. If positive or unknown, did mother receive antibiotics during labor? No__ Yes___ If yes, were antibiotics given at least 4 hours prior to delivery of baby? No__ Yes___ Unknown___
4. Was there any problem or maternal illness during this pregnancy? No__ Yes___ If yes, please circle any of the following that occurred: gestational diabetes, preeclampsia, low amniotic fluid, excess amniotic fluid, abnormal prenatal ultrasound, abnormal prenatal lab/blood test or other (_____). Please explain what needed to be done for the problem/illness:_____.
5. If the baby is male, is his penis intact or circumcised (circle one)?

Family History:
Has anyone in your child's immediate family had any of the following conditions?

	Yes	Relationship to child		Yes	Relationship to child
High blood pressure			Sickle cell anemia		
Heart attack age <55			Cystic fibrosis		
Stroke at age <55			Hemophilia		
Diabetes Type 1			Tuberculosis		
Diabetes Type 2			Hepatitis		
High cholesterol			AIDS		
Thyroid problems			Mental illness		
Obesity			SIDS		
Asthma			Cancer		
Allergic disorders			Genetic syndromes		
Seizures/epilepsy			Deafness		
Migraine headaches			Drug or alcohol abuse		

Social history:
Is this baby adopted? No__ Yes___If yes, from what country or geographic region? _____
Parent 1 Occupation:_____ Parent 2 Occupation:_____

What type of home do you live in?	House	Apartment	Other:
What is the source of your child's drinking water?	City	Public well	Private well Bottled
Is there a working smoke detector on every floor at home?	No	Yes	
Does your baby always ride in rear-facing car-seat in back-seat?	No	Yes	
Is there any violence in the home?	No	Yes	
Does anyone smoke in the home?	No	Yes	
Are there guns or firearms in your home?	No	Yes	If yes, how are they secured?_____
Do you have pets?	No	Yes	If yes, what kind of pet? _____

Please list all people living in your home, including age of person and relationship to baby:

Name	Age	Relationship

Signature: _____Name:_____ Date:____/____/_____
Relationship to child:_____

FOR OFFICE USE ONLY

__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?
__Abnormal prenatal ultrasound of infant's kidneys

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RSV Risk Assessment

Name of patient (baby)_____
Date of Birth:____/____/_____ Gender:_____ Today's date:____/____/_____
Birth Weight: ____lbs.____oz. (or _____g) Gestational Age at Birth:____weeks____days____

	No	Yes
1. Will the baby be less than 2 years old at the start of RSV season (November-April)?		
2. Does the baby have chronic lung disease, congenital heart disease (requiring medication, oxygen or cardiologist) or other conditions that affect lung or immune function (not including prematurity)?		
3. Was patient born prematurely (<35 weeks) – see below if "YES"		
<=28 weeks gestational age – Less than 1 year old at the start of RSV season		
29-32 weeks gestational age - Less than 6 months old at the start of RSV season.		
32-35 weeks gestational age – Less than 6 months old at the start of RSV season.		
IF the answer is "Yes" for either question #2 or #3, please answer all of the following questions.		
4. Will the baby attend childcare with at least 4 unrelated children for at least 4 hours/week?		
5. Does the baby have school age siblings?		
6. Will the baby be exposed to environmental air pollutants regularly?		
7. Does the baby have a neuromuscular disease?		
8. Does the baby have a congenital abnormality of the airway(s)?		
9. Did the baby have a low birth weight (<2500g)		
10. Was the baby born from a pregnancy of multiple fetuses (twins, triples, quadruplets, etc.)?		
11. Does/will the baby be exposed regularly to tobacco smoke?		
12. Does/will the baby live in crowded conditions?		
13. Is there a family history (parent, sibling) of recurrent wheezing?		
14. During the RSV season (November-April), will the baby be less than 12 weeks old?		

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Family Registration Form

Patient Information. Please list all children

Child's Full Name Date of Birth Gender Race/Ethnicity (may leave blank) Language

1._____
2._____
3._____
4._____

Parent Information Gender _____
Full Name:_____
Date of Birth:____/____/_____
Address:_____
City/State/Zip:_____
County:_____

Employer Name_____
Occupation_____
Work Phone_____
Home Phone_____
Mobile Phone_____
Email address:_____

Parent Information Gender _____
Full Name:_____
Date of Birth:____/____/_____
Address:_____
City/State/Zip:_____
County:_____

Employer Name_____
Occupation_____
Work Phone_____
Home Phone_____
Mobile Phone_____
Email address:_____

My child(ren)'s physician, nurse, or other Mack Pediatrics employee may leave messages pertaining to my child/children at the phone numbers I have listed above.

Who has insurance coverage? Father_____ Mother_____ Other _____
Who has custody? Father_____ Mother_____ Both_____ Other_____
Marital Status (circle one) Single Married Separated Divorced Widowed
In Emergency, notify _____(not either parent), phone _____
Please indicate emergency contact's relationship to family):_____

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 Mack Pediatrics. I also realize that this person(s) 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:_____

Signature: _____Name:_____ Date:____/____/_____
Relationship to child:_____

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Vaccination Policy (please complete one per child)

The physicians and staff of Mack Pediatrics fully support the efficacy and safety of vaccines (aka shots, immunizations, vaccinations). We follow the standard vaccination schedule as recommended by the ACIP (Advisory Committee on Immunization Practice, part of the CDC Centers for Disease Control and Prevention) and the North Carolina State Law as the minimum requirement for vaccination for all of our patients. Mack Pediatrics expects our patients to be vaccinated on time per the ACIP schedule, starting with the Hepatitis B vaccine in the first 24 hours of life in the hospital or birthing center (if vaccine is available).

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 delayed or behind on shots, you will be asked to schedule a vaccine consultation 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 for your child's current age. However, if a requested vaccine consultation does not occur, or if you are not willing to comply with NC vaccination laws, Mack Pediatrics is not the right practice for your family and we will not accept the child as a new patient. If you decide during the course of being a patient family here at Mack Pediatrics that you do not wish to continue to comply with the NC vaccination laws, then you acknowledge here that your children will be dismissed from Mack Pediatrics and will need another pediatric practice.

We are happy to discuss your questions about vaccines during wellness 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. Such consultations usually range in cost from $150-$300, depending on the amount of time spent with the physician.

Vaccine Consent Form:

By signing this consent, I am giving Mack Pediatrics permission to vaccinate my child at this and future appointments. I will be offered a Vaccine Information Statement explaining each vaccine before it is administered. I may also refer to https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html for the Immunization Schedules of the Centers for Disease Control and Prevention.

I, parent/guardian of _____ (child's name) have read the vaccination policy and give permission for age-appropriate immunizations to be administered.

Signature: _____Name:_____ Date:____/____/_____

Relationship to child:_____

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Insurance Questionnaire

New Primary Insurance:_____
Effective Date of Insurance:____/____/_____
Name of Policy Holder:_____
Date of Birth of Policy Holder:____/____/_____
List all children covered on this policy:_____

Previous Insurance Company:_____
Termination Date of Insurance:____/____/_____

Do you have Secondary Insurance? No__ Yes___ If yes, please provide details below:
Name of Secondary Insurance:_____
Effective Date of Secondary Insurance:____/____/_____
Name of Policy Holder for Secondary Insurance:_____
Date of Birth of Policy Holder for Secondary Insurance:____/____/_____
List all children covered on this secondary insurance policy:_____
_____

Signature: _____Name:_____ Date:____/____/_____
Relationship to child:_____

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

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Payment Policy and Agreement

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

Mack Pediatrics participates in 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. To benefit from this discount, you must pay in full the day of the service.

The following are our financial guidelines relative to financial responsibility:

_____ (initials) Please be prepared to pay Mack Pediatrics your copay or a $50 deposit for high-deductible plans without copay, at the time service is rendered. If your insurance plan has a deductible (regardless of copay), you will be billed for the balance after your insurance company has let us know the amount they will pay. If your deductible has been met we will credit your account for any excess payments received or send you a reimbursement check.

Please provide your child's health insurance card at each visit for us to copy.

As a courtesy to our patients we accept cash, check, money order, Visa and Mastercard, American Express and Discover.

We cannot extend professional courtesy discounts.

_____ (initials) A service charge of $35.00 will be added for

1. Returned checks.
2. Refiling of claim due to incomplete/incorrect insurance information given at the time of service.
3. Administrative fee associated with accounts turned over to collection agencies.

_____ (initials) Any amount not covered by the patient's insurance including applicable deductibles, additional co-pays, etc., will be due 30 days from the time of service. Late payments will incur an additional billing fee of $10.00 per month.

_____ (initials) 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 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. In case of extraordinary financial pressures, Mack Pediatrics will assist you with a payment plan. 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.

_____ (initials) There is a $35.00 fee for missed appointments (No-Shows) and late-cancellations. Late-cancellations with less than 2 hours notice prior to appointment will incur a $35.00 fee; however, late cancellations of long appointments (consultations or medication rechecks) require 24 hour notice. See "No Show Policy". Families with 3 or more "No Shows" for entire family will be dismissed.

_____ (initials) A "Rush" fee of $30.00 will be charged for any letter that you need a physician to write for your child in less than 5 business days. This fee is due when the letter is requested.

_____ (initials) A "Rush" fee of $30.00 will be charged for any form or paperwork requiring completion in less than 2 business days. This fee will be paid at the time the form is dropped off. Forms brought in at the time of the well child visit or physical exam, and which are not needed in less than 2 business days, will be free of charge. If Mack Pediatrics does not have medical records from your previous practice, because you are a new patient, no "Rush" forms are possible.

Office Hours:

Monday-Friday:

Regular office hours 8:00 am – 5:00 pm with phone lines to receptionist open.

Walk-in Clinic 8:00am – 8:30 am (no appointment needed)

Urgent care sick visits by appointment only 6:00 pm – 6:30 pm for urgent same day appointments. Please call our office to schedule*

Saturday:

Urgent care sick visits by appointment only 10:00 am – 12:00 pm. Please call our office after 8:00 am to schedule urgent same day appointments.*

*The clinic is closed 5 pm to 8 am Monday-Friday, and closed on Saturday-Sunday. Please do not walkin for urgent appointment outside of normal walk-in clinic hours or when office is closed.

_____ (initials) Please note that any appointment after 5:00 pm weekdays and all weekend appointments will incur an extra charge. Your insurance company may not cover this charge; it will be your responsibility to pay this charge if insurance does not cover it.

_____ (initials) There are no walk-in appointments on after 8:30am M-F, on weekends or evenings. Walk-ins outside the walk-in clinic time detailed above (M-F 8am-8:30am) will incur an Emergency Service fee, which your insurance may not cover and will be your responsibility to pay.

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

Please sign and initial this document.

Signature: _____Name:_____ Date:____/____/_____

Relationship to child:_____

_____

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No Show Policy

Mack Pediatrics promises to honor all appointments scheduled with your family. When a family does not come to an appointment and does not call to cancel said appointment ahead of time, that is considered a "No Show".

Mack Pediatrics has a $35.00 No-Show fee for missed appointments of any type (including shot-only or flu-shot). In addition, cancellations less than 2 hours before appointment time will incur a $35.00 fee for all of the following standard appointment types: Wellness Check, Physical Exams, Sport Physicals, Shot-Only, or Flu-Shot.

Cancellations in less than 24 hours for long appointments like Medication Rechecks or Consult/consultations will incur a $35.00 fee.

It is the policy of Mack Pediatrics to respect and appreciate all families. Families who repeatedly miss or late-cancel appointments may be dismissed by Mack Pediatrics. Families with 3 or more "No Shows" for the entire family will be dismissed. If a family is dismissed, we will provide care for another 30 days for emergency sick visits only. This allows the family time to choose a new pediatrician and get insurance cards changed to indicate a new primary care doctor. We will also copy records and send them to the new pediatrician upon request. The fee for copying records is $0.25 per page, with a minimum charge of $15.00 per patient.

Please sign below to indicate that you have read and understand this No Show policy.

Signature: _____Name:_____ Date:____/____/_____
Relationship to child:_____

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Behavior Policy

Mack Pediatrics runs a family-friendly pediatric office, caring for impressionable young children and their families. Although incidents are rare, Mack Pediatrics feels strongly that our patients, their families and our staff deserve to be protected from verbal abuse and aggressive behavior. Respect for each other is our Golden Rule and we expect a civil and harmonious environment for our pediatric patients, their families and staff.

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 theft/larceny. This applies to any action toward patients, family members, visitors and staff of Mack Pediatrics. Furthermore, these rules shall also apply to telephone calls and written communications with our office staff and clinicians, as well as to phone/live conversations that take place in our office between others.

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 it necessary. We may press charges at our discretion.

Thank you for your mutual commitment to making Mack Pediatrics' office and grounds a wholesome, safe, and family-friendly environment.

Signature: _____Name:_____ Date:____/____/_____
Relationship to child:_____