Bright Oaks Pediatric Center
2111 Laurel Bush Road, Suite H
Bel Air, MD 21015
www.brightoakspediatrics.com
(410) 569-3300
(410) 569-8199 (fax)

AUTHORIZATION TO RELEASE/DISCLOSE PROTECTED MEDICAL INFORMATION

PLEASE READ THE FORM CAREFULLY AND FILL OUT COMPLETELY.

1. I authorize:	**2. To release information to:**
Name Of Sending Person/Organization	**Name Of Receiving Person/Organization**
Full Address	**Full Address**

3. **INFORMATION TO BE RELEASED:** (Check all applicable)
☐ Patient Problem List ☐ Immunization Records (no charge) ☐ Growth Charts (no charge)
☐ Lab Reports (additional charge) ☐ All Progress Notes (additional charge)
☐ Others_____

4. **RECORDS FROM THE TIME PERIOD_____TO_____**

5. **PURPOSE OR NEED FOR DISCLOSURE:**
☐ Continued Medical Care ☐ Payment of Insurance Claims ☐Legal ☐ Personal
☐ Workers Compensation Claims ☐ Other:_____ (*If you are transferring out of our practice please let us know why*)

Please Initial:

_____6. I understand that this authorization shall be valid from _____ to _____. I understand that I may revoke this consent in writing at any time except to the extent that the action has already been taken.

_____7. The requester may be provided with a copy of this authorization.

_____8. I understand that if my protected health information is disclosed to someone who is not required to comply with federal health insurance probability act and accountability act of 1996(HIPAA) regulations, then such information may be re-disclosed and would no longer be protected.

_____9. If this release pertains to alcohol, drug information, mental health problems, or psychotherapy, please note that this information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR, part 2). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict and use of the information to criminally investigate or prosecute and alcohol or drug abuse patient.

_____10. I understand that I have the right to inspect my child's protected health information and make authorization changes and copies, if needed.

_____11. **I understand that a reasonable fee may be charged for duplication of records. The fee will include $0.76 per page for photocopying plus the actual cost of the postage and handling PLUS $22.88 for retrieval of records, if applicable**.

_____ _____
Patient name **Date of Birth**

_____ _____
Street Address Daytime Phone Number

_____ _____
City State Zip Code Date of Request

_____ _____
Printed Name of Authorized Parent/Guardian Signature /Relationship to Patient

Bright Oaks Pediatric Center
2111 Laurel Bush Road, Suite H
Bel Air, MD 21015
www.brightoakspediatrics.com
(410) 569-3300
(410) 569-8199 (fax)

Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Amy Stansfield at 2111 Laurel Bush Rd. Suite H, Bel Air, MD 21015; Telephone: 410-569-3300

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders and Test Results. Our practice may use and disclose your IIHI to contact you and remind you of an appointment or to report test results.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure

and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Amy Stansfield at 2111 Laurel Bush Rd., Suite H, Bel Air MD 21015; Telephone: 410-569-3300** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Amy Stansfield at 2111 Laurel Bush Rd., Suite H, Bel Air, MD 21015; Telephone: 410-569-3300**
Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Amy Stansfield at 2111 Laurel Bush Rd. Suite H, Bel Air, MD 21015; Telephone: 410-569-3300** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Amy Stansfield at 2111 Laurel Bush Rd., Suite H, Bel Air MD 21015; Telephone: 410-569-3300**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing **Amy Stansfield at 2111 Laurel Bush Rd., Suite H, Bel Air MD 21015; Telephone: 410-569-3300**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same

12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Amy Stansfield at 2111 Laurel Bush Rd., Suite H, Bel Air MD 21015; Telephone: 410-569-3300**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Amy Stansfield at 2111 Laurel Bush Rd., Suite H, Bel Air MD 21015; Telephone: 410-569-3300** All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Amy Stansfield at 2111 Laurel Bush Rd., Suite H, Bel Air MD 21015; Telephone: 410-569-3300**

Bright Oaks Pediatric Center
2111 Laurel Bush Road, Suite H
Bel Air, MD 21015
www.brightoakspediatrics.com
(410) 569-3300
(410) 569-8199 (fax)

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, representing _____have
Parent Name Patient's name

received a copy of Bright Oaks Pediatrics Notice of Privacy Practices.

_____ _____
Signature of Patient/Parent Date

Bright Oaks Pediatric Center
2111 Laurel Bush Road, Suite H
Bel Air, MD 21015
www.brightoakspediatrics.com
(410) 569-3300
(410) 569-8199 (fax)

Patient's Name: _____

Date of Birth: _____

Information Release

Please read and initial the following:

_____ I authorize the release of any medical information necessary to process claims for benefits. Bright Oaks Pediatric Center, LLC and its employees are hereby released from all liability of any nature that may arise from the release of such information.

Assignment of Benefits

Please read and initial the following:

_____ I authorize the payment of any and all insurance, PIP, third party settlement and/or government benefits directly to Bright Oaks Pediatric Center, LLC for services rendered. I understand and agree that I am financially responsible for any charges not paid by the insurance company.

Medical Assistance Waiver

Please read and initial the following:

_____ I am aware that Bright Oaks Pediatric Center, LLC does not participate with Maryland State Medicaid programs. This includes Medicaid held as a secondary insurance Bright Oaks Pediatric Center, LLC will not bill Medicaid under any circumstances, and the Parent/Guardian will be responsible for any balance due after the primary insurance has paid their portion.

Parent/Legal Guardian:

_____ _____
Signature Print Name

_____ _____
Relationship to Patient Date

Bright Oaks Pediatric Center
2111 Laurel Bush Road, Suite H
Bel Air, MD 21015
www.brightoakspediatrics.com
(410) 569-3300
(410) 569-8199 (fax)

Consent for Treatment of a Minor

I, _____

being the parent or legal guardian of

_____ ,
(Child's Name)

give my consent and authorize the administration and performance of all treatment and diagnostic procedures, including laboratory tests, which in the judgment of Bright Oaks Pediatric Center, LLC's licensed physicians, nurse practitioners and designees are considered necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this Consent may receive all medical care provided according to generally and currently accepted standards of pediatric care.

Please list Parent(s)/Legal Guardian(s)

Parent/Legal Guardian Name: _____ Relationship to minor: _____
Parent/Legal Guardian Name: _____ Relationship to minor: _____

In the absence of the parent/legal guardian, the following people are authorized to bring this minor for medical treatment and have access to his/her medical information (You may name relatives, friends, grandparents, stepparents, non-custodial parent, daycare providers, foster parents or others.)

Name: _____ Relationship to minor: _____
Name: _____ Relationship to minor: _____
Name: _____ Relationship to minor: _____
Name: _____ Relationship to minor: _____

If no other person is authorized, please write NONE: _____

Please initial the following:

_____ If a minor is brought by any other person not recorded above, Bright Oaks Pediatric Center, LLC will make reasonable attempts to contact Parent/Guardian for **verbal consent** to treat.

_____ I understand that consent from the parent(s)/legal guardian(s) or authorized person(s) named above, is required for all **non-emergent** situations.

_____ If the parent(s)/legal guardian(s) or authorized person (s) named above cannot be reached in an **emergent situation**, I consent to Bright Oaks Pediatric Center, LLC to render medical care as **deemed necessary**.

_____ I have the right to revoke or change this consent to treat in writing.

_____ If the custody or guardianship of this minor has changed, I will furnish Bright Oaks Pediatric Center, LLC with the legal forms that are required to be included in the minor's medical record to explain the change. This will alleviate any confusion that may occur over who may or may not consent to minor's treatment.

Parent/Legal Guardian Signature _____
Parent/Legal Guardian Printed Name _____
Date of Consent: _____

Bright Oaks Pediatric Center
2111 Laurel Bush Road, Suite H
Bel Air, MD 21015
www.brightoakspediatrics.com
(410) 569-3300
(410) 569-8199 (fax)

Financial Policy Statement

Please initial each statement indicating your agreement.

Thank you for choosing Bright Oaks Pediatrics Center, LLC. as your child's healthcare provider. The following is our Financial Policy. Please read and sign each statement, prior to us treating your child.

_____ 1. It is the policy of Bright Oaks Pediatrics Center, LLC. to help keep your healthcare costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways: Always bring your child's current health insurance card to the office. Please notify us at the time of Check-In of any changes in insurance, address, telephone or family status. Failure to notify us of any changes may result in incorrect billing for which you may be responsible.

_____ 2. Co-pays, deductible balances and co-insurance balances are part of your contract with your insurance, and are due at the time of service. Failure to comply could jeopardize your insurance coverage. You will be expected to pay in full if you do not have insurance, or Bright Oaks Pediatrics Center, LLC. does not participate with your health plan, or you are unable to present a valid member identification card from your insurance carrier at your visit, or we are unable to verify your insurance coverage. If you do not have medical insurance, or elect to self-pay your account, payment is due at the time of service, at a discounted rate.

_____ 3. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for such charges. It is your responsibility to ensure our providers actively participate with your insurance plan; know your benefit coverage, as well as your dependents, prior to receiving services. Make sure that all individuals on your policy have the correct primary care physician selected. Ensure that all pre-approval requirements, if any, are met to avoid denials or out-of-network benefits.

_____ 4. You may receive a separate bill for medical care for lab, x-ray or other diagnostic services from another facility. You are financially responsible to pay that facility for any co-pay or balance due for those services. Such bills are not generated from Bright Oaks Pediatric Center, LLC. so you will need to call the facility where services were provided.

_____ 5. A $35 fee will be charged for all returned checks. Immediate remittance in the form of cash, money order, credit card or certified funds is required for a returned check in the original amount plus the $35 fee. After two returned checks, families will be required to pay in the form of cash, money order, credit card or certified funds for subsequent visits.

_____ 6. Full payment of your account balance is expected within 30 days from the billing date. Delinquent accounts (unpaid balances past 90 days from the due date), will be sent to our collection agency. Collection costs and attorney's fees will be added to the balance due, for each child with a past due balance. Thirty days after an account has been turned over to our collection agency the family will be discharged from our practice.

_____ 7. Do not ignore billing statements. If you receive a statement which you believe is incorrect, please contact us immediately. If we do not hear from you, we will assume that you have accepted responsibility for the statement.

_____ 8. Any family that files for bankruptcy, and includes any balances due to Bright Oaks Pediatrics Center, LLC., will be dismissed from our practice 30 days after we receive such notification.

_____ 9. Bright Oaks Pediatrics Center, LLC. does not get involved in financial, legal, separation or divorce disputes. Therefore, if the guarantor is delinquent in paying the account, the balance will be transferred to the person who registered the child at the time of the visit. If a divorce decree or such requires the other parent to pay all or part of the treatment costs, it is the registering party's responsibility to pay the balance and collect from the other parent.

_____ 10. Bright Oaks Pediatrics Center, LLC. does not get involved with any visits related to on-the-job or motor vehicle injuries. The patient will need to pay in full at the time of the visit.

_____ 11. There is a $10 fee for filling out various forms, including, but not limited to: school, camp, sports and daycare forms. The fee must be paid before or at the time of pick-up.

_____ 12. We require 24 hours notice to cancel appointments you are unable to keep. This allows us the ability to schedule another patient in that time slot. Failure to cancel an appointment properly may result in a $50 missed appointment fee. If you are more than 15 minutes late for an appointment, your appointment may be rescheduled.

_____ 13. Medical records are our documentation that services were rendered to your child. Copying records requires staff time, equipment usage, supplies and postage. Maryland State statute permits providers to charge for retrieval and preparation, a per page copying charge, and the actual cost for postage and handling. You will be notified of the fee prior to release of records and payment is required prior to the release of the records. Only the records generated by our practice will be released.

I have read this financial policy, and I understand and agree to the terms stated above for today and any future visits, and the agreement will be in full force and effect.

_____ _____

Parent/Guardian Printed Name Signature

Patient's name: _____ Today's Date: _____

BRIGHT OAKS
Pediatric Center

2111 Laurel Bush Rd. Suite H
Bel Air, MD 21015
410-569-3300(p)
410-515-2027(f)
www.BrightOaksPediatrics.com

Vaccination Policy

At Bright Oaks Pediatric Center, we strive to provide the best care that is based on the most up-to-date and accurate literature for our patients and families. In order to do this, we ask that all of our patients receive the recommended immunizations based on the guidelines by the Centers for Disease Control and Prevention and The American Academy of Pediatrics.

While we respect one's choice to not vaccinate, we feel we would be doing a disservice to our patients and community, and feel uncomfortable as a practice caring for children who do not receive these recommended immunizations.

Vaccines are a simple and easy way to prevent deadly illnesses and diseases. We ask that should you have questions or concerns regarding immunizations, ask your child's healthcare provider. Unfortunately, there is a lot of misinformation on the internet, as anyone can publish or post an article. When researching, ensure you are looking at reputable and quality resources, such as information from the Centers for Disease Control and Prevention or the American Academy of Pediatrics.

We look forward to caring for your child(ren) at Bright Oaks!

Please read the following statement and sign & date below to acknowledge your understanding:

I acknowledge that I will be given a copy to read or have explained to me the Vaccine Information Statement(s) about the vaccine(s) my child/I will receive, and the disease(s) they prevent.
I further acknowledge that upon receipt of the Vaccine Information Statement(s) I will have a chance to ask any questions and have them answered to my satisfaction, so that I may understand the risks of the vaccine(s) to be administered to my child/myself, for whom I am authorized to make this decision.

Child/Patient Name: _____

Parent/Patient Signature: _____

Date: _____

Parent/Guardian Contact Information

Name: ____

Relationship to Child (Circle One): Biological Mom/Dad, 2nd Mom/Dad, Step Mom/Dad, Adoptive Mom/Dad,

Other: ________________________, Legal Guardian(specify):_____________________

Primary Phone number: _________________________ Alternate Phone number: ________________________

DOB: _________________ Email: ____

Address: ____

Billing address (if different): ____

Name: ____

Relationship to Child (Circle One): Biological Mom/Dad, 2nd Mom/Dad, Step Mom/Dad, Adoptive Mom/Dad,

Other: ________________________, Legal Guardian(specify):_____________________

Primary Phone number: _________________________ Alternate Phone number: ________________________

DOB: _________________ Email: ____

Address: ____

Billing address (if different): ____

Name: ____

Relationship to Child (Circle One): Biological Mom/Dad, 2nd Mom/Dad, Step Mom/Dad, Adoptive Mom/Dad,

Other: ________________________, Legal Guardian(specify):_____________________

Primary Phone number: _________________________ Alternate Phone number: ________________________

DOB: _________________ Email: ____

Address: ____

Billing address (if different): ____

Emergency Contact

Name: ____

Relationship to Child: _______________________________ Phone Number: ______________________________

Privacy

Initial all that apply:

_______ OK to leave voice messages; appointment reminders, non-urgent messages/lab results

_______ OK to send email reminders

_______ OK to send text reminders

_______ Person to person contact only

_______ Other Restriction: ____

New Patient Medical History

PLEASE REVIEW THE PROBLEM LIST AND ANSWER ACCORDINGLY FOR THE CHILD/PATIENT

PROBLEM	CIRCLE ONE	COMMENTS
Significant Birth History/Complications	YES or NO	
Serious Injuries or Accidents	YES or NO	
Surgeries	YES or NO	
Hospitalizations	YES or NO	
History of Chickenpox	YES or NO	
Frequent Ear Infections/Sinus Infections	YES or NO	
Pharyngitis/Tonsillitis	YES or NO	
Other Infectious Illnesses	YES or NO	
Food Allergies	YES or NO	
Rashes/Skin Problems	YES or NO	
Outdoor/Indoor Allergies	YES or NO	
Asthma/Wheezing	YES or NO	
Bronchiolitis, Pneumonia or Croup	YES or NO	
Sleep Apnea	YES or NO	
Heart Problems or Heart Murmur	YES or NO	
Hypertension	YES or NO	
Abdominal Pain or Reflux	YES or NO	
Chronic Diarrhea	YES or NO	
Constipation	YES or NO	
Bladder or Kidney Infections/ Urologic Problems	YES or NO	
Bedwetting (After Age 5)	YES or NO	

Patient Name: _____

PROBLEM	CIRCLE ONE	COMMENTS
Eye Conditions/Corrective Lenses	YES or NO	
Problems with Ears or Hearing	YES or NO	
Chronic or Recurrent Skin Problems (Acne, Eczema)	YES or NO	
Anemia or bleeding problems	YES or NO	
History of Blood Transfusion	YES or NO	
Frequent Headaches	YES or NO	
Fainting	YES or NO	
Seizures	YES or NO	
Neurologic Disorders	YES or NO	
Mental Health Concerns	YES or NO	
ADD/ADHD	YES or NO	
Developmental Delays	YES or NO	
Muscle, Joint or Bone Problems	YES or NO	
Broken Bones	YES or NO	
Diabetes	YES or NO	
Thyroid or other Endocrine Problems	YES or NO	
Use of Alcohol or Drugs	YES or NO	
School/Learning/Behavioral Problems	YES or NO	
Emotional Problems	YES or NO	
If Female, have menstrual periods started? If so, at what age?	YES or NO	
If Female, Are there any issues with periods?	YES or NO	
Any Other Significant Health Problems?	YES or NO	

Patient Name: _____

NEW PATIENT- FAMILY HISTORY QUESTIONNAIRE

PLEASE REVIEW THE PROBLEM LIST AND CHECK ANY FAMILY MEMBER THAT HAS THAT PROBLEM

PROBLEM	Natural Mother	Natural Father	Sibling	Maternal G-Mother	Maternal G-Father	Maternal Aunt	Maternal Uncle	Paternal G-Mother	Paternal G-Father	Paternal Aunt	Paternal Uncle
Allergies											
Anemia											
Asthma											
Attention Disorder											
Birth Defects											
Bleeding/ Clotting Disorder											
Cancer (List type in Checkbox)											
Crohn's/Colitis/ Intestinal Problems											
Diabetes											
Emotional Disorder											
GERD											
Heart Attack Under Age 50											
High Blood Pressure											
High Cholesterol											
Learning Disability											
Kidney Disease											

Patient Name: _____

PROBLEM	Natural Mother	Natural Father	Sibling	Maternal G-Mother	Maternal G-Father	Maternal Aunt	Maternal Uncle	Paternal G-Mother	Paternal G-Father	Paternal Aunt	Paternal Uncle
Mental Retardation											
Migraines											
Peptic Ulcer											
Seizure											
Sudden Cardiac Death											
Sudden Infant Death Syndrome											
Tuberculosis											
Urinary Reflux											
Any Other Significant Family History- (please list)											

Patient Name: _____