Parent/Guardian – Well Check Questionnaire – Part 1

Patient's Name & DOB ____ Today's Date __________________

We are asking these questions to help us better assess any medical risks that may affect your adolescent's health.
This information is strictly CONFIDENTIAL.

PLEASE CHECK ONLY THE ITEMS THAT APPLY TO YOU AND YOUR ADOLESCENT

I have discussed with my adolescent:

- ☐ Their use of alcohol, tobacco or other drugs
- ☐ Their sexual orientation and sexual behavior
- ☐ Safe driving as a passenger and as a driver
- ☐ Bike Safety and rules of the road
- ☐ Injury prevention i.e., swimming, on the job safety, sports, operating machinery
- ☐ Firearm safety, if there is a gun present in your household

I feel I have:

- ☐ Established fair, negotiable rules
- ☐ Respected my adolescent's privacy
- ☐ Allowed them to make decisions about their health, friends, and activities
- ☐ Provided support and encouragement

What do you find most rewarding about being the parent of your adolescent?

Parent/Guardian – Well Check Questionnaire – Part 2

Patient's Name & DOB ____ Today's Date __________________

Parent/Guardian, please answer the following questions:	**Yes**	**No**
Has a provider ever denied or restricted your child's participation in sports for any reason?		
Do you or does someone in your family have sickle cell trait or disease?		
Has a doctor ever said that your child has any heart problems?		
Has a doctor ever requested a test for your child's heart? For example, electrocardiography (ECG) or echocardiography.		
Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy(HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
Does your child have any ongoing medical issues or recent illness?		
Have there been any changes to your child's family, social, or medical history? i.e.; family/marital changes, living arrangements, school changes, medical diagnoses, etc.?		
Do you have any concerns that you would like to discuss with the provider?		
If yes to any please explain:		

Parent/Guardian Signature ____

Screening Questionnaire for Child and Teen Immunization

The following questions will help us determine which vaccines your child may be given today if they are due.

If you answer Yes or Unsure to any question, please fill in the Explain column. A Yes response does not necessarily mean your child should not be vaccinated today; it just means additional questions must be asked. If a question is not clear, please ask the provider to clarify.

Patient's Name & DOB ____ Today's Date ___________________

Screening Question:	Yes	No	Unsure	Explain
1. Is the child sick today?				
2. Does the child have allergies to any medication, food or any vaccines?				
3. Has the child had a serious reaction to a vaccine in the past?				
4. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes) or blood disorder?				
5. Has a healthcare professional told you that the child has had wheezing in the past 12 months?				
6. Has the child had a seizure, brain or other nervous system problems?				
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?				
8. Has the child taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past 3 months?				
9. Has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug in the past year?				
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?				
11. Has the child received any vaccinations in the past 4 weeks?				

Patient Name: ____

Tuberculosis Risk Screening: (every well child visit from 1-21 years)

HAS YOUR CHILD BEEN IN CONTACT WITH:

Anyone with tuberculosis? **Yes_________ No________**

Anyone who has had a positive TB test? **Yes_________ No________**

Was your child born in Africa, Asia, Central America, or Eastern Europe? **Yes_________ No________**

Has your child traveled to Africa, Asia, Central America, or Eastern Europe for more than one week? **Yes________ No________**

Any of the following individuals: HIV infected, homeless, residents of nursing homes, institutionalized or imprisoned persons, user of illicit drugs, migrant farm workers, or foster children? **Yes_________ No_________**

Has your child ever tested positive for HIV? **Yes_________ No_________**

Children whose parents immigrated (with unknown tuberculin skin test status) from regions of the world with high prevalence of tuberculosis or continued potential exposure by travel to the endemic areas and/or household contact with persons from the endemic areas (with unknown TB stats)? **Yes_________ No________**

The American Academy of Pediatrics recommends that a child be screened yearly for tuberculosis and a PPD (skin test for TB) be performed if the child has a positive screen.

Cholesterol Risk Screening: (every well child visit from 2-21 years)

DO ANY OF THE FOLLOWING APPLY:

A family history (parent, sibling, grandparent, uncle, aunt) of high cholesterol, triglycerides, or premature heart disease? **Yes_________ No________**

A family history of early heart attack (less than 50 years of age in men and less than 60 years of age in women)? **Yes_________ No________**

DOES YOUR CHILD HAVE A HISTORY OF:

Smoking **Yes_________ No________**

Physical inactivity **Yes_________ No________**

Obesity, weight >30% of ideal weight **Yes_________ No________**

Metabolic disease like diabetes, kidney disease, liver disease, or biliary tract disease, high blood pressure, hypothyroidism, or elevated cholesterol **Yes_________ No________**

Lead Risk Assessment: (every well child visit from 6 months up to 6 years)

Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling? **Yes_________ No________**

Ever lived outside the United States or recently arrived from a foreign country? **Yes_________ No________**

Any sibling, housemate/playmate being followed or treated for lead poisoning? **Yes_________ No________**

Lives in “at risk” zip code found on other side of this page? **Yes_________ No________**

Does your child frequently put things in his/her mouth such as toys, jewelry, keys, or eat non-food items? (paint chips, dirt, railings, poles, furniture, old toys, etc.) **Yes_________ No________**

Is there any family member who is currently in an occupation or hobby where lead exposure could occur? (auto mechanics, ceramics, commercial painter, etc.) **Yes_________ No________**

Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal, potter, or pewter? **Yes_________ No________**

Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead? **Yes_________ No________**

The states of Maryland and Pennsylvania define the entire states as “at risk” for lead exposure starting in 2016. For children over 2 years of age, there are “at risk” zip codes for lead exposure. Please review the zip codes below and circle your current zip code and any zip code your child has lived in previously if listed.

Maryland Childhood Lead Poisoning Targeting Plan
At Risk Areas by Zip Code

Allegany
All

Anne Arundel
20711
20714
20764
20779
21060
21061
21225
21226
21402

Baltimore Co.
21027
21052
21071
21082
21085
21093
21111
21133
21155
21161
21204
21206
21207
21208
21209
21210
21212
21215
21219
21220
21221
21222
21224
21227
21228
21229
21234
21236
21237
21239
21244
21250
21251
21282
21286

Baltimore City
ALL

Calvert
20615
20714

Caroline
ALL

Carroll
21155
21757
21776
21787
21791

Charles
20640
20658
20662

Dorchester
ALL

Frederick
20842
21701
21703
21704
21716
21718
21719
21727
21757
21758
21762
21769
21776
21778
21780
21783
21787
21791
21798

Garrett
ALL

Harford
21001
21010
21034
21040
21078
21082
21085
21130
21111
21160
21161

Howard
20763

Kent
21610
21620
21645
21650
21651
21661
21667

Montgomery
20783
20787
20812
20815
20816
20818
20838
20842
20868
20877
20901
20910
20912
20913

Prince George’s
20703
20710
20712
20722
20731
20737
20738
20740
20741
20742
20743
20746
20748
20752
20770
20781
20782
20783
20784
20785
20787
20788
20790
20791
20792
20799
20912
20913

Queen Anne’s
21601
21617
21620
21623
21628
21640
21644
21649
21651
21657
21668
21670

Somerset
ALL

St. Mary’s
20606
20626
20628
20674
20687

Talbot
21612
21654
21657
21665
21671
21673
21676

Washington
ALL

Wicomico
ALL

Worcester
ALL

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Financial Policy Statement

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.
Please initial each statement indicating your agreement.

_____ 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 Parent/Guardian Signature Date

Child Name & DOB ____

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Consent for Treatment of a Minor

I, ________________________________, being the parent or legal guardian of ________________________________
Parent/Guardian Name Child's Name/DOB

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(s) 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)

Name: ____________________________ Relationship to minor: ______________ Phone: __________________

Name: ____________________________ Relationship to minor: ______________ Phone: __________________

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

Name: ____________________________________ Relationship to minor(s): _____________________
Name: ____________________________________ Relationship to minor(s): _____________________
Name: ____________________________________ Relationship to minor(s): _____________________
Name: ____________________________________ Relationship to minor(s): _____________________
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) name 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.

____________________________________ ____________________________________
Printed Name of Parent/Guardian Signature of Parent/Guardian

_______________ ____________________________________
Date Email Address