

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

<u>Allegany</u> All	<u>Baltimore City</u> ALL	<u>Harford</u> 21001 21010 21034 21040 21078 21082 21085 21130 21111 21160 21161	<u>Prince George's</u> 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	<u>Somerset</u> ALL
<u>Anne Arundel</u> 20711 20714 20764 20779 21060 21061 21225 21226 21402	<u>Calvert</u> 20615 20714	<u>Howard</u> 20763		<u>St. Mary's</u> 20606 20626 20628 20674 20687
<u>Baltimore Co.</u> 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	<u>Caroline</u> ALL	<u>Kent</u> 21610 21620 21645 21650 21651 21661 21667		<u>Talbot</u> 21612 21654 21657 21665 21671 21673 21676
	<u>Charles</u> 20640 20658 20662	<u>Montgomery</u> 20783 20787 20812 20815 20816 20818 20838 20842 20868 20877 20901 20910 20912 20913	<u>Queen Anne's</u> 21601 21617 21620 21623 21628 21640 21644 21649 21651 21657 21668 21670	<u>Washington</u> ALL
	<u>Dorchester</u> ALL			<u>Wicomico</u> ALL
	<u>Frederick</u> 20842 21701 21703 21704 21716 21718 21719 21727 21757 21758 21762 21769 21776 21778 21780 21783 21787 21791 21798			<u>Worcester</u> ALL
	<u>Garrett</u> ALL			



2111 Laurel Bush Rd. Ste H
Bel Air, MD 21015
(p) 410-569-3300 (f) 410-569-8199
www.BrightOaksPediatrics.com

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



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 _____