UNIFOUR PEDIATRICS, PA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Unifour Pediatrics, PA may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Unifour Pediatrics, PA's Notice of Privacy practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Unifour Pediatrics, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Unifour Pediatrics, PA Privacy Officer at PO Box 1347, Hickory, NC 28603.

With my consent, Unifour Pediatrics, PA may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Unifour Pediatrics, PA may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment cards and patient statements.

By signing this form, I am consenting to Unifour Pediatrics, PA's use and disclosure of my child's protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Unifour Pediatrics, PA may decline to provide treatment to my child.

_____

Signature of Parent or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Parent or Legal Guardian

UNIFOUR PEDIATRICS, PA

PARENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Unifour Pediatrics, PA to use and/or disclose certain protected health information (PHI) about my child to or for the party or parties listed below.

This authorization permits Unifour Pediatrics, PA to use or disclose to

_____

(Persons or Entities to receive the information)

the following individually identifiable health information. Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.

___ All medical information

___ Nurse Calls ___ Lab Results ___Prescription Pick up Only

This authorization will expire on _____

When my child's information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Unifour Pediatrics, PA has acted in reliance upon this authorization. My written revocation must be submitted to Unifour Pediatrics, PA's Privacy Officer at PO Box 1347, Hickory, NC 28603.

Signed by: _____ _____

Signature of Parent or Legal Guardian Relationship to Patient

_____ _____

Patient's Name (Please Print) Date of Birth

_____ _____

Print Name of Parent or Legal Guardian Date Signed

NEW PATIENT REGISTRATION FORM

Unifour Pediatrics PA www.UnifourPeds.com

Please Print, then sign & mail to: Unifour Pediatrics, Box 1347, Hickory NC 28603 … or FAX to 828-328-1119 … or deliver to the office before seen.

Today's Date:_____. Previous PCP (Primary Care Provider) … Pediatrician or Family Physician: _____

PATIENT INFORMATION

Last name:	First:	Middle:	Sex: ☐ Male ☐ Female	Primary Language: English ☐ Spanish ☐ Hmong ☐ Other ☐
Birth date:	Age:	Preferred Contact: Self ☐ Mother ☐ Father ☐		
Street address:		Email Address (if patient has one)		Home phone no.: ( )
P.O. box:	City:		State:	ZIP Code:
Grade Level (or Occupation):	School (or Employer):			School (or Employer) phone no.: ( )

MOTHER/GUARDIAN INFORMATION

Last name:	First:	Middle:		Primary Language(s): English ☐ Spanish ☐ Hmong ☐ Other ☐
Birth date:	Age:	Email Address:		
Home Street address: ☐ Same as Child		Cellular Phone: ( )		Home phone no.: ☐ Same as Child ( )
P.O. box:	City:		State:	ZIP Code:
Occupation:	Employer:		Full or Part-time: Full ☐ Part ☐	Work Phone: ( )

FATHER/OTHER GUARDIAN INFORMATION

Last name:	First:	Middle:		Primary Language(s): English ☐ Spanish ☐ Hmong ☐ Other ☐
Birth date:	Age:	Email Address:		
Home Street address: ☐ Same as Child		Cellular Phone: ( )		Home phone no.: ☐ Same as Child ( )
P.O. box:	City:		State:	ZIP Code:
Occupation:	Employer:		Full or Part-time: Full ☐ Part ☐	Work Phone: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: (or ☐ work) ( )
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Cell phone no.: (or ☐ work) ( )

CONTACTING YOU: BEST METHODS AND TIMES

Select the preferred methods of contacting you (lab reports, etc.): Comments:

☐ Mom >>>>>:	☐ by Cell Phone	☐ by Home Phone	☐ by Work Phone	Best Times:	☐ Healow Phone App	☐ Web Portal
☐ Dad: >>>>>:	☐ by Cell Phone	☐ by Home Phone	☐ by Work Phone	Best Times:	☐ Healow Phone App	☐ Web Portal
☐ Self: ☐ Other:	☐ by Cell Phone	☐ by Home Phone	☐ by Work Phone	Best Times:	☐ Healow Phone App	☐ Web Portal

CONTINUED ON THE NEXT PAGE

INSURANCE INFORMATION

(Please give your Insurance card or Medicaid or Health Choice card to the receptionist … each visit)

Person responsible for the bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Occupation:	Employer:	Employer address:	Employer phone no.:
			( )

Is this patient covered by insurance?	☐ Yes	☐ No

Please indicate **primary insurance**	☐ BCBS-NC	☐ Cigna	☐ MedCost	☐ UnitedHealthCare	☐ Primary Physician's Care

☐ WellPath	☐ Aetna	☐ Carolina Health Choice *(Please provide Health Choice Card)*	☐ Medicaid (Carolina Access Care) *(Please provide Medicaid Card)*	☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
					$

Patient's relationship to subscriber:	☐ Child	☐ Self		☐ Other	

Name of **secondary insurance** (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Child	☐ Self		☐ Other	

PURPOSE OF THE FIRST VISIT

Reason for this first scheduled visit:	☐ Routine Check-up/Physical	☐ Camp	☐ Sports	☐ School	☐ Other:
Appointment needed?:	☐ Already have one	☐ Need one – Please call me			☐ Not now

BE SURE TO SIGN HERE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Unifour Pediatrics PA and/or my health insurance company to release any information required to process my claims.

_____ _____

Patient/Parent/Guardian signature (age–dependent) *Date*

Other Forms needed: (available as downloads from the web-site: www.UnifourPeds.com)

1. Records Release Form (transfer of records) … it would be helpful to have the information prior to being seen … preferably, sent to us one week prior to the appointment.
   - ✔ Send the information to us early so that we can have your chart ready.
   - ✔ Fill the forms out prior to coming to the office ... this will reduce your waiting time.
   - ✔ this will limit the amount of paperwork when you arrive at the office.

Send this form to:
Unifour Pediatrics PA,
PO Box 1347,
Hickory, NC 28603

-or-

Deliver this form to: Map ... Directions
3411 Graystone Place, Conover
(directly across from Catawba Valley Medical Center)

-or-

FAX the forms to: 828-328-1119

Unifour Pediatrics, PA

Cancellation Policy

Failure to keep your scheduled appointments at Unifour Pediatrics, PA hinders our ability to provide the best care to our patients. So, to limit missed appointments, we have implemented a cancellation policy, effective May 1, 2010.

We ask that you show our practitioners and our other patients consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient. Please call Unifour Pediatrics, PA at **(828) 328-1118** for any changes to your scheduled appointment.

Repeated cancellations, rescheduled appointments, or no-shows are disruptive to the optimal delivery of care to you and our other patients. As a result, after three cancellations, rescheduled appointments or no-shows to Unifour Pediatrics and referrals to specialists, within 6 months, you will be discharged from our office. Of course, late cancellations due to illness or family emergency are excluded from this policy if the cancellation is in enough time to reasonably offer the appointment to another patient.

I understand the cancellation policy of Unifour Pediatrics, PA and understand my responsibility to plan appointments accordingly, and notify our office appropriately if I have difficulty keeping my scheduled appointments.

Financial Policy

Thank you for choosing us as your health care provider. Our main concern is that you receive the proper and optimal care needed to maintain/restore your health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to contact our billing staff.

Please present your current insurance ID card at every visit and if anything changes we ask that you contact us immediately. In the event we do not participate with your insurance plan you will be responsible for the entire bill.

As a service to you, our office makes every reasonable effort to obtain payment according to your coverage. Regardless of the type of insurance you have, you are ultimately responsible for paying your medical bills. If your insurance company rejects the claim or denies payment, the office will bill you for the entire amount. It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question your insurance company about any unpaid claims.

All co-payments are due and should be paid at time of service. This policy is in accordance with legal requirements for collecting patient responsibility amounts. Unresolved balances may be placed with an outside collection agency and may also be subject to finance charges, attorney fees and collection agency fees. In the case of an unpaid balance you will be dismissed from our practice.

A $25.00 fee will be charged for all checks that are returned to us by your financial institution and will be payable immediately.

Our practice accepts cash, checks, Visa, MasterCard, Discovery, and American Express for your convenience. We will ask you for your co-payment at time of service, if you are unable to pay your co-payment we may need to reschedule your appointment.

Authorization: I agree to abide by the terms of the above financial policy and accept responsibility for any balance not covered by my insurance company(s). I authorize my insurance company(s), or other parties to pay Unifour Pediatrics, PA and /or provide any information regarding payment of my bill. If my account becomes delinquent, I agree to pay all costs incurred in collection of the account, including any necessary attorney fees.

I authorize Unifour Pediatrics, PA to administer medical care as is necessary, including allowing release of records or medical reports on my condition to any party involved in my treatment.

I consent to abide by the Cancellation Policy and Financial Policy:

_____	_____	_____	_____
Parent/Guardian Signature	Date	Witness Signature	Date

Patient Name: _____ Patient Date of Birth: _____

Revised 4/24/2017

Unifour Pediatrics Appointment Confirmation Policy

Effective immediately, if your child's appointment is not verbally or electronically confirmed by 3:00 PM the day before the appointment, the appointment will be cancelled.

It is very important that you provide us with your current phone numbers so our attempt to confirm the appointment will be successful. You will receive an automated reminder call, text, or email to confirm your child's appointment. Most contact methods include an option to confirm your appointment. If we are unable to speak directly with you, we will leave a message. Leaving a message, however, does not constitute a confirmation., We must confirm the appointment with you or the appointment will be offered to another patient who may be waiting patiently for an appointment.

Thank you for your cooperation.

_____

Signature of Parent/Guardian:

_____

Patient's Name: Date of Birth:

_____ _____

Today's Date:

_____

Unifour Pediatric Associates, P.A.

Comprehensive Medicine ... Infants through College-age

David M. Millsaps, MD, FAAP, Lead Physician
Susan Huffman, CMPE, Practice Administrator

3411 Graystone Place
PO Box 1347
Hickory NC 28603-1347

Phone: (828) 328-1118
Fax: (828) 328-1119
Website: www.UnifourPeds.com

NAME OF CHILD / *NOMBRE DEL NINO* _____ DATE OF BIRTH / *FECHA DE NACIMIENTO* _____

MEDICAL HISTORY / *HISTORIA MEDICA*

I. BIRTH / *NACIMIENTO*

A. Length of Pregnancy / *Tiempo de embarazo* _____

B. Mother during pregnancy / *Madre durante el iempo de embarazo* :

1 Age / *Anos* _____

2 Prenatal Care / *Cuidados Prenatal* : Yes / *Si* _____ No / *No* _____ Where? / *Donde?* _____

3 Blood type (if known) / *Tipo de Sangare (si sabe)* : O _____ A _____ B _____ AB _____ RH: Pos _____ Neg _____

4 Illnesses (circle and give month that occurred) / *Enfermedades (circula una y el mes que occurió)*

a. severe vomiting / *severos vómitos*	_____	b. swelling / *inflamaciones*	_____
c. increased blood pressue / *alta presión*	_____	d. vaginal bleeding / *sangra miento vaginal*	_____
e. viruses (flu, colds, etc) / *virus (flu-gripe)*	_____	f. rashes / *comezón picazon*	_____
g. kidney infections / *infecciones del rinon*	_____	h. hospitalizations / *hospitalizaciones*	_____
i. depression / *depresión*	_____	j. other / *otros*	_____

5 Total weight gain / *Cuantas libras ganaste* _____ pounds / *libras*

6 Drugs taken during pregnancy / *Medicinas durante el embarazo* _____

II. C. LABOR / *EL PARTO*

1 Spontaneous / *Espontaneo* _____ Induced / *Lo indujeron* _____

2 Water broke how long before delivery? / *La fuente de agua rompió cuanto tiempo antes del parto?* ____ days / *dias* ____ hours / *horas*

3 Fever during labor or week before? / *Fiebre durante el parto o semanas antes?* Yes / *Si* _____ No / *No* _____

4 Length of labor / *Tiempo del parto* _____ hours / *horas*

5 Known distress of baby during labor? / *Extaviste estresada por la llegada del niño durante el parto?* Yes / *Si* _____ No / *No* _____

D DELIVERY / *LLEGADA DEL NIÑO*

1 Type / *Tipo* : Vaginal / *Vaginal* _____ C-Section / *Cesarea* _____

2 Presentation / Presentación: Vertex (head first) / *Cabeza primero* ? _____ Breech (buttocks first) / *Nalgas primero* ? _____

3 Condition at birth / *Condición al nace* r : _____

4 Type anesthesia / *Tipo de anestesia* : Gas / *Gas* _____ Spinal / *Espina dorsal* _____ Local / *Local* _____ None / *Nada* _____

5 Birthplace / *Lugar de nacimiento* : Hospital / *Hospital* _____ City / *Ciudad* _____ State / *Estado* _____

E NEWBORN / *RECIEN NACIDO*

1 Birth Weight / *Peso al nacer* _____

2 Blood type (if known) / *Tipo de sangre (si lo sabes)* O _____ A _____ B _____ AB _____

3 Problems in hospital nursery (respiratory difficulties, jaundice, blueness, convulsions, bleeding, feeding difficulties, deformities, others). Yes _____ No _____

If yes, explain: _____

Problemas en al enfermeria del hospital de recién nacidos (dificultad de respirar, si su niño tiene icetericia (es cuando su niño tiene la piel amarilla) tornarse azul, convulsiones Sangramientos, dificultad de comer, deformidades, y otras cosas. Si _____ No _____

Se es si, explica: _____

4 Went home on day number / *A los cuantos dias te fuiste a la casa?* _____

F MOTHER'S PREGNANCY HISTORY / *HISTORIA DE LA MADRE EMBARAZADA*

1 Total number pregnancies / *Números de embarazos* _____

2 Number of full term births / *Números de niños que han nacidos* _____

3 Number weighing less than 5 1/2 pounds / *Número de niños que han nacidos con menos de 5 libra y media* _____

4 Stillbirths or miscarrages / *Abortos* _____

5 Living children / *Niños qu viven* _____

6 This child was pregnancy number / *Esta embarazo fue el numero* _____

7 Difficulties with other pregnancies, labor, delivery or new born infants? Yes _____ No _____

If yes, explain: _____

Dificultades con otros embarazos, o a la hora del parto, o los recién nacidos? Si _____ No _____

Si es que si, explica el porque _____

III. FEEDING / *ALIMENTACIÓN*

A. Breast / *Pecho* _____ Formula / *Formula* _____ Type / *Tipo* _____

1 Weaned from breast at what age / *Le quito el pecho a que edad* _____

2 Taken off formula at what age / *Lo quito de la formula a que edad* _____

B Supplemental vitamins / *Vitaminas de suplemento* _____ Yes / *Si* _____ No / *No* How long / *Cuanto tiempo* ? _____

C Supplemental Iron / *Hierro de suplemento* _____ Yes / *Si* _____ No / *No* How long / *Cuanto tiempo* ? _____

D Any feeding problems during first year of life?

If yes, explain _____

Algun problema durante el prier ano de vida?

Se es si, esplica: _____

IV. GROWTH / *CREMIENTO* :

Separate form - please provide us with any previous height, weight, or head circumference measurements at your disposal.

Forma separada - por favor de proveernos cualquier altura, peso, o el Tamaño de la circunferencia de la cabeza

V DEVELOPMENT / *DESARROLLO* (Age child first performed the following / A la edad en que el niño comenzo hacer lo siguiente)

A Rolled Over / *Moverse de un lado a otro* _____

B Sat without support / *Sentarse sin ayuda* _____

C Stood unassisted / *Quererse parar sin ayuda* _____

D Acquired first tooth / *Cuando le salio el primer diente* _____

E Walked alone (more than 4 steps) / *Caminar solo (mas de 4 pasos)* _____

F Said first word (other than mama, dad) / *Dijo la primera palabra (otra que sea mama, dada)* _____

G Put two words together (other than bye-bye) / *Poner dos palabras juntas (otra como bye-bye)* _____

H Bladder control most of the time / *Controlando los orines el mayor tiempo* _____ daytime / *de dia* _____ nights / *de nocha*

I Bowel control most of the time / *Controlando hacer caca el mayor tiempo* _____ daytime / *de dia* _____ nights / *de nocha*

VI ALLERGIES / *ALERGIAS*

List / Lista: A: to what subtances allergic (e.g.) drugs, plants, chemicals, animals, dust foods, unknown

A. que sustancia es alérgico, medicinas, plantas, químicos, animales, polvos, y otros.

B. what type reaction experienced (e.g.) asthma, hayfever, eczema, hives, rash, etc.

B. que tipo de reacción experimenta: asma, fiebres altas, comezón o picazón, etc.

A Allergic to / *Alérgico a*	**B** Type reaction / *Tipo de reacción*
_____	_____
_____	_____
_____	_____

VII ILLNESSES / *ENFERMEDADES*

A Circle previous illnesses. Give approximate age and severity or complications / *Circula una de las enfermedades (si la ha tienido). De aproximadamente la edad y complicaciones.*

1 Asthma or wheezing / *Asma o respiración asmática* _____

2 Pneumonia / *Neumonia* _____

3 Rheumatic Fever / *Fiebre reumática* _____

4 Chickenpox / *Sarampión* _____

5 Mumps / *Paperas* _____

6 Kidney or bladder infections / *Infección de vejiga o riñones* _____

7 Seizures / *Ataques* _____

8 Other / *Ostros* _____

9 Other / *Ostros* _____

10 Other / *Ostros* _____

B List any illnesses or conditions recurring or persisting for months or years (for example; repeated ear infections, allergies, seizures)

Liste cualquier enfermedad o condición que haya persistido por meses o anos (por ejemplo, repetidas infecciones del oído, alergias, ataques)

_____

_____

C Hospitalizations (other than birth, injuries or surgery) / *Hospitalizaciones (otra vez que no sea cuando tuvo el niño, algún cortadura, o cirugía)*

Diagnosis / *Diagnostico*	Age / *Edad*	Where / *Donde*	Treatment or Outcome / *Tratamiento*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VIII INJURIES / *CORTADURAS O ACCIDENTES*

Type / *Tipo*	Age / *Años*	Where Treated / *Que Hospital*	Long-Term Effects / *Cuanto tiempo*

IX SURGERY / *CIRUGIA*

Type / *Tipo*	Age / *Años*	Where / *Donde*	Complications / *Complicaciones*

X ENVIRONMENT / *MEDIO AMBIENTE*

A Water Source / *Ague de* : _____ City / *Ciudad* _____ Well / *De pozo* _____ Other / *Otro tipo*

B Pets (list) / *Animales (liste)* _____

C Farm animals (list) / Animales de granja (liste) _____

D Foreign travel (places and dates) / Viajes a paises del extranjero (lugares y fechas) _____

_____

E Persons living in patient's home other than parents, brothers,sisters / *Personas que viven en la casa con este paciente, fuera que sea los padres, hermanos y hermanas*

1 _____ 3 _____

2 _____ 4 _____

F Any exposure to chemicals, poisons, fumes? / Cualquier exposicion a quimicos, venenos, humos? _____

XI EDUCATION / *EDUCACION*

	Yes / *Si*	No / *No*	Where / *Donde*	How Long / *Cuanto tiempo*

A Attended nursery school / *Asiste a una guardería infantil?*

B Attended Kindergarten / *Atiende al Kinder*

C Age enetered first grade / *Anos que entro al primer grado* _____ years / *anos* _____ months / *meses*

D Performance in school / *Funcionamiento en la escuela*

	Below average / *Bajo del average*	Average / *Average*	Above average / *Encima del average*
1 Overall achievement / *Realización* :			

2 Subjects of special difficulty / *Materia de dificultad* _____

3 Grades repeated / *Grado que repitió* _____

E Behavior / *Comportamiento* _____

XII IMMUNIZATIONS / *INMUNIZACIONES*

Separate form: Please provide us with any records of past immunizations form health clinics, school, or other physicians

Formas separadas: Favor de proveernos caulquier récord de immunicación del pasado, de alguna clinica, escuela, u otros medico que el haya estado

XIII SOCIAL / *SOCIAL*

A Interpersonal Relationships / *Relaciones interpersonales*

Does child have any difficulty in relationships with teachers, other family members classmates? _____

El niño tiene dificultad con su relación con sus profesores, u otros mienbros de la familia, or compañero de curso? _____

If so, explain / *Si es si, explique* _____

B Habits / *Hábitos*

Does child have any habits which have been a problem (thumb sucking, head banging, dirt eating, temper tantrums, nail biting, etc)? _____

El niño tiene algún habito que le cause problema (ponerse el dedo en la boca, menear la cabeza, comer cosas sucias, tartamudear, comerse las unas, etc.)? _____

If so, explain / *Si es si, explique* _____

C Sleep / *Dormir*

Does child have any sleep difficulties (nightmares, frequent awakening, etc)? _____

El niño tiene dificultad de dormir (pesadillas, frequentemente se levanta, etc)? _____

If so, explain / *Si es si, explique* _____

_____

_____

XIV CHILD'S FAMILY HISTORY / *HISTORIA FAMILIAR DEL NIÑO*

Member / *Miembro*	Name / *Nombre*	Year of Birth / *Fecha de Nacimiento*	Health (If deceased, give cause) / *Salud (Si esta muerto, diga la causa)*
Father / *Padre*			
Mother / *Madre*			
Brothers / *Hermanos*			
Brothers / *Hermanos*			
Brothers / *Hermanos*			
Sisters / *Hermanas*			
Sisters / *Hermanas*			
Sisters / *Hermanas*			

Is there any family history of the following including grandparents, aunts uncles, 1st cousins:
Hay alguna historia familiar que incluya los abuelos, tias, tios y primos cercanos:

1 Asthma (wheezing) / *Asma (con apretamiento del pecho)*
2 Serious Allergies / *Serias alergias*
3 Diabetes ('sugar') / *Diabático (azúcar)*
4 Convulsions (seizures) / *Ataques de convulsiones*
5 Mental retardation / *Retardado mental*
6 Blood disorders / *Desordenes en la sangre*
7 Bleeding tendencies / *Tendencia al sangra miento*
8 Thyroid disease / *Tiroides*
9 Liver disease / *El higado*
10 Kidney disease / *Riñones*
11 Rheumatic Fever / *Fiebres*
12 Childhood heart disease / *Enfermedad del corazón*
13 Birth Defects / *Problemas de nacimiento*
14 Death in first year of life / *Muerte en el primer ano*
15 Tuberculosis / *Tuberculosis*
16 Cancer / *Cáncer*
17 Obesity (overweight) / *Obesidad*
18 High blood pressure */ Alta presión*
19 Heart attacks before age 50 / *Ataque al corazón (50)*
20 Strokes before age 60 / *Ataque al corazón (60)*
21 Any other condition occuring in 2 or more family members
Cualquier otra Condición que haya ocurrido en 2 o mas en la familia

_____
_____
_____
_____

XV List any other significant information from the past or present medical history, social situation, or experiences of the patient and his family which might have an effect on his physical or emotional health.

Menicone alguna otra información que tenga del pasado o presente del historial medico, situación social, o alguna experiencia que haya tenido el paciente con su familia, o su familia haya tenido efecto de su salud emocional.

Please explain / *Si es así por favor explique*

_____
_____
_____

XVI Additional explanations, clarification or changes in this form. (Give item number and explain).

Explicación adicional, clarificación, o cambios enesta forma. (De explicación de cada articulo)

Item # / *Articulo #*	

Form Initially Completed ***Tiene que poner sus inciales para que esta forma sea completada:*** **Date / *Fecha* :** _____ **By / *Por* :** _____ **Relationship / *Relación* :** _____	Revised / *Revisado* : _____ Revised / *Revisado:* _____ Revised / *Revisado:* _____ Revised / *Revisado:*

UNIFOUR PEDIATRICS, PA

Consent to Obtain External Prescription History

I, _____, (parent or guardian of minor child, or patient if over 18 years old) whose signature appears below, authorize Unifour Pediatrics, PA and Its Affiliated Providers to obtain my child's / my (if 18 years or older) external prescription history from all sources for use in patient care.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____, _____
Patient Name Date of Birth

_____
Signature of Parent or Guardian, (or patient, if 18 years or older)

_____
Date

Revised 4/18/2017

Unifour Pediatrics Family Behavior Policy

Patient Name: _____ Date of birth: _____

This practice is a family-friendly pediatric office caring for impressionable young children and their families. Although occurrences are rare, Unifour Pediatrics feels strongly that our patients, their families, AND our staff deserve to be protected from verbal abuse and threatening, aggressive, and destructive behavior. We all need to respect each other and to "follow the golden rule".

For this reason, we have developed and strictly enforce a "No Tolerance Policy" for abusive conduct, "cussing", crude language, crude graphics or writing on clothing, threatening or aggressive behavior, vandalism, damage to property, larceny, and marking on or graffiti to walls, cabinets or other inappropriate surfaces. These restrictions apply to any such actions toward patients, other family members and visitors, and Unifour Pediatrics staff. You are also responsible for the actions of your children and other accompanying family members and friends. Visitors should never open or go through examination room drawers, potentially contaminating medical supplies and causing us to dispose of such items. Furthermore, these rules shall also apply to telephone calls and written communications to our office staff and clinicians. We expect a civil and harmonious environment for our pediatric patients, families, visitors, and staff.

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. (We will provide up to 30 days of emergency care while you are completing this transfer of care.) 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 necessary. We may press charges at our discretion.

Thank you for your interest in making the Unifour Pediatrics office and grounds a wholesome and safe, family-friendly environment.

Signed: _____ Relationship: _____

Printed name: _____ Date: _____

Unifour Pediatrics Vaccine Policy

Revised 4/19/2017

Patient Name: _____, Date of Birth: _____

At Unifour Pediatrics, we strongly believe that having your child immunized on time is essential to maintaining not only the health of your child, but also the health of the community at large.

We are not a "delayed-immunizing" or "non-immunizing" pediatric practice. If such is your intention, then we are not the appropriate pediatric office choice for your family, and we suggest that you seek medical care elsewhere. Of course, in cases of significant acute febrile illness and/or rare specifically defined medical conditions (defined by the CDC, AAP, ACIP, etc.) we may temporarily delay vaccines until the specified medical condition resolves. When the problem resolves, you are expected to reschedule immunizations, and to not ignore the need to "catch these up" without delay.

We firmly believe that your child should be vaccinated as recommended by the Advisory Committee on Immunization Practices (ACIP) originating from the CDC and endorsed by the American Academy of Pediatrics. **It is our policy that our patients receive the recommended vaccinations according to the ACIP schedule, and at a minimum the required vaccinations for NC. Your child's care here will be terminated if you choose to withhold the required immunizations from your child** (see reverse side of this document for the required vaccines, internet links to recommended schedule, and for additional immunization information from reputable sources). We feel strongly about vaccinations, because we believe that immunizations are best for your child's health. This is why we, as knowledgeable healthcare providers, uniformly immunize our own children and grandchildren per this schedule, and without hesitation or concern.

Regarding specific recommended but not required vaccines: Certain vaccines (Rotavirus, Hepatitis A, Human Papillomavirus (HPV), and Influenza) are not yet required by the state of NC, but are uniformly recommended by the CDC, ACIP, AAP. AAFP, etc.. In you choose NOT to receive or delay one or more of these specific vaccines, then you will be required to sign a liability release form. By signing this declination form, you (and not Unifour Pediatrics PA) will assume responsibility for a potential subsequent illness, health problem (or even death) from a specific infectious disease, when the child is left unprotected by not having received the related immunizations.

Vaccines are among the best researched treatments for children, and have, over the decades, dramatically decreased the death rate in children. Multiple large well-researched scientific studies show that the vaccines are safe and *do not* cause permanent neurologic or developmental diseases in children (as has been touted in the past by celebrities, anecdotal stories, and sensational non-scientific websites). Furthermore, it is essential to keep immunization rates high so that we do not experience outbreaks or resurgences of many of these easily transmittable diseases.

For further information, consult the CDC or AAP websites. For additional immunization information, visit the National Network for Immunization Information, and the internet links on the reverse side of this document.

Signed: _____ Relationship: _____

Printed Name: _____, Date: _____

See reverse side for links and information

Immunizations for Children

Recommended Schedule

The complete list of vaccines and the ages at which children ought to receive doses of vaccine is called a vaccine schedule. You can find the immunization schedule for children and a catch up immunization schedule for children and adolescents here:

- Childhood Immunization Schedule
- Catch up Immunization Schedule for Children and Adolescents

Required vs. Recommended in North Carolina All children in North Carolina are required to be vaccinated against:

- Diphtheria
- Hepatitis B
- Hib Disease
- Measles
- Meningococcal
- Mumps
- Pertussis (whooping cough)
- Pneumococcal
- Polio
- Rubella
- Tetanus
- Varicella (chickenpox)

The CDC also recommends children be vaccinated against the following diseases, although immunization against these diseases is not required for children in North Carolina:

- Hepatitis A
- Influenza
- Rotavirus
- Human Papillomavirus

For details, please refer to: http://www.immunize.nc.gov/family/nc_immnz_requirements.htm
(Specifics from North Carolina: The link shown above will be updated as changes are made over time)
National Network for Immunization Information: http://www.who.int/vaccine_safety/initiative/communication/network/NNii/en/
CDC Information experts: https://www.cdc.gov/vaccinesafety/index.html
https://www.cdc.gov/vaccines/parents/protecting-children/index.html
https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
American Academy of Pediatrics – Expert immunization information:
https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunization/Pages/default.aspx
Other resources: http://www.vaccinateyourbaby.org/ and http://www.vaccineinformation.org/
For multiple immunization links: http://www.unifourpeds.com/WellChildCheckupsList.aspx#Immunizations