

Chapel Hill Pediatrics and Adolescents, PA
Newborn New Patient Demographics Sheet
Please print clearly.

Date _____ / _____ / _____ Form Completed By _____

Child's Name _____ Nickname _____

M () F () Birth Date (DOB): _____ / _____ / _____ Child's SS# _____ - _____ - _____

Race _____ Ethnicity: Hispanic Non Hispanic Primary Language _____

Address _____
 Street _____ City _____ State _____ Zip _____

***Best contact phone# (_____) _____ - _____ home cell work

Alternate # (_____) _____ - _____ home cell work Whose _____

Alternate # (_____) _____ - _____ home cell work Whose _____

Alternate # (_____) _____ - _____ home cell work Whose _____

Preferred Email Address: _____

Preferred method of communication: Text E-mail Phone

How did you hear about Chapel Hill Pediatrics? _____

Family Information

Parent's Name _____ SS# _____ - _____ - _____ DOB _____ / _____ / _____

Occupation _____ Employer _____

Parent's Name _____ SS# _____ - _____ - _____ DOB _____ / _____ / _____

Occupation _____ Employer _____

Emergency Contact (other than parent) _____ Relation to child _____

Home # (_____) _____ - _____ Work# (_____) _____ - _____ Cell # (_____) _____ - _____

Please list all those living in the child's home:

Name	Date of Birth (DOB)	Relationship to child	Health problems	Occupation (adults)

Are there siblings not listed above? If so, please list their name(s), date(s) of birth, and where they live:

Patient Past History

Patient Name: _____ Date of Birth (DOB): ____ / ____ / ____

General	YES	NO	Explanation
Is your child in good health?			
Does your child have any serious illnesses?			
Has your child has any surgery? What/when?			
Has your child been hospitalized? When?			
Has your child ever been to the emergency room (ER)? When?			
Has your child ever seen a specialist? Whom?			
Does your child take any medications regularly?			
Is your child allergic to medicine or drugs? Which ones?			
Is your child exposed to smoke at home (even outside)?			

What is the child's living situation?

Both Biological Parents Foster Family Single Custody
 Adoptive Parent(s) Joint Custody Other

Please describe if needed: _____

Birth History

I don't know birth history

Birth weight: ____ lbs ____ oz

Was the baby born:

At term (38 – 41 weeks) Early; ____ weeks Late; ____ weeks

Where there any complications with pregnancy, delivery, or immediately after birth?

No Yes, please explain: _____

Was a NICU (neonatal intensive care unit) stay required?

No Yes, please explain: _____

During pregnancy, did mother:

<input type="checkbox"/> Use tobacco	<input type="checkbox"/> Use Drugs or Medications (what, when) _____
<input type="checkbox"/> Drink alcohol	<input type="checkbox"/> Use Prenatal Vitamins

Was the delivery:

Vaginal Cesarean: Why? _____

Was baby's initial feeding:

Formula Breast milk: How long breastfed _____

Was the baby discharged from the hospital at the same time as the mother?

Yes No, please explain _____

Family History

Patient Name: _____ Date of Birth (DOB): ____ / ____ / ____

Directions:

If you answer yes to any of the following questions, please provide more details under "comments"

Child being seen	Sibling(s)	Biological Father	Biological Mother	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other relatives (list)
Have any biological family members had...?								Comments
Childhood hearing loss								
Nasal allergies/ hay fever								
Asthma								
Food Allergies								
Cystic Fibrosis								
Tuberculosis/ positive PPD								
Stroke (before 55 years old)								
Heart disease (before 55 years old)								
High cholesterol/takes cholesterol medication								
Anemia								
Bleeding disorder/hemophilia								
Dental decay								
Cancer (before 55 years old)								
Liver disease								
Kidney disease								
Diabetes (before 55 years old)								
Bed wetting (after 10 years old)								
Obesity								
Epilepsy/convulsions/seizures								
Alcohol abuse								
Drug abuse								
Tobacco abuse								
ADHD								
Anxiety								
Depression								
Mental health problems								
Autism								
Developmental disability								
Birth defects/chromosomal abnormalities								
Immune problems, HIV, or AIDS								
Migraine headaches								
Lazy eye								
Vision problems								
Hip dysplasia								
Hip problems								
Any other significant problem								

Consent for Treatment of a Minor Child

I, being the parent or guardian of the following patient(s):

Patient Name	Date of Birth

do hereby request and authorize **Chapel Hill Pediatrics and Adolescents, PA Physicians and Staff** to perform necessary services for my child(ren) which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have my permission to bring my child(ren) in for treatment:

Patient(s) by him/herself *if* age 16 years or older.

Name: _____ Relationship to Child: _____

Signature of Parent or Guardian

Date

Printed Name of Parent or Guardian

Witness Signature

Date

****Consent in effect until changed****

Chapel Hill Pediatrics and Adolescents, P.A.

Waiver Form

Patient Name: _____

Account Number: _____ Date of Service: _____

Name of Health Insurance: _____

Treatment/Procedure:

Sick Visit Follow-up Visit Nurse Immunizations
 Physical Exam Labs Consultation

It is the policy of Chapel Hill Pediatrics and Adolescents, P.A. that the person who initiates services for a child is the party responsible for payment. **WE DO NOT BILL ANOTHER PERSON OR AN ESTRANGED SPOUSE.**

No insurance card was presented at the time of service.
 New insurance/I have not received my card.
X New infant that is not yet added as a dependent.

In the event that services are not covered or not authorized, I understand all charges incurred will be my sole responsibility. I understand I have not presented my current insurance card at the time of service. I also understand, should my insurance carrier deny coverage for the date of service, that all charges incurred will be my responsibility.

Signature of Parent or Policy Holder

Date

Printed Name of Parent or Policy Holder

Authorization for Release of Information/Communication

Patient(s) Name: _____ DOB: _____

Chapel Hill Pediatrics and Adolescents, P.A. is authorized to release Protected Health Information regarding the above-named patient(s) to the Legal Guardian(s) in the following manner:

- Voicemail
 - Lab Results
 - Appointment Reminders
 - Other _____
- Text
 - Appointment Reminders
 - Other _____
- For text communication: I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive text communication as selected.
- Photos of the patient(s)
 - To be received from the patient or legal guardian
 - To be taken by staff members
 - To be posted in the Clinic
 - To be posted on the Chapel Hill Pediatrics Website

We grant access to the following people to have access to the patient(s)

FINANCIAL and/or MEDICAL information:

Name and Phone #: _____

Patient Rights:

- I have the right to revoke this authorization at any time
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and my treatment will not be conditioned on signing.
- This authorization will remain in effect until revoked by the patient or guardian.

Signature of Guardian: _____ Date: _____

Chapel Hill Pediatrics and Adolescents, PA

Patient Payment Policy

Revised: June 2025

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

Insurance

- Please provide a copy of your insurance card at each visit.
- We participate with most insurance plans. Your insurance coverage and benefits are a contract between you and your insurance company. Each plan has different benefits as well as different financial obligations. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits.
- We are required to file with your primary insurance. If you have secondary insurance that we are in network with, then we can file your secondary insurance. If you have secondary insurance that we are **NOT** in network with, then it is your responsibility to file any charges with them for reimbursement.
- **If you have insurance coverage under a plan with which we do not have a contract**, you will be treated as a "self-pay" (cash pay) patient and will be provided documentation to assist you in filing your own claim. We offer a reasonable discount for our cash paying patients. We will give you an estimate of what will be due at the time of service.
- We cannot extend professional courtesy discounts.

Payment

Payment is expected at the time of service. This includes co-pays, co-insurance, balances, and deductibles.

As a courtesy to our patients, we gladly accept check, Visa, MasterCard, American Express and Discover. **We do not accept cash.**

- **Yearly deductible plans:** Families who must meet yearly deductibles will be required to pay \$75.00 at the time of service. A claim will be generated to your insurance company so that this amount will be credited to your deductible. In addition, we require a copy of your health savings account debit/credit card or a personal debit or credit card to remain on file in our office. Your card will be charged, and a receipt generated once your insurance company sends us your explanation of benefits for the claim. If there has been an overpayment, we will issue you a refund check the following business day.
- In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. **We do not bill another individual or estranged spouse for payment.**
- **We require debit, credit card, or HSA card on file for all insurance coverage, except for Medicaid. This allows us to obtain payment for balances left on your account after insurance processes or for unpaid copayments.**

Appointments and Cancelling Services

Initials: _____

- An appointment written in our schedule with your child's name on it is a bond of trust that we will be here to serve you, and you will be present for that appointment. The appointment is made with your approval and is considered confirmed whether or not you receive a reminder e-mail, call, or postcard. Running behind schedule may occur due to attending to unanticipated needs of other patients.
- We require 24 hours' notice to cancel prescheduled appointments and 2 hours' notice to cancel a same day appointment. **We charge a \$75 no-show fee for missed appointments.** We cannot accept cancellations of appointments left through Phreesia.

Balances

- Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.
- **No balance over \$500.00 can be carried on a family account.**
- Accounts **may be** turned over to a collection agency if past due 60 days or more. The patient family will be responsible for all collection costs involved with the collection of this account including court cost, reasonable attorney fees and all other expenses incurred with collection if there is a default on any unpaid balance.
- **Should you have extraordinary financial pressures, we will assist you with a payment plan.**

Form Fees

- A fee of \$10 will be assessed for each **camp** form.
- A \$35 expedition fee will be assessed for any form requiring completion in less than 5 business days.

After Hours Nurse/Triage Calls

- For patients over 2 months of age, within North Carolina, a fee of \$16 will be assessed for each after hours/weekend triage call.

Urgent Care Hours/Holidays

- Appointments Monday – Friday before 8am and 5pm or later, appointments during our weekend hours Saturday and Sunday 8am until 12pm, and same day appointments during a holiday are considered to be “urgent care.”
- There is a fee of up to \$45 for each urgent care visit. This fee will be billed to the insurance we have on file.

Important note about Billing:

Insurance companies have very specific regulations about billing for health care services. As your health care providers, we are required to follow those regulations in how we report services provided to you. All physicians/providers must report to the insurance company in a universal code system linked to the service, treatment or procedure provided. **It is not uncommon for a patient to receive a regular check-up and an evaluation of an acute or chronic illness (ex: ADD/ADHD, asthma, earaches, and sore throats). In these cases, your insurance may be billed for a well child exam and an additional office visit.**

Further examples:

- Your child is evaluated and treated for an ear infection as well as examined for his well child exam. Both services must be reported to the insurance company.
- A child with asthma may have his/her asthma evaluated at the same time as the well child exam. Again, both services must be reported to the insurance company.

Insurance companies handle these reported codes differently. **Some insurance companies may require an additional co-pay to cover the charge and/or the charge may go towards your co-insurance or deductible; this is determined entirely by your insurance company.** If you have questions, please check with your insurance carrier.

We appreciate the opportunity to participate in your family's healthcare. As always, we are dedicated to providing the best possible care for your family. If our billing office can help, please contact them at 919-942-4173 extension 896.

I have read both pages of the above financial policy and understand and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles are my responsibility.

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian

Chapel Hill Pediatrics and Adolescents, PA

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name and Address (print clearly):

I have received a copy of the Notice of Privacy Practices for the above named practice.

Signature

Date

Printed Name

For Office Use Only

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for signature by return mail.
- Unable to communicate with the parent for the following reason:

 Other: _____

Prepared by _____

Signature _____

Date _____

Chapel Hill Pediatrics and Adolescents

Notice of Privacy Policies

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions about this notice please contact the Privacy Officer.

Effective Date: April 14, 2003 Revised: April 11, 2023

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: www.chapelhillpeds.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practices that may provide medical care for you such as home health agencies.

We participate in an Organized Health Care Arrangement with providers in the UNC Health Alliance. We may use your PHI for our own health care operations and for those of the Organized Health Care Arrangement in which we participate.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or to improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclose your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal Proceedings: To assist in any legal proceedings or in response to court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law.
- Medical Research: We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional Institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by use as authorized to comply with workers' compensation laws and other similar legally established programs.

Other uses and disclosure of your health information:

- Business Associates: Some services are provided through the use of contracted entities called "business associates." We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. Examples of business associates include billing companies or transcription services.
- Health Information Exchange: We may make your health information available electronically to other health care providers outside of our facility who are involved in your care.
- Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object:

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share this information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care or your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing.

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: We must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12-month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about privacy practices you can contact:

Practice Administrator, 919-942-4173 x 199

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective 4/2003, revised 4/2023.

TYLENOL/ ACETAMINOPHEN DOSING

Give every 4 to 6 hours, as needed, no more than 5 times in 24 hours.

Consult your doctor if fever persists for more than 3 days or pain last more than 5 days.

Child's Weight	Child's Age	Infant Suspension 160mg/5ml	Children's Suspension (liquid and elixir) 160mg/5ml	Children's Tablets 80mg in each tablet	Junior Strength 160mg in each tablet
6-11 lbs (2.7- 5.4 kg)	0-3 months	1.25 ml	---	---	---
12- 17 lbs (5.5- 7.9 kg)	4- 11 months	2.5 ml	½ teaspoon	---	---
18- 23 lbs (8.2- 10.5 kg)	12- 23 months	3.75 ml	¾ teaspoon	---	---
24- 35 lbs (11- 15.9 kg)	2- 3 years	5 ml	1 teaspoon	2 tablets	---
36- 47 lbs (16- 21.9 kg)	4- 5 years	---	1 ½ teaspoons	3 tablets	---
48- 59 lbs (22- 26.9 kg)	6- 8 years	---	2 teaspoons	4 tablets	2 tablets
60- 71 lbs (27- 31.9 kg)	9- 10 years	---	2 ½ teaspoons	5 tablets	2 ½ tablets
72- 95 lbs (32- 43.9 kg)	11 years	---	3 teaspoons	6 tablets	3 tablets

ADVIL/ MOTRIN/ IBUPROFEN DOSING

Give every 6 to 8 hours, as needed, no more than 4 times in 24 hours. Do not use for more than 3 days for fever or pain unless directed by a physician.

Child's Weight	Child's Age	Infant Suspension 50mg/1.25ml	Children's Suspension (liquid and elixir) 100mg/5ml	Children's Tablets 50mg in each tablet	Junior Strength 100mg in each tablet
12- 17 lbs (5.5- 7.9 kg)	6-11 months	1.25 ml	---	---	---
18- 23 lbs (8.2- 10.5 kg)	12- 23 months	1.875 ml	¾ teaspoon	---	---
24- 35 lbs (11- 15.9 kg)	2- 3 years	---	1 teaspoon	2 tablets	---
36- 47 lbs (16- 21.9 kg)	4- 5 years	---	1 ½ teaspoon	3 tablets	---
48- 59 lbs (22- 26.9 kg)	6- 8 years	---	2 teaspoons	4 tablets	2 tablets
60- 71 lbs (27- 31.9 kg)	9- 10 years	---	2 ½ teaspoons	5 tablets	2 ½ tablets
72- 95 lbs (32- 43.9 kg)	11 years and up	---	3 teaspoons	6 tablets	3 tablets

1 teaspoon = 5 ml

Avoid Aspirin- Children should not take aspirin if they have symptoms of a cold or viral infection. Aspirin has been linked to a severe illness called Reye's syndrome

Recommended Immunization Schedule

Birth	Hep B
2MO	Pediarix (Dtap, Hep B, Polio), Rotavirus, Prevnar 13, HIB* ~ Must be at least 6 weeks old~
4MO	Pediarix (Dtap, Hep B, Polio)*, Rotavirus, Prevnar 13, HIB* ~ Must be at least 4 weeks after 2MO Shots~
6MO	Pediarix (Dtap, Hep B, Polio)*, Rotavirus, Prevnar 13 ~ Must be on or after 6mo birthday~
12MO	MMR*, Varivax (Varicella)*, Hep A ~ Must be on or after 1st Birthday~
15MO	HIB*, Prevnar
18-24MO	DTap*, Hep A ~ Must be at least 6 months after 1st dose~
4-6YRS	MMR*, Varivax (Varicella)*, Kinrix (DTap, Polio)* ~ Must be on or after 4th Birthday~
10YRS	Tdap, Gardasil (HPV)
11YRS	Meningococcal*, Gardasil (HPV)
16YRS	Meningococcal Booster (*required for college entry)
16-18YRS	Meningococcal B (+ booster 6 month later) * OPTIONAL
Yearly	Influenza (as early as August or when supplies come in)

* = North Carolina School Entry Requirement

Well Baby Check-ups

Birth

2 Weeks

1 Month

2 Months

4 Months

6 Months

9 Months

12 Months

15 Months

18 Months

24 Months

30 Months

36 Months

Yearly

Chapel Hill Pediatrics and Adolescents

Vaccine Policy

Your pediatric providers at Chapel Hill Pediatrics and Adolescents (CHPA) care deeply for the health and well-being of your child. One of the most essential services we provide our patients is vaccination against life-threatening diseases. Our practice believes in the safety and effectiveness of vaccines and supports the recommended vaccine schedule published by the American Academy of Pediatrics (AAP).

1. Adherence to Immunization Guidelines:

- a. Our practice advises that all children and adolescents adhere to the vaccine schedule published by the American Academy of Pediatrics <https://www.healthychildren.org/English/safety-prevention/immunizations/Pages/Recommended-Immunization-Schedules.aspx>

2. Vaccinations for School Entry:

- a. Our practice advises that children and adolescents receive all vaccines that are required for school entry by the state of North Carolina.

<https://www.dph.ncdhhs.gov/programs/epidemiology/immunization/schools>

- b. Vaccines that are not required for school entry but are part of the AAP vaccine schedule are strongly encouraged but remain optional for patients. (Rotavirus vaccine, Hepatitis A vaccine, Human Papillomavirus vaccine)

- c. Seasonal vaccinations are not required for school entry but are part of the AAP vaccine schedule and remain optional for patients.

(Influenza, Covid and RSV antibody)

3. Documentation and Compliance:

- a. For new patients to our practice starting January 1, 2026, a plan must be documented to ensure that vaccines will be received. Delaying or altering the vaccine schedule puts children and adolescents at risk for developing serious illnesses. If families chose to split vaccines between the well child/adolescent visits then these patients will need to be up to date by age two, six, twelve and seventeen years of age with the required vaccines for school entry.

- b. Patients that have a medical exemption due to an acute illness or chronic medical condition will have a plan documented for when it is advised that they receive vaccines.

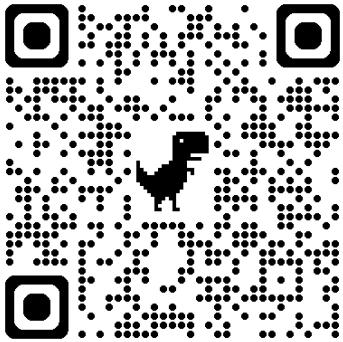
- c. For existing patients that have had an alternate vaccine schedule or have not received vaccines, our practice will continue to provide care for these patients. We will continue to provide education and updates regarding vaccines and encourage you to consider vaccination to help protect your child and provide community immunity. Vaccination declination forms will be signed and scanned into the medical record. New siblings born after January 1, 2026, will need to adhere to this vaccine policy.

- d. As indicated above, vaccines that are not a requirement for school entry in North Carolina are strongly encouraged but remain optional for patients.

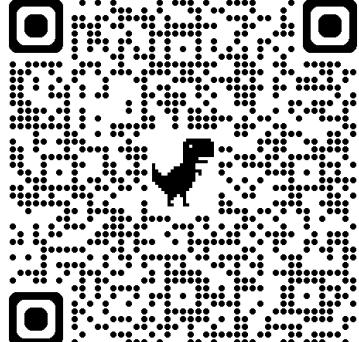
4. New Patients Non-compliant with our Vaccine Policy

a. New patients entering our practice after January 1, 2026, that do not intend to follow the vaccine schedule published by the AAP and our vaccine policy, except for a documented medical reason, will need to find another healthcare provider.

The development of vaccines is considered one of the greatest public health advances of the past century. Our practice has created this policy to protect children and adolescents from life-threatening diseases that are preventable. We are dedicated to the health and well-being of our patients and community.



State of NC required vaccines for School



American Academy of Pediatrics

Signature of Parent/Guardian

Date

Printed Name of Parent/Guardian