Chapel Hill Pediatrics and Adolescents, PA

New Family Demographics Sheet

Please print clearly.

Date _____ /_____ /_____ Form Completed By _____

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? _____

Child's Name _____Nickname _____

M ( ) F ( ) Birth Date (DOB): _____/_____/_____

Race _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language _____

Child's Name _____Nickname _____

M ( ) F ( ) Birth Date (DOB): _____/_____/_____

Race _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language _____

Child's Name _____Nickname _____

M ( ) F ( ) Birth Date (DOB): _____/_____/_____

Race _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language _____

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 # (_____) _____ –_____

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

_____

_____

_____

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"

Have any biological family members had…?	**Child being seen**	**Sibling(s)**	**Biological Father**	**Biological Mother**	**Maternal Grandfather**	**Maternal Grandmother**	**Paternal Grandfather**	**Paternal Grandmother**	**Other relatives (list)**	**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****

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 of 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 of 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.

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

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.

<u>There is one exception</u>: 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.

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?			

Does your child have or has your child ever had:	YES	NO	WHEN?	Explanation
Chicken pox				
Frequent ear infections				
Hearing loss or problems with ears or hearing				
Nasal allergies/hay fever				
Problems with eyes or vision				
Asthma, bronchitis, bronchiolitis, or pneumonia				
Any heart problem or heart murmur				
Anemia or bleeding problem				
Blood transfusion				
Immune problems, HIV, or AIDs				
Frequent abdominal pain or constipation				
Urinary tract infections or problems				
Bed wetting (after 5 years old)				
Metabolic/genetic/chromosomal disorders				
Cancer				
Sleep problems or snoring				
Chronic or recurrent skin problems (acne/eczema)				
Frequent headaches				
Convulsions/seizures or other neurologic problems				
Obesity				
Diabetes				
Thyroid or other endocrine problems				
High blood pressure				
History of serious injuries/fractures/concussions				
Use of alcohol, tobacco, or drugs				
Smoke exposure in the home (even outside)				
ADHD				
Anxiety, depression, or mood problems (specify)				
Autism or developmental delay/difference				
Dental decay				
History of family violence				
Sexually transmitted infections				
Pregnancy				
(for girls) Problems with periods				
Any other significant problem (specify)				

Patient Past History (continued)

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

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

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

What is the child's living situation, if not with both biological parents?

___ Adoptive Parents ___ Joint Custody ___ Mother with Partner ___ Other

___ Foster Family ___ Single Custody ___Father with Partner

Please explain: _____

_____

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:

☐ Use tobacco ☐ Use Drugs or Medications (what, when) _____

☐ Drink alcohol ☐ 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 _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____
(Print Patient's Full Name) (Birth Date: mm/dd/yyyy)

_____ _____
(Street Address) (Cell Phone Number)

_____ _____
(City, State, Zip Code) (Home Phone Number)

At the request of the individual, I _____, do hereby authorize:
(Parent/**Child if over 12**)

_____
(Name of Facility/Previous Doctor's Office)

_____
(Address of Facility/Previous Doctor's Office including State and ZIP Code)

_____
(Phone/Fax Number of Facility/Previous Doctor's Office)

To release:
___Progress notes___ Pathology Reports___ Other Doctor Notes ___ Lab Reports___ OB/GYN Notes ____ All Records
___Radiology Reports___Hospital Notes___ECG/EEG/Cardio___Other:_____

I do / Do Not: Authorize release of information related to AIDS/HIV, or any other communicable diseases, psychiatric care, and/or psychological assessments, along with treatment for alcohol and/or drug abuse.

Information Release To: **Chapel Hill Pediatrics and Adolescents, P.A.**
205 Sage Road, Suite 100
Chapel Hill, NC 27514
(P) 919-942-4173 (F) 919-933-3473

Purpose of disclosure: ____Referral to Specialist ____Insurance ____ Worker's Comp____ Legal Investigation
____ Disability ____ Personal ____Relocated____ Other (specify):_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that I may REVOKE this authorization at any time.

Reason for transferring:_____

I understand that I am solely responsible for any fees incurred in copying and/or obtaining these records.

_____ **Date:** _____
Patient signature if over 12 yrs.

_____, _____ **Date:** _____
Signature of individual or guardian or personal representative of patient's estate. **Relationship to patient**

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