Weiss Pediatric Care

2201 Cantu Court, #117 Sarasota, FL 34232 | P: 941-552-8341 | F: 941-487-8025 | weisspediatriccare.com

PATIENT INFORMATION

Name of Patient and all Siblings (First, Middle, Last Name)	*Sex*	*Birth Date*
*1.*_____	☐M ☐F	_____
*2.*_____	☐M ☐F	_____
*3.*_____	☐M ☐F	_____
*4.*_____	☐M ☐F	_____
*5.*_____	☐M ☐F	_____

Preferred Language* (Patient) ☐English ☐Spanish ☐Other _____

Race*☐American Indian or Alaskan Native ☐Asian ☐Black ☐Hawaiian Native or Pacific Islander ☐White ☐Declined to Answer

Ethnicity* ☐Hispanic ☐Non-Hispanic ☐Other _____

Preferred Contact Method for general messages: ☐Phone ☐Text ☐Home Email ☐Work Email

Preferred Contact Method for appointment reminders & recalls: ☐Phone ☐Text ☐Home Email ☐Work Email

Best telephone contact number: _____ ☐ home ☐cell ☐work

*WPC requests information of Language/Ethnicity/Race to meet Federal Meaningful Use criteria.

PARENT OR GUARDIAN INFORMATION

Responsible Party Name _____ *Other Parent or Guardian*_____

Relationship to Patient _____ Relationship to Patient_____

Birth Date _____ Birth Date _____

Address_____ Address_____

City_____ State ____ Zip _____ City_____ State ____ Zip_____

Occupation _____ Occupation _____

Employer _____Employer _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

Email _____ Email _____

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Patient(s) Lives With _____ Referred by_____

How may we address you? ☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Mom ☐Dad ☐Other_____

How did you hear about us? _____

INSURANCE INFORMATION – (Please provide a copy of your Insurance Card)

Please list below additional persons who may bring the child to appointments, or who we are authorized to communicate with regarding visits, medical information, etc. Example: Step-Parents, Grandparents, Nanny, etc.

Contact Name: _____Relationship: _____Phone # _____

Contact Name: _____Relationship: _____Phone # _____

Contact Name: _____Relationship: _____Phone # _____

Contact Name: _____Relationship: _____Phone # _____

EMERGENCY CONTACT INFORMATION

In an emergency please contact (other than above) _____

Relationship_____ Phone (___)_____

CONSENT FOR PAYMENT/ASSIGNMENT OF INSURANCE BENEFITS/PRIVACY POLICY

- I understand that I am financially responsible for all professional charges that I may incur. Payment for these services is due at the time of service. Patients covered under a contracted insurance plan are required to pay any co-payment, deductible, or co-insurance at the time of service or promptly when billed. I understand that Insurance Cards should be presented at EVERY VISIT
- I hereby authorize payment of medical benefits directly to Weiss Pediatric Care. I further authorize the release of any medical information nec4essary for processing the insurance claim. I understand that all costs not paid by insurance will become my responsibility unless otherwise prohibited by state or federal regulations.
- Acknowledgment of Receipt of HIPAA NOTICE OF PRIVACY PRACTICES: I have received, or have been given the opportunity to receive, a copy of HIPAA Notice of Privacy Weiss Pediatric Care, LLC.

SIGNATURE

_____ _____

Patient (Over 18)/Parent/Guardian Signature *Date*

WEISS PEDIATRIC CARE

NEW PATIENT MEDICAL HISTORY
Newborns to 6 Months

Thank you for taking the time to provide the following information that is very important to your child's health.

Child's name: _____ Birth date: ___/__/_____
Where was your child born? _____ Is child adopted or fostered? Y__ N__
Has your child *ever* previously been seen *in this practice*? Y__ N__

If you answer **YES** below, please check which **BIOLOGICAL RELATIVE** has the condition: **Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather**
List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	NO	YES	If YES - Please check which biological relative						
			Mom	Dad	Sib	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Type 1									
Type 2									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Mental retardation or developmental disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Obese or overweight									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

SOCIAL HISTORY	No	Yes	
Lives with both mother and father in same house			
If no, please explain custody/living arrangements			Lives with:
Does non-custodial parent have visitation rights?			
Are there siblings?			Live in same house?
Are there pets in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			
Other issues:			

Birth Weight:_____lb_____oz Birth Length:_____inches

NEWBORN HISTORY – while in hospital	**No**	**Yes**	**If YES - explain**
Resuscitation at delivery (needed help to start breathing/crying)			
Premature infant			
Did NOT get vitamin K and / or eye prophylaxis			
Feeding: Breast milk or formula? Or both?			
Hypoglycemia (low blood sugar)			
Hypothermia (low temperature)			
Sepsis screening lab work (to check for infection)			
Elevated Bilirubin (jaundice)			
Circumcision			
Delayed passage of first bowel movement			
Heart Murmur			
Breathing problems			
Needed oxygen or help breathing			
Needed antibiotics while in nursery			
Apnea (stopping breathing)			
Needed head ultrasound			
Needed ophthalmologic (eye) exam			
Other issues:			
MOTHERS PRENATAL HISTORY	**No**	**Yes**	**If Yes - explain**
Was this an assisted conception? (required help getting pregnant)?			
Was this a High-Risk Pregnancy?			
Did you have Amniocentesis / CVS?			
Did you have little or late prenatal care?			
Did you use alcohol or tobacco while pregnant?			
Did you use any non-prescription drugs while pregnant?			
Was there any problem with your maternal health?			
Was there any problem with the baby before birth?			
Water broke more than 24 hours before delivery?			
Did you have antibiotics or other medications during labor?			
Was your labor induced (started by medications)?			
Was this delivery vaginal or by C-section?			
Was there meconium (green bowel movement) present when your water broke?			
Other Issues:			

What else, if anything, would you like us to know regarding your baby's health?

I attest that all the medical history information is true and correct to the best of my knowledge:

Signature: _____ Relationship to patient: _____

Print Name: _____ Today's Date: _____/_____/_____

Rev: 05.11.2018

WEISS PEDIATRIC CARE

NEW PATIENT MEDICAL HISTORY
6 Months & Older

Thank you for taking the time to provide the following information that is very important to your child's health.

Child's name: _____ Birth date: ___/___/_____
Where was your child born? _____ Is child adopted or fostered? Y___ N___
Has your child *ever* previously been seen *in this practice*? Y___ N___

BIRTH HISTORY
Birth Weight: lbs. oz. Vaginal birth? C-section?
Was the baby: (circle one) Full term Early Late
If early, how many weeks gestation?
Did the baby have any problems right after birth?
Did mother have any problems with the pregnancy?

PATIENT ALLERGIES	**No**	**Yes**	If No - explain
This child does not have any known Drug Allergies			
If you answered No - Is your child allergic to:			
Penicillin (Amoxicillin, Augmentin)			
Cephalosporins (Omnicef, Keflex, Rocephin, Ceclor, Suprax)			
Sulpha (Septra/Bactrim)			
Zithromax/erythromycin			
Other Antibiotics or medications? Give name:			Reaction:
Peanuts or other nuts – Give name or Group:			Reaction:
Milk			
Eggs			
Seafood			
Other Foods – give name here:			Reaction:
Bees / Wasps			
Indoor Allergens (pets, molds, dust)			
Outdoor Allergens (trees, weeds, pollens)			
Latex			
Other Allergies:			Name:
PATIENT SOCIAL HISTORY	**No**	**Yes**	
Does patient live with both mother and father in same house?			
If no, please explain custody/living arrangements			Lives with:
Does non-custodial parent have visitation rights?			
Are there siblings?			Live in same house?
Are there pets in the home?			
Are there smokers in the home?			
Are there guns in the home?			
Are guns locked and kept separate from ammunition?			

PATIENT - PAST MEDICAL HISTORY	No	Yes	If Yes – explain
Serious accidents or injuries			
Surgeries			
Hospitalizations			
Chicken Pox Disease			What age:
Frequent ear infections or sinus infections			
Frequent sore throats or tonsillitis			
Other infection illnesses			
Allergic rhinitis or other allergy			
Asthma, bronchitis, bronchiolitis, pneumonia or croup			
Heart problems or heart murmur			
Abdominal pain/reflux			
Constipation requiring doctor visits			
Bladder or kidney infection or other urologic problem			
Bed-wetting (after age 5)			
Eye conditions / wear corrective lenses			
Problems with ears or hearing			
Chronic or recurrent skin problems/ acne			
Anemia or bleeding problem			
Past blood transfusion			
Frequent headaches			
Convulsions, seizures, or past concussions?			
Mental health concerns			
Seizures, developmental delays, ADD/ADHD or other neurological disorders			
Orthopedic problems			
Diabetes			
Thyroid, diabetes or other endocrine problems			
If female, have menstrual periods started?			
If female, any problems with periods?			
Use of alcohol or drugs			
Emotional or mental health problems			
Other significant issues:			

Current Medications and Dosage: (include any over the counter, herbal, or supplements)

_____ _____

_____ _____

_____ _____

Does your child see any specialists? If so, who and where?

_____

_____

Child's name: _____ Birth date: ___/___/_____

If you answer **YES** below, please check which **BIOLOGICAL RELATIVE** has the condition: **Mother, Father, Sibling, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather**
List or explain condition if possible.

FAMILY – PAST MEDICAL HISTORY	**NO**	**YES**	If **YES** - Please check which biological relative						
			Mom	Dad	Sib	Maternal Gr Mth	Maternal Gr Fth	Paternal Gr Mth	Paternal Gr Fth
Nasal allergies or other allergies									
Asthma/lung disease									
Heart disease or heart condition									
High blood pressure									
High cholesterol									
Diabetes or other endocrine problem									
Type 1									
Type 2									
Cancer									
Anemia									
Bleeding disorders									
Epilepsy or convulsions									
Developmental Disorders									
Neurological disorder including ADHD/ADD									
Liver disease									
Other GI disease / disorder									
Kidney disease									
Obese or overweight									
Bed-wetting (after age 10)									
Hearing impairment									
Vision impairment or eye disorder									
Immune problems, recurrent infections or HIV-AIDS									
Alcohol Abuse									
Drug Abuse									
Mental Illness									
Tuberculosis									
Other issues:									

Is there anything else regarding your child's health that you think we should know that has not already been asked?

_____

_____

I attest that all the medical history information is true and correct to the best of my knowledge:

_____ _____ ____ /____/____

Signature **Relationship to patient** **Date**

_____ _____ ____ /____/____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Weiss Pediatric Care may use and disclose protected health information ("PHI") about me to carry out treatment, payment and healthcare operations ("TPO"). Please refer to Weiss Pediatric Care 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. Weiss Pediatric Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Weiss Pediatric Care Privacy Officer at 2201 Cantu Court, Ste 117, Sarasota, FL 34232.

With my consent, Weiss Pediatric Care 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 TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Weiss Pediatric Care may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Weiss Pediatric Care may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Weiss Pediatric Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, Weiss Pediatric Care may disclose personal photographs/cards with or without names or other identifiable information that I have provided or sent to the office for the purpose of posting on our bulletin board, Weiss Pediatric Care facebook page or Weiss Pediatric Care website. I understand that I have the right to revoke this authorization in writing.

By signing this form, I am consenting to Weiss Pediatric Care's use and disclosure of my PHI to carry out 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, Weiss Pediatric Care may decline to provide treatment to me.

HIPAA Notice of Privacy Practices
Acknowledgment of Receipt

I acknowledge that I have received a copy of **Weiss Pediatric Care** Notice of Privacy Practices with the effective date of December 26, 2014.

Authorization for Parents, Family, Friends, or Advisors to receive information about my child's medical condition.

The following individual(s) are authorized to receive written and/or oral communications about my child's medical condition, care and appointments.

_____

Patient Name

Authorized Individual(s), including Parents (Please Print Names)

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____	_____	_____
Signature (parent or guardian if patient is a minor)	**Printed Name**	**Date**

HIPAA Email Consent

- Most popular email services (eg. Gmail ©, Yahoo ©, Hotmail ©) do not utilize encrypted email.
- **When we send you an email or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Weiss Pediatric Care to communicate with me via unencrypted email.

_____	_____
Signature	**Date**

OPTION 2- **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to communicate with Weiss Pediatric Care via email.

_____	_____
Signature	**Date**

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FINANCIAL & OFFICE POLICY

Thank you for choosing Weiss Pediatric Care as your Pediatric provider. It is our hope that our patients understand our credit, collections and office policies are a necessary part of assuring the financial resources required to maintain vital health care services for our patients and the community. Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office and financial policies allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Credit Card on File Program

We are excited to offer an innovative program to help you manage your health care dollars. As a result of the changes in healthcare, many families have chosen individual high deductible health plans to help lower their monthly insurance premiums. With the *Credit Card on File Program* we securely save your credit or debit card and work with your health plan to determine your payment amount after each visit. You will receive an email 7 days before your card is charged letting you know the amount. We process the payment for you automatically and email you the receipt. The *Credit Card on File Program* eliminates the hassle of writing a paper check and mailing in a payment. We do all the work for you! Plus, you will not receive a paper invoice in the mail. This eliminates the chance your personal information can be viewed or stolen by others.

Please see the *Credit Card on File Program* FAQ's for more information, and complete the Authorization Form attached to begin enjoying the benefits today!

Initial:_____

Appointments:

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we require no less than a 24-hour cancellation notice. If 24-hour notice is not received, no-show and late cancellation fees will apply and are as follows: $50.00 well visits, ADHD visits, and Asthma Care Plan appointments; $40.00 all other appointments. If there are 3 no shows within one year you will be asked to transfer care to another practice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
- All children under the age of 18 must be accompanied by an adult for well visits, ADHD, chronic illnesses, lab follow-ups, and allergy testing. Children 16 and older may be unaccompanied for sick visits with a signed *authorization for treatment* on file.

Initial:_____

Insurance Plans:

- It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you come prepared to present your insurance card at every visit to verify that our office has the most updated card on file.
- All newborns are considered SELF PAY until we can verify insurance. If your newborn is covered by insurance, please contact us with the name of the plan, the subscriber name, and ID number. Most insurance plans give you 15 -30 days to add newborns to family plans.
- If the insurance card/plan you present is incorrect or invalid, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- As we are your primary care provider, make sure our name/phone number appears on your most up to date card. If your insurance has not been informed that we are your primary care provider and we cannot confirm that we are, you must pay for the visit or reschedule.
- It is your responsibility to understand your benefit plan. Well Appointments – According to children's age there are surveys that will be required for you or your child to complete. They are a necessary part of the visit and are standard of care. The survey must be billed and charged under individual billing code separate from the well visit code. If these services are not covered, you will be responsible for payment.
- Not all plans cover well child visits, vision/hearing screenings, or other services provided by us that are recommended by the American Academy of Pediatrics and are the standard of care. If these services are not covered, you will be responsible for payment.
- If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment.

Initial:_____

Referrals:

- Advance notice is needed for all non-emergent referrals, typically 3 business days.
- It is your responsibility to know if a selected specialist or lab participates with your insurance.

Initial:_____

Financial Responsibility:

- We do not get involved with domestic disputes and custody issues. Our policy is to obtain payment at the time of service from the parent/guardian bringing the child to the office. The person who the patient resides with is responsible for any balances due upon receipt of a statement.
- According to your insurance plan, you are responsible for any and all co-pays, deductibles, and coinsurances.
- Co-pays are due at the time of service.
- Self-pay patients are expected to pay for services in full at the time of visit. This includes patients that we do not participate in their insurance plan. Our office will be happy to furnish a print out with all the necessary codes for you to file the claim for reimbursement with your insurance company for which we do not participate.
- Patient balances are billed monthly and we ask that you pay your statement balance in a timely manner.
- If previous arrangements have not been made with our billing office, any account balances over 60 days old will be forwarded to a collection agency. If your account is sent to Collection Company you will be asked to transfer your care to another practice.
- For scheduled well appointments, any outstanding balances must be paid prior to the visit or you will be asked to reschedule.
- We accept cash, check, and all major credit cards.
- A $30.00 fee will be charged for any checks returned for insufficient funds or any other reason the check would be declined, Checks will no longer be permitted as a method of payment.
- Weiss Pediatric Care reserves the right to change fees without notice.
- Any families asked to transfer care for non-compliance of our policies will not be accepted back in to our practice.

Initial:_____

Forms:

- We require 3 business days to complete requested forms.
- No charge for Health/Immunization Forms requested at time of well visit; Additional copies are available at no charge via your patient portal.
- $10 fee for additional printed copies of Health/Immunization Forms requested at times other than at well visit appointment.
- $25 Convenience Fee for "rush" same day/next day forms

Initial:_____

Medical Records:

- No charge for medical records sent via fax to another physician's office
- Printed copies of medical records provided to patient are charged based on current Florida guidelines.The fee must be paid at time of receipt.
- If the patient is over the age of 18 we will only release the records to the patient unless there is a written permission to release to other individuals.

Initial:_____

Prescription Refills:

- For medication refills, we require 72 hours' notice, during regular business hours. Please plan accordingly.

Initial:_____

I have read and understand this Financial and Office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this document.

Patient Name - list all children that are patients at Weiss Pediatric Care

_____DOB_____
_____DOB_____
_____DOB_____
_____DOB_____

Responsible Party's Name:_____Relationship:_____

Responsible Party's Signature:_____Date:_____

Rev 08/16/16; Rev 03/23/18, Rev 05/11/18

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Vaccine Statement

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of our vaccines.

We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies, that neither vaccines nor thimerosol cause autism or other developmental disabilities.

We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and the published schedule are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

Unfortunately, the vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such successes can make us complacent about the need for vaccination. However, as such opinions are becoming more globally widespread, we are witnessing the resurgence of many of these diseases. This is already leading to tragic results.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will try our best to address your concerns and doubts and help show you that vaccinating according to the recommended schedule is in the best interest of your child and the community as a whole.

Please understand that delaying or “breaking up” the vaccines to give one or two at a time over two or more visits goes against expert recommendations and can put your child at risk for serious illness or even death. Doing these things also goes against our medical advice at Weiss Pediatric Care.

As medical professionals, we feel strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Should you choose not to vaccinate your child, or wish to alter the recommended vaccination schedule, we advise you to choose another health care provider who shares your views.

We will gladly address any additional items you would like to discuss on an individual basis.

Rev 10/14/15; Reviewed 5/11/18

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IMMUNIZATION POLICY

Childhood immunization was one of the greatest advances in public health in the 20th century. It has saved millions of children and adults throughout the world from developing meningitis, encephalitis, brain damage, severe respiratory problems, poliomyelitis, paralysis, and other severe illnesses, which can require hospitalization or cause death. And to this day, childhood immunization remains a cornerstone of pediatric care and public health.

Immunizations are most effective when an entire community participates. In recent years, localized outbreaks of mumps, measles, whooping cough and polio have occurred in the United States in communities with low vaccination rates. When you immunize your child, you are not only protecting your child from serious disease, but you are also helping to protect your entire family, your friends and your neighbors.

At Weiss Pediatric Care, we strongly believe in the importance of immunizations and fully support the childhood immunization schedule established by the American Academy of Pediatrics. Therefore, **our policy requires that every patient within our group receive the vaccinations listed below according to the prescribed schedule:**

By 12 months of age, your child will receive the following:

Type of Immunization	
Hepatitis B	3 doses
Diphtheria, Tetanus and Pertussis **(DTaP)**	3 doses
Inactivated Polio Vaccine **(IPV)**	3 doses
Haemophilus Influenza (HIB)	4 doses
Pneumococcal Conjugate Vaccine	4 doses
Varicella Vaccine **(Chicken Pox)**	1 dose
Measles, Mumps and Rubella (**MMR)**	1 dose
Rotavirus	3 doses

At 15 months, your child will receive these vaccines:

Diphtheria, Tetanus and Pertussis **(DTaP)**	4th dose

At 4 years, your child will receive these vaccines:

A fifth dose of **DTaP**
A fifth dose of **IPV**
A second dose of **MMR**
A second dose of **Varicella (Chicken Pox)**

At 11 years, your child will receive these vaccines:

1 dose of Meningococcal ACWY Vaccine
1 dose of Tetanus, Diphtheria and Pertussis **(Tdap)**

At 16 years, your child will receive this vaccine:

1 booster dose of Meningococcal ACWY Vaccine

At 19 years, your child will receive this vaccine:

1 booster dose of Tetanus, Diphtheria and Pertussis **(Tdap)**

In addition, we highly recommend (but do not require) the following vaccinations:

Hepatitis A: 2 doses, beginning at 15 months of age
Influenza Vaccine: 2 doses first year received and 1 dose annually after that
Human Papillomavirus (HPV) Vaccine: 1 dose followed by one additional dose 2 months later if under 14 years of age, or 2 additional doses 2 and 6 months later if over 15 years of age.
Meningococcal Vaccine (MenB): 1 dose at 16 years, followed by an additional dose 4 weeks later

We are aware of the concerns about vaccine safety that have been voiced by a very small yet vocal minority. These claims have no scientific or statistical basis. To date, there have been over 30 scientific studies, which have proven, conclusively, that vaccines are safe.

By signing, I understand and agree to follow Weiss Pediatric Care's Immunization Policy by completing all required vaccines in accordance with the timing and schedule published by the American Academy of Pediatrics and the Centers for Disease Control and noted above.

_____ _____

Patient Signature (Over 18)/Parent/Guardian **Date**

WEISS PEDIATRIC CARE

Credit Card on File Program

Authorization Form

I authorize Weiss Pediatric Care to charge the amount deemed patient responsibility by my insurance plan to the following credit card:

First Name: _____ Last Name:_____

Card Holder Name: _____ Zip Code: _____

Email Address: _____

Card Number: _____ Expiration Date: _____

I understand that after my health plan has paid their portion for my child's care, I will receive an Explanation of Benefits (EOB) from my insurance company. The health plan EOB will state any balance remaining to be paid by me. I will receive an email 7 days prior to my card being charged. Once my card is charged I will be emailed a receipt of payment.

Patient/Guarantor Signature: _____ Date:_____

Patient/Guarantor Printed Name:_____

Please list all children that are patients at Weiss Pediatric Care

Name	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____

Created: 07/18/16
Rev: 08/11/16

Weiss Pediatric Care

New Cell Phone Policy

We have been advised by our Compliance Consultant that cell phones must be stored while in our exam rooms in order to avoid possible privacy violations.

If you need to take a call while in the exam room, please feel free to step outside. We will move on to the next patient and work your child back into the schedule as soon as you have returned.

With your help we can ensure that we are honoring all privacy standards.

Dr. Weiss & The Weiss Pediatric Care Team

By signing below, I acknowledge that I have received **Weiss Pediatric Care's Cell Phone Policy**.

_____ _____

Print Name of Patient Date of Birth

_____ _____

Signature of Parent or Legal Guardian or Patient (over 18) Date

_____

Print Name of Parent/Legal Guardian or Patient (over 18)