SANDUSKY PEDIATRICIANS

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Dear Patient:

Welcome to Sandusky Pediatricians !

Thank you for choosing us to provide medical care for your new baby. We appreciate this opportunity and look forward to establishing a provider-patient relationship with the newest member of your family.

Enclosed you will find the necessary paperwork required to create accounts for your newborn in both our Electronic Medical Record (EMR) system and Scheduling/Billing system.

FORMS TO BE COMPLETED AND RETURNED PRIOR TO YOUR APPT:
(Please have these forms completely filled out before you arrive and you may fax to 419-626-2477 or email to SanduskyGP@uhhospitals.org to expedite your appointment)

1. **Registration/Demographics form**
2. **Parent/Guardian Consent to Treat Minor Patients**, *if you want to authorize someone besides parents/legal guardians to bring your child to appointments.*
3. **Appointment & No Show Notification**
4. **Parent/Guardian Account PHR Request form** for access to your child's UH Personal Health Record. THIS FORM IS OPTIONAL

FORMS YOU MAY KEEP:

5. Well Child / Baby Care Check Up Policy
6. UH RPCI: 2018 Recommended Vaccination Schedule that is still current.
7. Late Arrival Policy
8. Sandusky Pediatricians Brochure (if one is not included it is still in our revision process)

We also suggest bringing your baby in easy change clothing, or wearing only a onesie and diaper with blankets as needed to keep warm, since we will weigh Baby in only a diaper to ensure an accurate weight

Please arrive 15 minutes prior to your scheduled appointment.

Thank you again. We look forward to seeing you. Congratulations!

Sandusky Pediatricians
University Hospitals Medical Practices

Recommended Tip regarding insurance:
You will need to contact your insurance company and/or your employer's Human Resources Department directly to enroll your newborn on your insurance plans(s). ***Most insurance plans only allow Member's to enroll a newborn within thirty (30) days of the newborn's birth and may require you to provide a copy of your child's birth certificate and social security number****. We highly recommend you do this as soon as possible.*

*(Internal Use: initial/date when entered _____ ** give copy to OM if no shared parenting)* Rev 07/21

Sandusky Pediatricians
Registration for minor children to be completed each year and for any changes by Mother, Father, Legal Guardian ONLY

Today's Date: ____/____/____ Completed by: _____

Name of the Financially Responsible Guarantor who agrees to receive bills: _____
(UH does not follow Court Order billing. If Guarantor is other than yourself, you will be responsible if above party does not pay)

- **PRIMARY insurance policy holder for the children:** **Mother** **Father** **Other**_____
  (UBR states it is parent w/ the first birthdate of a calendar year, UNLESS waived by a Court Order)
- **PRIMARY Residential Parent, if parents do not live together:** **Mother** **Father** **Other**_____

	Minor Child's LEGAL Name	Date of Birth	M/F	Social Security #:
1.				
2.				
3.				
4.				
5.				

Appointment Reminder preferences - Please complete each line with one of each. COMPLETE EACH ONE PLEASE.

- Appt Reminder via **Email:** _____ initial to opt out_____
- Appt Reminder via **Phone Call#:** _____ initial to opt out_____
- Appt Reminder Via **Text#:** _____ initial to opt out _____

PLEASE ASK RECEPTIONIST FOR A SEPARATE FORM FOR CHILDREN WITH DIFFERENT PARENTS

****

Mother / Legal Guardian

Legal Name_____ Birthdate_____ SS#_____

Maiden Name (if applicable)_____

Mailing Address: _____ City_____ State_____

Home Phone _____ Cell Phone_____ Work Phone_____

Email Address: _____ Employer Name_____

Step Father Name (if applicable) _____ Birthdate_____

***If biological parents are divorced, do you have Shared Parenting? ____YES or ____NO** If NO, Please provide Court Order**

****

Father / Legal Guardian

Legal Name_____ Birthdate_____ SS#_____

Mailing Address: _____ City_____ State_____

Home Phone _____ Cell Phone_____ Work Phone_____

Email Address_____ Employer Name_____

Step Mother Name (if applicable) _____ Birthdate_____

***If biological parents are divorced, do you have Shared Parenting? ____YES or ____NO** If NO, Please provide Court Order**

****

Name of an Emergency Contact who does not live with you:

Name_____ Phone _____ Relationship to child_____

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NAME OF OFFICE PRACTICE: SANDUSKY PEDIATRICIANS

PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

Accompaniment

SECTION # 1: ***Please complete this section to authorize someone <u>besides a biological parent or legal guardian</u> to bring your child(ren) to appointments. (Ex: step-parents, grandparents, babysitters)***

I, the Legal Guardian, _____, of the minor child(ren):

1. Minor Child's Name: _____ Birthdate: _____
2. Minor Child's Name: _____ Birthdate: _____
3. Minor Child's Name: _____ Birthdate: _____
4. Minor Child's Name: _____ Birthdate: _____

give my consent for my children to be accompanied by the individuals listed below to office visits and treatment that requires only general consent. I have already signed the general consent form.

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

No Accompaniment

SECTION # 2: ***Please complete this section ONLY if you consent for any of your minor children to transport himself/herself <u>ALONE</u> to office visits and treatment that requires only general consent.***

My minor child(ren) has my permission to transport himself/herself to receive general treatment that does not require general consent, which I, (*print name of legal guardian*)_____ as guardian, have already given.

1. Minor Child's Name: _____ Birthdate: _____
2. Minor Child's Name: _____ Birthdate: _____
3. Minor Child's Name: _____ Birthdate: _____
4. Minor Child's Name: _____ Birthdate: _____

Signature

SECTION # 3: ***<u>LEGAL GUARDIAN SIGNATURE</u>**

You can contact me by phone:

Home:_____ Cell:_____ Work:_____

I understand that this consent is in place until revoked by me and/or the expiration of one year.

Legal Guardian Signature:_____ **Date:**_____

Relationship of Legal Guardian to child:_____

Internal Use: Staff, please initial/date when entered: _____

REV 05/21

MINOR PATIENTS

Internal Use: entered by initials/date:_____

University Hospitals

University Hospitals Physician Services: No-Show Policy

Sandusky Pediatricians

Missed Appointments Hurt Everyone

Missing a scheduled appointment without notification prevents others from having desired appointments. We understand that situations may arise which make it impossible for you to keep a scheduled appointment. The earlier you let us know, the more likely we can offer the appointment time to another patient.

Giving the office at least 24-hour notice of the need to cancel an appointment is considerate of other patients and greatly appreciated. We strive to provide compassionate care in a cost-effective manner. Missed appointments waste valuable physician and staff resources, and prevent other patients from obtaining care.

No-Show Policy

A missed appointment (with no phone call) is considered a "No-show." It is important to call us if you cannot make your scheduled appointment. We prefer you call us the day prior to your appointment to reschedule or cancel. Failure to call to cancel prior to your appointment time may result in a $25.00 fee. *(Note: insurance companies will not cover this fee.)*

Repeated missed appointments may result in dismissal from our practice.

I acknowledge receipt and review of the No Show Policy

Printed Name _____

Signature _____ Date _____

MINOR Patient Names:

1. _____ Birthdate: _____
2. _____ Birthdate: _____
3. _____ Birthdate: _____
4. _____ Birthdate: _____
5. _____ Birthdate: _____

University Hospitals

Parent/Guardian Account Request Form

Person requesting access must be a parent or legal guardian.

A Parent/Guardian Account allows a parent or legal guardian to have access to the UH Personal Health Record (PHR) of a patient in his/her care. To open a Parent/Guardian Account, please fill out the form below and return to your doctor's office.

By completing and signing this form:

1. I certify that I am the parent/legal guardian of the patient and I have the legal right to access his or her health information.
2. I understand that any individuals I name below will have online access to personal health information, including, but not limited to, viewing portions of the health record, requesting appointments, and requesting medication refills.
3. I understand that additional information may be made available to me through the PHR in the future.
4. I understand that this form only gives access to the patient's PHR. This form does not authorize the release of the patient's medical record by other methods or in other formats. To request copies of the patient's medical record, please contact your doctor's office or any UH Hospital.
5. I understand that access to the patient's PHR is provided by University Hospitals as a convenience to its patients. University Hospitals has the right to deactivate access to the PHR at any time, for any reason.

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____ DOB: _____

PARENT/GUARDIAN INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Date of Birth: _____

Email Address (please print): _____

Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

Parent/Legal Guardian Signature: _____ Date: _____

*Any person signing this form other than the birth or adoptive parent of the patient MUST provide a copy of legal paperwork that such person has the right to this information. Failure to submit legal paperwork will result in denial of access.

ADDITIONAL PARENT/GUARDIAN ACCOUNT(S)

By completing this section, I am requesting UH to give access to the patient's PHR to the following individual(s):

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone Number: _____ Date of Birth: _____
Email Address (please print): _____
Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Phone Number: _____ Date of Birth: _____
Email Address (please print): _____
Relationship to Patient: ☐Birth or Adoptive Parent ☐Legal Guardian* ☐Other* _____

(Rev. 8/20/18)

Provider Office Use Only – REQUIRED INFORMATION:
MRN: _____ Practice/Office: SANDUSKY PEDIATRICIANS
Reviewer Name: _____ Office Phone #: 419-626-3821
Date: _____ Office Email: SanduskyGP@UHhospitals.org
☐ Requestor(s) Eligible for Access ☐ Requestor(s) Not Eligible for Access
Reason: _____

SANDUSKY PEDIATRICIANS
UNIVERSITY HOSPITALS MEDICAL PRACTICES

WELL CHILD / BABY CARE CHECK UP POLICY

Dear Patient:

Our records indicate we have not seen your child for a ***well child*** check up (routine preventative examination) in over one year. **Yearly medical well child check ups performed by your child's established primary care provider meet the standard of care as determined by the American Academy of Pediatrics (AAP).** As members of the AAP, we support this standard and feel it is important for quality medical care. Therefore, check ups are mandatory to provide the medical care your family deserves.

A well child check up is a scheduled appointment when your child is not ill. This visit includes a history and physical examination, developmental assessment, and health supervision issues appropriate for your child's age, *all of which are **not** provided at illness visits.*

A scheduled well child check up will be billed to your insurance company as a Preventative Visit. We realize this may be determined a non covered or limited service by your insurance company. However, the fact that your insurance company does not pay for this service does not mean that your child should not receive it.

Our Preventative Check Up Schedule is as follows. Compliance with this schedule is required to maintain *current patient status.*

Age 0-1
Check Up required at 1, 2, 4, 6, 9, and 12 months.

Age 1-2 years
Check Up required at 15, 18, 24 months.

Age 2-18 years
Check Up required at 2 ½ years, and annually beginning at age 3 years to 18 years of age.

Maintaining *current patient status* enables us to provide the following:

- *Illness visits*
- *After hours Emergency On-Call Provider Availability*
- *Immunizations*
- *College, School, Daycare Form completion*
- *Telephone Consultation by Nurse or Provider*
- *Prescription refills, and school medication permission form completion*
- *Sports Card, Work Permit form completion*
- *Referrals and Consultation to Specialty Providers*
- *Use of Telephone Hour (8:00 AM –9:00 AM – Monday through Friday)*
- *Other miscellaneous paperwork and/or orders for required services.*

Thank you for your understanding and cooperation with this Policy. It is our privilege to provide your medical care.

University Hospitals Rainbow Babies & Children's Hospital SANDUSKY PEDIATRICIANS

UH RPCI: 2018 Recommended Vaccination Schedule

Vaccine	MFG	CPT Code	Birth	2 Mths	4 Mths	6 Mths	9 Mths	12 Mths	15 Mths	18 Mths	Year 2	Year 4-5	Year 11	Year 12	Year 16	Year 17	Year 18
Hiberix (Hib)	GSK	90648		X	X	X			X								
Pediarix (DTaP, IPV, HepB)	GSK	90723		X	X	X											
RotaTeq oral solution (not injection)	Merck	90680		X	X	X											
Prevnar 13 (Pneumococcal)	Wyeth	90670		X	X	X			X								
Vaqta (Hep A)	Merck	90633						X		X							
Varivax (Varicella)	Merck	90716						X									
MMR II	Merck	90707						X									
ProQuad (MMRV)	Merck	90710								X							
Infanrix (DTaP)	GSK	90700							X								
Kinrix (DTaP/IPV)	GSK	90696										X					
Menveo (Men A, C, W-135, Y)	GSK	90734											X		X		
Gardasil 9 (HPV) (male & female patients)	Merck	90651											X	X			
Boostrix (Tdap)	GSK	90715											X				
Bexsero (Men B)	GSK	90620													X,X		
Influenza Quadrivalent 0.25 mL *(preserv free)*	GSK	90685	6 -35 months									9+ years = 1 dose					
Influenza Quadrivalent 0.5 mL *(preserv free)*	GSK	90686		36 months-8 years: 1 to 2 doses per guidelines*													

** If first flu dose, give two doses 1 month apart.*

Please contact your insurance company to confirm coverage by providing the correct CPT code.

Appropriate administration fees are billed per vaccine

Late Arrival Policy

Our providers, nurses and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy.

If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled.
This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients.

New patients are encouraged to complete new patient paperwork that we mail to you and fill it out prior to coming in. The paperwork may also be printed from our website, Rainbow.org/SanduskyPeds.
Otherwise, new patients need to arrive at the office at least 15 minutes prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time.

The providers and staff at **Sandusky Pediatricians** truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.

Thank you