carine
PEDIATRICS

Welcome to Our Practice

Children hold endless potential. We feel our job is to partner with our families in the growth and development of their children. In addition to wholistic medical care, we hope to help families navigate the toxic exposures our children face, complex medical systems, educational challenges, and the nutritional deficiencies of our current food supply. As parents we often feel overwhelmed by information, we hope we can help you make decisions that are best for your family.

Our practice is striving to provide a whole new experience in Pediatric medical care. There are several aspects of our practice that make us unique and we want to help you understand our office.

Please read this over in its entirety, we know that you have a lot of paperwork to review, but this document will help you navigate the practice and our policies.

We hope we can do better!

Appointments

1. **General:** Care delivered at our office is done in a team setting. All routine care is provided by our nurse practitioners with the oversight of Dr. Carine. Osteopathic and complex consults are with Dr. Carine by appointment. These visits have a maximum of 30 minute time slots. If your child has chronic or complex needs you may need more than one visit to cover all the aspects we need to discuss about your child, adjusting the plan of care as we manage the issue.
2. **Phone and email consultations are not possible.**
3. **Well Child** Visits: "Well Checks" are intended to address overall basic health questions, monitor development, complete forms, and address preventative topics such as vaccines. These are ALWAYS scheduled with one of our nurse practitioners. *Dr. Carine no longer performs any Well Checks.* Acute symptoms and/or chronic conditions are not intended to be addressed at well child visits. These visits are designed by the government, which dictates certain criteria to be met for it to qualify as a Well Check and which criteria will not be covered. We encourage Well Checks near a child's birthday, forms will be completed for a year when needed and applicable.
4. **Ill** Visits are intended to address symptoms your child is experiencing. Clear communication of your concerns to the staff at the time of scheduling is vital to ensure enough time is allotted to address your concerns:
   a. **Same Day Sick** Visits: We leave time in our schedule, and often stay late hours, to ensure that any child in our practice who has an *acute* illness can be seen that day. We hope that this will limit your need for urgent care visits to a doctor who has no knowledge of your child. These visits are not intended to address chronic illnesses and ongoing difficulties your child is experiencing. Please call **as early as possible** to make these same day appointments, or email the office the night before. These visits, generally less complex, are built into our schedule to be **10 minutes**.
   b. **Conference** (prearranged "ill") Visits: These are intended to address/follow up on chronic health concerns. There is not always time on the schedule to arrange *same day* Conferences so please be sure to schedule ahead if you wish to discuss a child's chronic condition. These visits, generally more complex,

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are built into our schedule to be **20 minutes**. Please refrain from discussing areas of emotional or behavioral trouble your child is experiencing in depth while the child is present, we try as we can to remain positive during their visits. Feel free to excuse your child to the playroom after their physical assessment, send them home with someone, or bring help to entertain them while you continue with the Conference portion of the visit.

5. **Osteopathic Manipulation Treatments (OMT)**: A minimal amount of this visit can be used to address other topics, but any in depth discussion should be arranged for another day (**Conference** visits are ideal for this). Dr. Carine needs to focus her attention on the needs of your child, both interactively and osteopathically, to ensure they receive the best care possible.
6. **Referrals**: Nationwide Children Hospital referrals must be made through our office. For physicians outside the hospital, we encourage you to check with your insurance plan and make those appointments yourself.
7. **Prescriptions**: Chronic maintenance medications are given refills until the next time your child needs to be seen. If your child is out of refills it is best to schedule a re-check appointment. This is especially true of asthma medications. Controlled substances, such as ADHD medications, are regulated by the DEA and require regular Med Check visits at least **every 90 days, or within 30 days if the dosage has been change**. Do not wait until the child is out of medication to call us, those requests will ONLY be considered if we have seen and assessed your child in the appropriate time frame.
8. **Forms**: Forms for school, work, camps and other such facilities are completed based on the child's up to date Well Check. IF your child has not had the most recent Well Check please call to schedule that visit and bring the form with you! IF, your child has had their Well Check in the last year please complete the parent portion of the form FIRST (with child's name and date of birth for accuracy) and send the form to our office. We will return the completed form within 2-5 business days. Please note forms are low priority tasks compared to our visits.
9. **Messages**: When we are in office we are **in visits, involved in direct patient care**. If your child is having symptoms you would like us to assess that day please schedule a visit. We cannot assess a child over the phone or via email. If you opt to leave a message for the clinical staff instead of scheduling a visit, you may not get an answer the same day.
10. **Wait times**: While we endeavor to perform all visits during the time in which they're scheduled, there are occasions when we will need to spend more time with an child. Please bear with us and recognize that when it is your child who needs extra time or attention, you will be very glad to have it. IF you wish to avoid wait times, we recommended you schedule your visits early in the morning or early in the afternoon. The later inf the morning/afternoon that you schedule the more likely you are to have a wait.

Billing

Our billing policy requires a credit card be placed on file during check-in at the first visit. This is required for care at our office. For more details visit https://www.drcarine.com/billing.

Bills generated by the office are submitted to insurance for payment. We follow guidelines from Centers for Medicare and Medicaid Services (CMS) for all services provided. Patient responsibility is always determined by your carrier. The majority of what we bill is covered by insurance, however, we cannot keep track of what benefits your plan provides. Bills that are rejected by insurance, and not easily corrected by our staff, are the patient's responsibility.

Please remember it is the patient's responsibility, at all times, to know their insurance policy. Patients should be aware of their benefits coverage, including: which physicians are contracted with their plan; covered and non-covered benefits; (pre)authorization requirements; and costs share information such as deductibles, co-insurance, and co payments. If you are not familiar with an aspect of your plan coverage, we recommend you contact your carrier directly. It is the patient's responsibility, at all times, to provide us with accurate billing information for each family member at the time of service.

Please refer to our website for more information: www.drcarine.com.

Carine Pediatrics / Ali M. Carine, D.O., LLC
New Patient Registration Form (MINOR)

Child's (Patient) Information
This section is directly regarding the child to be seen at our office.

Last Name: _____ First Name: _____ M.I.: _____

Preferred name: _____ Date of Birth: _____ Age: _____

Previous name (if adopted/renamed): _____ (Biological) Mother's Maiden Name: _____

Sex: _____ SSN: _____ Race & Ethnicity (this is a government required question): _____

We consider the "Home" to be the location where the child spends more than 50% of their time. If the time is split 50/50 (or some other ratio) please be sure to make note that below for our reference when contacting parents.

Home Address: _____

_____

_____

Child lives with (please circle **ONLY** one): BOTH Parents (in **one** home) Mother Father Other

If "Other" was selected from the options above (due to shared parenting, or step-parents for example), please take a moment to explain this child's home/living situation so we can address each parent/guardian appropriately (note individual's name and relation to the patient as well).:

_____

_____

_____

Our office will be (please circle **ONLY** one): PRIMARY CARE CONSULTATIVE CARE

Parent/Guardian Information
"1st Contact" should be the parent/guardian accompanying the child to the office visits *most often*, and/or *most likely* to be available by phone for scheduling and clinical needs. Contact information for **billing** should be detailed on the next page. We will sign you up for our automated calls and text messages to help you remember to schedule and keep your child's visits. You may opt out of this by signing an additional form.

1st Contact

Name: _____ Relation to Child: _____

Date of Birth: _____ Sex: _____ SSN: _____

Billing Address (if different): _____

Phone #: _____ Email: _____

2nd Contact

Name: _____ Relation to Child: _____

Date of Birth: _____ Sex: _____ SSN: _____

Billing Address (if different): _____

Phone #: _____ Email: _____

-We will utilize the "1st Contact" information FIRST to convey scheduling and pertinent medical information to you using the contact information you have provided above. Please be sure this contact information is always accurate and up to date.

-Who ELSE may we speak to regarding this child's Protected Health Information (PHI), or contact in an emergency? This would be AFTER parent/guardian contact information listed above. Unless we have legal documents on file restricting access to medical information, both parents have the right to access a child's PHI. However, we CANNOT give any protected health information to anyone other than a parent/guardian unless they are listed by name in this section. If you want your child to be seen in our office with anyone other than the parent/guardian, that individual should be listed here. Please tell the accompanying adult they should have their photo ID, the child's insurance card, and be prepared to answer questions as well as make any applicable payment for that visit.

Full Name: _____ Relation to Child: _____ Phone #: _____

Full Name: _____ Relation to Child: _____ Phone #: _____

Carine Pediatrics / Ali M. Carine, D.O., LLC
New Patient Registration Form (MINOR)

Insurance and Billing Information

This section is both an attestation of your insurance coverage, and used to clarify the best contact for billing concerns like balances, refunds, or claim reprocessing. This contact information is primarily for insurance and/or billing matters. The contact information for scheduling/clinical calls should be detailed on the top of the first page. Who would you like us to **contact for billing related issues?**

Name: _____ Relation to Child: _____

Date of Birth: _____ Sex: _____ SSN: _____

Billing Address (if different): _____

Phone #: _____ Email: _____

Please disclose all medical insurance policies, including but not limited to, any MEDICAID insurance coverage. Failure to disclose medical insurance coverage could result is exclusion/expulsion from the practice. Please understand there are certain insurances that have accompanying regulations for our office.

Primary Insurance: _____ ID#: _____ Policy Holder: _____ DOB: _____

Secondary Insurance: _____ ID#: _____ Policy Holder: _____ DOB: _____

Tertiary Insurance or any additional information related to patient insurance coverage: _____

Consent & Attestation

All sections should be completed prior to this one. This section MUST be completed to make any of this information valid for our office. Without completion of this section your child (the patient) cannot and will not be registered at our practice.

You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure. This consent is first an effort to obtain your permission for Carine Pediatrics' personnel to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s) and/or assessment of development.

This consent provides Carine Pediatrics with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at our practice. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan your provider about the purpose, potential risks, and benefits of any test ordered for you. If you have concerns regarding any services initiated or provided by Carine Pediatrics, we encourage you to ask questions.

"I voluntarily request a physician, nurse practitioner, and other medical designee at Carine Pediatrics, as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care here. I understand that any specimens which cannot be processed at Carine Pediatrics (including collection of blood, urine, stool, swabs, and other specimens) and their corresponding billing will be sent to, and processed by **Nationwide Children Hospital (NCH)** Labs, unless otherwise specified by me prior to collection. Verbal consent given to Carine Pediatrics' personnel to collect specimens will constitute consent for billing of the test. I understand all charges generated by Carine Pediatrics follow guidelines from Centers for Medicare and Medicaid Services (CMS), and pricing for insured patients is determined by the insurance carrier."

"I, _____, certify that I have read and fully understand the above statements; and I consent fully and voluntarily to its contents. I attest that all information included herein is correct and that any falsification/omission may lead to exclusion/expulsion from Carine Pediatrics."

Signature: _____ Date: _____

(OPTIONAL) How did you hear about our office? _____

Carine Pediatrics / Ali M. Carine, D.O., LLC
Detailed Patient History Form

Name: _____ **Date of Birth:** _____ **Sex:** _____

Previous or Referring Doctor: _____ **Date of last Well Check/Physical:** _____

Please BRING the following to your 1st visit at our office:

1) **1 baby & current picture.**
2) **Your child's vaccination history & notes from their last Well Check/Physical (if possible).**
3) **Insurance card(s) & credit card to put on file for billing.**

Pages 1-2: To be completed for EACH patient.

Page 3-4 & accompanying GRID page: To be completed for any patient with a complicated medical history or major diagnosis.

Prenatal and Birth History

Maternal age at delivery: _____ Place of birth: _____ Mother used drugs? _____ Alcohol? _____

Illness and/or medication(s) pregnancy: _____

Complications during pregnancy: _____

Complication during labor: _____

Full term/Premature, how many weeks: _____ Mode of delivery: C-section/Vaginal

If C-section, explain why: _____ If vaginal, did they use forceps? _____ Vacuum? _____

Medication(s) during labor and delivery: _____

Complications after delivery: _____

Mediation(s) given to child during hospital stay: _____

Infant History

During the first 6 months of life was you baby fussy, "needy", did they have difficulty sleeping, were they diagnosed with reflux? Describe: _____

Did you change your child's food to discover which food they do best with? If yes, what were the changes and any results: _____

Did your child have baby acne, cradle cap, or eczema? Describe: _____

Did your child have wheezing or major respiratory infections as a baby? Describe: _____

_____

Social History

How many siblings: ___ List the children and their ages: _____

Who else lives in the home with the child(ren) (grandma, e.g.): _____

Is your child involved in any sports, music, or other programs/activities? Please describe program, participation timeframe and frequency. _____

Does your child attend: DAYCARE FACILITY/IN HOME CHILDCARE/SCHOOL/HOME-SCHOOLED, Grade: _____

Describe any concerns you have about development, academics, and social interactions: _____

_____

_____

What else do you think is important for us to know to take the best care of your child? _____

_____

Environmental History

Please list any pets you have in the home: _____

Was your home built prior to 1970? YES/NO Type of home: HOUSE/APARTMENT/TRAILER/OTHER: _____

Bowel Pattern/Habits – Indicate your child's TYPICAL stool pattern. (BM = bowel movements)

Frequent BM	Floating BM	Separate hard lumps/pellet like BM	Stomach pain, cramps, bloating
More than 48 hours withOUT a BM	Greasy BM	Very foul odor	Diarrhea
Loose BM	Oil lays on water after flushing	Discolored BM	Soiling underwear
Lots of gas	Ring in the toilet after flushing	BM that are hard to pass	Potty trained

Carine Pediatrics / Ali M. Carine, D.O., LLC
Detailed Patient History Form

Child's Medical History – Circle all that apply, and/or give more detail.

General:	Chills or feeling cold
	Chronic fatigue
	Fevers, night sweats
	Pain
Eyes:	Burning, stinging, pain, discharge
	Watery, itchiness
	Vision problem (i.e. glasses)
Ears, Nose, Throat:	Earaches, ear infections
	Frequent colds, sinus infections
	Hearing problems
	Frequent nosebleeds
	Frequent sore throat
	Colds lasting > 7 days
	Dental problems, bad teeth
	Mouth sores/cold sores
	Dark circles under eyes
Heart:	Had a heart murmur
	Had heart trouble or chest pain
	Had high blood pressure
	Dizziness or passing out
	Racing or irregular pulse
	Intolerance for exercise
	Blue discoloration of skin
Lungs:	Wheezing or asthma
	Cough with laughing or exercise
	Cough at night
	Bronchitis
	Respiratory disease
Gastro-Intestinal Tract:	Nausea and vomiting
	Abdominal pain
Genitourinary Tract:	Does you child wet the bed
	Wet their underwear
	Had a kidney infection
Musculoskeletal:	Muscle weakness or soreness
	Swelling or pain in the joints
	Back pain
Rashes or Skin:	Skin or scalp rash
	Acne
	Eczema
	Pale
Neurologic:	Convulsions, epilepsy, or seizures
	Been unconscious
	Fainting
	Headaches
	Numbness/tingling in fingers & toes
	Tics
Endocrine:	Recent weight gain or loss
	Frequent urination or thirst
	Low blood sugar
	Early or late sexual development
	Intolerance of heat or cold
	Appetite concerns
Psychological:	Depression, bi-polar, or suicidal thoughts
	Anxiety or unusual fearfulness
	ADD/ADHD
	Alcohol or substance abuse
	Obsessive or compulsive behaviors
	Anger, rage, violence
	Psychiatric care
Blood:	Anemia
	Easy bleeding or bruising
Immunology:	Allergies
	Recurrent infections
	Tuberculosis exposure
	Swollen glands

Sleep Pattern/Habits

What is your child's TYPICAL bedtime? _____ Waking time? _____

Does your child nap? YES/NO If yes, how long and how often/what time? _____

Does your child have difficulty falling asleep or wake during the night? YES/NO If yes, please explain: _____

_____

Medication Details

Medication/Supplement NAME	DOSING (amount and time)

For Children with a Complex Medical Concern/Diagnosis

Medication Details Continued

Medication/Supplement NAME	DOSING (amount and time)

Past/Current Primary Care Provider (PCP)

Name	Phone #	Fax #	City, State

Past/Current Therapist(s): Speech/Occupational/Physical/Other

Name	Phone #	Fax #	City, State

Other - **Specialists**/Nutritionists/Caregivers

Name	Phone #	Fax #	City, State

Surgeries

Type of Surgery	Date	Result

Injuries – Describe (broken bones, MVA, falls, etc.)

Event	Date	Result

Traumatic Events (Emotional/Physical) – Describe (Death of a sibling, parent, e.g.)

Event	Date	Result

Education Support Plans - Individualized Education Plan (IEP), e.g.

What are the identified needs?	Evaluation Date	Facility/Association

Diet/Nutritional History

Breast-fed? YES/NO, starting when and for how long? _____

Bottle-fed? YES/NO, which formula, starting when, for how long? _____

Foods? YES/NO, starting at what age? _____ First foods? _____

Does your child consume cow's milk (including cheese, ice cream, and yogurt)? YES/NO, starting at what age? _____

How many glasses of milk does your child drink per day? _____ Juice? _____ Water? _____

Please list any known allergies to food and corresponding reaction: _____

_____

Please list any suspected sensitivities to food and corresponding reaction: _____

Please list any food cravings: _____

Please list the 3 most common foods your child eats for each meal:

Breakfast: 1) _____ 2) _____ 3) _____

Lunch: 1) _____ 2) _____ 3) _____

Supper: 1) _____ 2) _____ 3) _____

Regarding your child's New Patient Consult visit (re: a complicated health concern)

Diagnosis or explanation given to you about your child: _____

_____

_____

Date of diagnosis: _____ Facility and doctor/practitioner relaying diagnosis: _____

What is the main thing you would like to accomplish at the first visit with our office: _____

_____

_____

Other problems to be addressed: _____

_____

When did you first notice your child's problem? _____

_____

_____

What did you first notice? _____

_____

Was the onset of your child's problem sudden or gradual? _____

_____

Was there any event or illness that you or others think brought on your child's symptoms? Describe: _____

_____

Therapies you have tired that helped or didn't help: _____

_____

_____

Tell us your child's story: _____

_____

_____

_____

_____

_____

_____

Please consider the disorders below in relation to this family tree. Write in the box of the family member (and include any other family members not listed) any corresponding condition(s). Remember to include deceased family members and note if there is limited/no contact with a family member.

PATERNAL SIDE				MATERNAL SIDE		
Grandfather	Grandmother				Grandfather	Grandmother
Uncle(s)	Aunt(s)	Father		Mother	Uncle(s)	Aunt(s)
Cousin(s)	Cousin(s)	Sibling(s)	THIS PATIENT	Sibling(s)	Cousin(s)	Cousin(s)

Autoimmune	**Cardiac**	**Gastrointestinal**	**Genetic**	**Neurologic**	**Psychological**	**Other**
Diabetes	Heart defects	Irritable bowel syndrome	Cystic fibrosis	Developmental delay	Anxiety	Unexplained deaths
Food Allergies	Arrhythmias	Lactose intolerance	Muscular dystrophy	Sensory processing disorder	Depression	Other cancer diagnoses
Seasonal Allergies	Hypertension	Constipation		Autism spectrum disorder	Schizophrenia	
Asthma	Heart disease < age 60	Diarrhea		ADD/ADHD	Bipolar	
Eczema	Stroke	Diverticulitis		Seizures	Substance Abuse	
Psoriasis	Sudden death	Colon cancer		Migraines		
Fibromyalgia		Crohn's		Headaches		
Rheumatoid Arthritis		Celiac disease		Meningitis		
Systemic Arthritis						
Systemic Lupus						
Sjogren's						
Scleroderma						

Carine Pediatrics / Ali M. Carine, D.O., LLC
Vaccination Policy

We believe that our job as providers is to put the health of your child as our first priority. This handout is designed to help you better understand our policy and your options.

A. Vaccination has undeniable benefits to society and childhood wellness. Our policy exists to honor parents' rights in regard to the care of their children.

B. There are many vaccinations in the current CDC schedule; each has been placed on the schedule for a different reason. The CDC schedule is intended to decrease cost and number of visits for families while vaccinating, as well as to give children protection against vaccine-preventable illnesses as efficiently as possible.

C. If parents desire to spread vaccines out for their child, we prefer they commit to the alternative schedule we have provided, rather than a schedule of their own. This limits opportunities for errors in administration.

D. Regarding deviations from either vaccine schedule:
   1. If a Practitioner recommends to defer vaccines at a specific appointment for your child due to medical reasons, they will help you determine an appropriate future time to schedule a vaccine catch-up (recheck) visit.
   2. If the parent chooses to decline one or more vaccines at a regularly-scheduled appointment, your child may catch up with these vaccines at a future regularly-scheduled well visit but may not schedule a separate nurse visit for vaccine delays which are not a specific Practitioner recommendation.

E. Disadvantage of delayed vaccination schedules: 1. More frequent visits to the office (these may generate co-pays, depending on your insurance). 2. Your child's vaccine record will appear "incomplete" to daycare centers and schools. Public institutions in Ohio are not allowed to keep you from being enrolled for these variations; however, they will require documentation. 3. Due to medical documentation requirements, any deviation from the CDC-recommended schedule by parental choice will generate a "vaccine refusal" code in your child's medical file. 4. Your child will remember more of the shots, because we are moving many of them into older ages. 5. The choice to delay certain vaccinations poses a risk of contracting that disease while awaiting vaccination.

F. If a child has never received vaccinations and parents wish to begin to catch them up, please schedule a one-time conference visit with a Practitioner to make a catch-up schedule. Please be aware that a minimum of 2 vaccines must be given at a time for catch-up with our office; if you elect to catch-up with one vaccine at a time, your child must receive these at the Health Department. Our reason for this policy is to honor the doctor-patient relationship by not having an older child associate our office with frequent negative psychological effects of receiving single shots over many visits.

The details of each vaccine, why it is in the CDC schedule, the disease it prevents, risks of catching the disease and more is available to you in a book by Dr. Robert Sears, "The Vaccine Book". The CDC vaccination website is: http://www.cdc.gov/vaccines/. The Immunization Action Coalition (IAC) website offers specific information at: http://www.immunize.org.

If you wish to discuss these policies in length, we require a separate office visit with a Nurse Practitioner. Although vaccines are an important part of your child's health, there are many other health issues we need to address at your child's well visits. We do not want to spend the time we have scheduled for your well visit solely on vaccines. We want to partner with you to raise your child to be as healthy as possible!

For your reference, we have included a list of the vaccine brands carried at our office. The vaccine brands we use have the lowest preservative content of options available on the current market. No vaccines we currently carry contain thimerisol/mercury.

Vaccine	Brand	Manufacturer
Hib	ActHib	Sanofi Pasteur
Prevnar	Prevnar 13	Pfizer
DTaP	Daptacel	Sanofi Pasteur
Polio	IPOL	Sanofi Pasteur
Pentacel (DTaP, Hib, Polio)	Pentacel	Sanofi Pasteur
Hep B	Recombivax	GSK
Hep A	Vaqta	Merck
MMR	MMR	Merck
Varicella	Varivax	Merck
Rotavirus	Rotateq (oral)	Merck
Tdap	Adacel	Sanofi Pasteur
Meningococcal	Menactra	Sanofi Pasteur
HPV	Gardasil	Merck
Flu	(varies by year and availability) – preservative-free unless we notify you otherwise	

The optional/alternative schedule keeps a child up to date for elementary school required vaccines. Not included in the optional/alternative vaccine policy is the Rotavirus Vaccine. The Hep A, Hep B, and MMR vaccines are also delayed.

Rotavirus is a very common infant diarrhea illness that frequently leads to the need for hospitalization for IV fluids, but rarely causes death in American Children. Children attending daycare centers are more likely to be affected by this illness and it may lead to more missed days of work by the parents if they do. Probiotics are a good option for the prevention and treatment of Rotavirus and for general immune health, but are not guaranteed to prevent infection.

Measles, Mumps, and Rubella (MMR), while significant illnesses to those who catch them, are uncommon in the U.S. children. Delaying also introduces risk of contracting measles, mumps, and rubella from 1-2 years old.

Hepatitis B is a disease transmitted through blood and body fluids. It is a deadly disease but most often infects individuals who are sexually active, medical employees or other occupations that handle infectious fluids. It is an important vaccine, but can safely be delayed unless the parents have been infected or exposed, in which case the Hep B vaccine should be administered within 24 hours of birth.

Hepatitis A commonly infects children and causes mild diarrhea. The risk of delaying vaccinating your child is that they may infect an adult around them and the adult may become ill. Infants rarely manifest serious illness from Hep A infection.

Carine Pediatrics / Ali M. Carine, D.O., LLC
Vaccination Policy

Standard Well Visit and Vaccination Schedule			
AGE	VISIT	VACCINES DUE (Option A – CDC standard schedule)	VACCINES DUE (Option B – delayed schedule)
Newborn (3-5 days old)	Wellness & Newborn check **+ Tdap vaccination of parent(s) for whooping cough if under-immunized**	(Hep B #1 if not given at birth-hospital)	x
2 Weeks Recheck	Weight Check (if necessary)	x	x
1 Month	Wellness & Development check	x	x
2 Months	Wellness & Development check	Pentacel #1 (DTaP+Hib+Polio), Hep B #2, Prevnar #1, Rotateq #1	Hib #1, Prevnar #1
*3 Mos. **	*Shot-only visit (not with practitioner)**	*(no visit)**	*DTaP #1**
4 Mos.	Wellness & Development check	Pentacel #2 (DTaP+Hib+Polio), Prevnar #2, Rotateq #2	Hib #2, Prevnar #2
*5 Mos. **	*Shot-only visit (not with practitioner)**	*(no visit)**	*DTaP #2**
6 Mos.	Wellness & Development check	Pentacel #3 (DTaP+Hib+Polio), Hep B #3, Prevnar #3, Rotateq #3	Hib #3, Prevnar #3
*7 Mos. **	*Shot-only visit (not with practitioner)**	*(no visit)**	*DTaP #3**
9 Mos.	Wellness & Development check	x	Polio #1, Hep B #1
12 Mos.	Wellness & Development check **+ AAP-recommended Lead and Hgb screening**	Hib #4, Prevnar #4, Hep A #1	Polio #2, Hib #4
15 Mos.	Wellness & Development check	MMR #1, Varicella #1	Polio #3, Prevnar #4
18 Mos.	Wellness & Development check	DTaP #4, Hep A #2	DTaP #4, Varicella #1
24 Mos.	Wellness & Development check	x	MMR #1, Hep B #2
30 Mos.	Wellness & Development check	x	Hep B #3
3 Yrs	Wellness & Development check	x	Hep A #1
*3 ½ Yrs. **	*Shot-only visit (not with practitioner)**	*(no visit)**	*Hep A #2**
4 Yrs.	Wellness & Development check **+ AAP-recommended Vision screening**	DTaP #4, Polio #4, MMR #2, Varicella #2	DTaP #4, Varicella #2
5 Yrs.	Wellness & Development check	x	MMR #2, Polio #4
6 Yrs.	Wellness & Development check	x	x
7 Yrs.	Wellness & Development check	x	x
8 Yrs.	Wellness & Development check	x	x
9 Yrs.	Wellness & Development check	x	x
10 Yrs.	Wellness & Development check	x	x
11 Yrs.	Wellness & Development check **+ AAP-recommended Lipid screening**	Tdap #1**, Menactra #1, HPV/Gardasil #1***	Tdap #1**, Menactra #1
12 Yrs.	Wellness & Development check	HPV/Gardasil #2***	HPV/Gardasil #1***
13 Yrs.	Wellness & Development check	HPV/Gardasil #3***	HPV/Gardasil #2***
14 Yrs.	Wellness & Development check	x	HPV/Gardasil #3***
15 Yrs.	Wellness & Development check	x	x
16 Yrs.	Wellness & Development check	Menactra #2	Menactra #2
17 Yrs.	Wellness & Development check **AAP-recommended Lipid screening**	x	x
18-21 Yrs., annually	Wellness & Development checks	x	x

** If following Option B vaccine schedule*
*** Second dose of Tdap due 10 years after first dose.*
**** If child receives first dose of HPV/Gardasil PRIOR TO his/her 15th birthday, only 2 doses are required and are given at least 6 months apart. If first dose of HPV/Gardasil is received AFTER a child's 15th birthday, 3 doses are required (at least 4 weeks between dose #1 and dose #2, and at least 6 months between dose #2 and dose #3). Coverage with the HPV/Gardasil vaccine is recommended for any individuals who are sexually active.*

Carine Pediatrics / Ali M. Carine, D.O., LLC
Vaccination Policy

Vaccine Schedule Selection

AGE: 0 – 5 Years

Outlined below are two options of vaccination schedules, the CDC's recommended vaccination schedule and an alternative vaccination schedule. Please choose between them. You can change your selection at any time. We have also supplied you with a copy of our vaccination policy. By signing below, you acknowledge that the choice to delay certain vaccinations poses a small risk of contracting that disease while awaiting vaccination.

	Option A / CDC's Recommended Schedule	**Option B / Optional Alternative Schedule**
Birth	Hep B	None
2 months	DTaP, Polio, Hib, Hep B, Prevnar, Rotateq	Hib, Prevnar
3 months	None	DTaP
4 months	DTaP, Polio, Hib, Prevnar, Rotateq	Hib, Prevnar
5 months	None	DTaP
6 months	DTaP, Polio, Hib, Hep B, Prevnar, Rotateq	Hib, Prevnar
7 months	None	DTaP
9 months	None	Polio, Hep B
12 months	Hib, Prevnar, Hep A	Polio, Hib
15 months	MMR, Varicella	Polio, Prevnar
18 months	DTaP, Hep A	DTaP, Varicella
2 yrs	None	MMR, Hep B
2 yrs, 6months	None	Hep B
3 yrs	None	Hep A
3 yrs, 6months	None	Hep A
4 yrs	DTaP, Polio, MMR, Varicella	DTaP, Varicella
5 yrs	None	MMR, Polio

Patient Name: _____ Date of Birth: _____

Please Select One in <u>Each Column</u> *below*:

_____ Option A/CDC's recommended vaccination policy.

_____ Option B/Optional alternative vaccination policy.

_____ I have chosen not to vaccinate my child _____

_____ I consent to sharing my child's immunization information with ImpactSIIS.

_____ I decline to sharing my child's immunization information with ImpactSIIS.

ImpactSIIS, Ohio's Immunization Registry: We may disclose the following health information to the state immunization registry; Immunization record, Body mass index, Vision screening, Lead screening, Tuberculosis results, and Hearing screening. You may request to be removed from the ImpactSIIS Immunization registry by requesting and completing a Registry Removal form. **Please make sure your selection here matches your selection on the HIPAA Acknowledgement form.**

--Please note that, if you decline one or more vaccines due according to the schedule you select for your child, these vaccines may be caught up at a future regularly-scheduled well visit (additional shot-only visits may <u>not</u> be scheduled except by practitioner discretion). Please be aware, deviations from either above schedule by parental request increase the chance of errors by our staff.

If your child has not received vaccines in the past and you wish to begin catch up, please schedule a conference with a practitioner to create a one-time vaccine catch up plan. Please note that this plan must include at least 2 vaccines per visit; if you wish to have your child receive one vaccine at a time these can be given at the Ohio Health Department.

Parent signature: _____ Date: _____

PRACTITIONER REVIEW: _____ Date: _____

Carine Pediatrics / Ali M. Carine, D.O., LLC
Vaccination Policy

Vaccine Schedule Selection

AGE: 6 – 21 Years

Outlined below are two options of vaccination schedules, the CDC's recommended vaccination schedule and an alternative vaccination schedule. Please choose between them. You can change your selection at any time. We have also supplied you with a copy of our vaccination policy. By signing below, you acknowledge that the choice to delay certain vaccinations poses a small risk of contracting that disease while awaiting vaccination.

	Option A / CDC's Recommended Schedule	**Option B / Optional Alternative Schedule**
6-10 yrs	None	(None/catch up for any vaccines not yet received)
11 yrs	Tdap**, Menactra, HPV/Gardasil**	Tdap**, Menactra
12 yrs	HPV/Gardasil***	HPV/Gardasil – optional***
13 yrs	HPV/Gardasil***	HPV/Gardasil – optional***
14 yrs	None	HPV/Gardasil – optional***
15 yrs	None	None
16 yrs	Menactra	Menactra
17-21 yrs	None	(None/catch up for any vaccines not yet received)

*** Second dose of Tdap due 10 years after first dose.*

**** If child receives first dose of HPV/Gardasil PRIOR TO his/her 15th birthday, only 2 doses are required and are given at least 6 months apart. If first dose of HPV/Gardasil is received AFTER a child's 15th birthday, 3 doses are required (at least 4 weeks between dose #1 and dose #2, and at least 6 months between dose #2 and dose #3). Coverage with the HPV/Gardasil vaccine is recommended for any individuals who are sexually active.*

Patient Name: _____ Date of Birth: _____

Please Select One in <u>Each Column</u> *below*:

_____ Option A/CDC's recommended vaccination policy.

_____ Option B/Optional alternative vaccination policy.

_____ I have chosen not to vaccinate my child _____

_____ I consent to sharing my child's immunization information with ImpactSIIS.

_____ I decline to sharing my child's immunization information with ImpactSIIS.

ImpactSIIS, Ohio's Immunization Registry: We may disclose the following health information to the state immunization registry; Immunization record, Body mass index, Vision screening, Lead screening, Tuberculosis results, and Hearing screening. You may request to be removed from the ImpactSIIS Immunization registry by requesting and completing a Registry Removal form. **Please make sure your selection here matches your selection on the HIPAA Acknowledgement form.**

--Please note that, if you decline one or more vaccines due according to the schedule you select for your child, these vaccines may be caught up at a future regularly-scheduled well visit (additional shot-only visits may <u>not</u> be scheduled except by practitioner discretion). Please be aware, deviations from either above schedule by parental request increase the chance of errors by our staff.

If your child has not received vaccines in the past and you wish to begin catch up, please schedule a conference with a practitioner to create a one-time vaccine catch up plan. Please note that this plan must include at least 2 vaccines per visit; if you wish to have your child receive one vaccine at a time these can be given at the Ohio Health Department.

Parent signature: _____ Date: _____

PRACTITIONER REVIEW: _____ Date: _____

Privacy Practices Acknowledgement Statement / HIPAA Acknowledgement

I hereby acknowledge that I have been made aware that Carine Pediatrics /Ali M. Carine, D.O., LLC has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient of Carine Pediatrics /Ali M. Carine, D.O., LLC I understand and acknowledge the following:

1. Carine Pediatrics /Ali M. Carine, D.O., LLC has a privacy policy in effect in their office.
2. Carine Pediatrics /Ali M. Carine, D.O., LLC has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar common area with patient access.
3. Carine Pediatrics /Ali M. Carine, D.O., LLC has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the Privacy Policy implemented by Carine Pediatrics /Ali M. Carine, D.O., LLC and have read and understand the acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time. Please also elect if you wish to consent or decline to sharing your child's immunization information with ImpactSIIS. **Please make sure your selection here matches your selection on the Vaccination Schedule Selection form.**

Please select ONE in <u>EACH box</u> below:

_____ <u>NO, I do NOT want a copy</u>, but acknowledge the Privacy Policy exists.

_____ <u>Yes, I DO want a copy</u> of the Privacy Policy and I received requested copy. Initials___

_____ I consent to sharing my child's immunization information with ImpactSIIS.

_____ I decline to sharing my child's immunization information with ImpactSIIS.

_____	_____	_____
Patient Name	Patient / Parent Signature	Date

For more information contact Carine Pediatrics /Ali M. Carine, D.O., LLC Compliance & Privacy Officer at 614.459.4200.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.
_____ Communication barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement.
_____ Other

_____	_____
Staff Signature	Date

Carine Pediatrics / Ali M. Carine, D.O., LLC
Medical Release of Information Authorization

--To have records sent **TO** Carine Pediatrics /Ali M. Carine, D.O., LLC--

I hereby authorize the below mentioned office (please include office name, address, phone and fax):

_____

_____

_____

Office Phone: ( ) - **Fax:** ( ) -

to release any and all medical records (as specified below), including but not limited to; hospitalization for diagnosis and/or treatment of psychiatric and/or medical condition, alcoholism, drug abuse, and/or HIV test results, AIDS, or AIDS related conditions **to** the following office:

Carine Pediatrics /Ali M. Carine, D.O., LLC
3300 Riverside Drive, Suite 200
Upper Arlington, Ohio 43221
Phone: (614) 459-4200, **Fax: (614) 459-1589**

USES

The purpose of the release of this information is (please select only **ONE** box below):

- ☐ Transfer of Primary Care
- ☐ Pending Legal Action
- ☐ Consultative Care ONLY
- ☐ Other (please specify): _____

RESTRICTIONS

The recipient should not further disclose medical information unless a valid authorization is obtained or unless such use or disclosure is specifically required or permitted by law.

DURATION

This authorization will expire 1 year from the signature date below or at an earlier date, at my election. To cancel this authorization prior to the above limit, written notification (bearing the non-minor patient, Parent, Legal Guardian, or Legal Representative's signature) must be sent to the Office/Medical Record Department of Carine Pediatrics /Ali M. Carine, D.O., LLC.

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: _____

Date(s) of Treatment: **ALL** unless otherwise specified here: _____

SIGNATURES

Parent/Guardian's Signature: _____ **Date:** _____
(or Legal Representative)

Patient's Signature: _____ Date: _____
(only needed if PATIENT is no longer a minor)