North Arlington Pediatrics

1430 N. Arlington Heights Road., Ste 210
Arlington Heights, IL 60004
(847) 253-3600
www.northarlingtonpediatrics.com

Welcome to the North Arlington Pediatrics family!

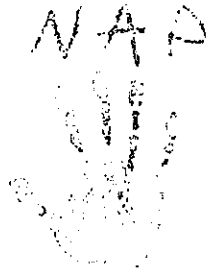
Attached is our New Patient Packet. Please complete the attached forms and turn them in by the end of your first appointment.

We are excited to have you join our practice!

Sincerely,
The Staff of North Arlington Pediatrics

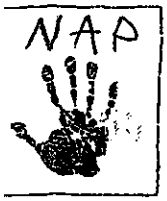
Forms Attached:
= Form needs to be completed and turned in to a Front Desk staff member by the end of your first appointment

- Notice of Privacy Practices (4 pages)
- Vaccination Schedule
- **Registration Form ***
  - Please make sure to list ALL children who are patients in our office, even if they are not here for today's appointment.
- Financial Policy (2 pages to read only)
- **Acknowledgement and Acceptance of Financial Policy***
  - Please make sure to list ALL children who are patients in our office, even if they are not here for today's appointment.
- Consent for Lactation Consultation ***(*-ONLY if you plan on seeing our Lactation Consultant within a year of today's date)***
- Newborn- 3 months History Questionnaire ***(* ONLY if you have a child that is younger than 3 months of age)***
- New Patient 3 months+ History Questionnaire ***(* ONLY if you have a child is who older than 3 months of age)***
- 2018 Screening*
  - Please make sure to list ALL children who are patients in our office, even if they are not here for today's appointment.



North Arlington Pediatrics
1430 N. Arlington Heights Road., Ste 210
Arlington Heights, IL 60004
(847) 253-3600
www.northarlingtonpediatrics.com

NOTICE OF PRIVACY PRACTICES



North Arlington Pediatrics, S.C.
1430 N. Arlington Heights Road
Suite 210
Arlington Heights, IL 60004

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about your child (as a patient of North Arlington Pediatrics, S.C.) may be used and disclosed, and how you can get access to your child's protected health information.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of our child's protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies your child. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your child's PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

How we may use and disclose your child's PHI.

Your child's privacy rights in his/her PHI.

Our obligations concerning the use and disclosure of your child's PHI.

Revised 2-18

The terms of this notice apply to all records containing your child's PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your child's records that our practice has created or maintained in the past, and for any of your child's records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

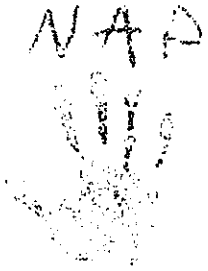
B. If You Have Any Questions About This Notice Please Contact: Privacy Manager, 1430 N. Arlington Heights Road, Suite 210, Arlington Heights, IL 60004, (847) 253-3600.

C. We May Use and Disclose Your Child's Protected Health Information (PHI) in the Following Ways

The following categories describe the different ways in which we may use and disclose your child's PHI.

1. Treatment. Our practice may use your child's PHI to treat your child. For example, we may ask your child to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your child's PHI in order to write a prescription for your child, or we might disclose your child's PHI to a pharmacy when we order a prescription for your child. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your child's PHI in order to treat your child or to assist others in your child's treatment. Additionally, we may disclose your child's PHI to others who may assist in your child's care, such as your spouse, children or parents. Finally, we may also disclose your child's PHI to other health care providers for purposes related to your child's treatment.

2. Payment. Our practice may use and disclose your child's PHI in order to bill and collect payment for the services and items your child may receive from us. For example, we may contact your health insurer to certify that your child is eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your



North Arlington Pediatrics

1430 N. Arlington Heights Road., Ste 210
Arlington Heights, IL 60004
(847) 253-3600
www.northarlingtonpediatrics.com

child's treatment to determine if your insurer will cover, or pay for, your child's treatment. We also may use and disclose your child's PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your child's PHI to bill you directly for services and items. We may disclose your child's PHI to other healthcare providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your child's PHI to operate our business. As examples of the ways in which we may use and disclose your child's information for our operations, our practice may use your child's PHI to evaluate the quality of care your child received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your child's PHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your child's PHI to contact you and remind you of an appointment.

5. Release of Information to Family/Friends. Our practice may release your child's PHI to a friend or family member that is involved in your child's care, or who assists in taking care of your child. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

6. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and Disclosure of Your Child's PHI in Certain Special Circumstances

The following categories describe unique scenarios in which we may use or disclose your child's protected health information:

1. Public Health Risks. Our practice may disclose your child's PHI to public health authorities that are authorized by law to collect information for the purpose of:

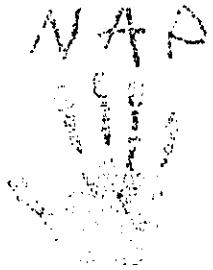
- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your child's employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your child's PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your child's PHI in response to a court or administrative order, if your child is involved in a lawsuit or similar proceeding. We also may disclose your child's PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release your child's PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process



North Arlington Pediatrics

1430 N. Arlington Heights Road., Ste 210
Arlington Heights, IL 60004
(847) 253-3600
www.northarlingtonpediatrics.com

- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Deceased Patients.** Our practice may release your child's PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation.** Our practice may release your child's PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if your child is an organ donor.

7. **Serious Threats to Health or Safety.** Our practice may use and disclose your child's PHI when necessary to reduce or prevent a serious threat to your child's health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. **Military.** Our practice may disclose your child's PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. **National Security.** Our practice may disclose your child's PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your child's PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. **Inmates.** Our practice may disclose your child's PHI to correctional institutions or law enforcement officials if your child is an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to your child, (b) for the safety and security of the institution, and/or (c) to protect your child's health and safety or the health and safety of other individuals.

11. **Workers' Compensation.** Our practice may release your child's PHI for workers' compensation and similar programs.

12. **Research.** We may disclose your child's 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 child's protected health information.

13. **Other Uses and Disclosures.** Our practice does not use or disclose your child's PHI to an employer or health care sponsor, for underwriting and related purposes, for facility directories, to brokers and agents, or for fund-raising. If an individual wants the practice to release your child's PHI to employers or health plan sponsors, for underwriting and related purposes, for facility directories, to brokers and agents, then you can contact our practice and complete an appropriate authorization.

E. Your Rights Regarding Your Child's PHI

You have the following rights regarding your child's PHI that we maintain about your child:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your child's health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to: **Privacy Manager, 1430 N. Arlington Heights Road, Suite 210, Arlington Heights, IL 60004**, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your child's PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your child's PHI to only certain individuals involved in your child's care or the payment for your child's care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat your child. In order to request a restriction in our use or disclosure of your child's PHI, you must make your request in writing to: **Privacy Manager, 1430 N. Arlington Heights Road, Suite 210, Arlington Heights, IL 60004.** Your request must describe in a clear and concise fashion:

North Arlington Pediatrics

1430 N. Arlington Heights Road., Ste 210
Arlington Heights, IL 60004
(847) 253-3600
www.northarlingtonpediatrics.com

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about your child, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: **Privacy Manager, 1430 N. Arlington Heights Road, Suite 210, Arlington Heights, IL 60004, (847) 253-3600** in order to inspect and/or obtain a copy of your child's PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Autodial and Electronic Contact. I authorize group, its physicians, practitioners, independent contractors, business associates, agents and/or affiliates to contact me using autodialed calls, texts, robocalls and artificial voices or prerecorded voices, at the telephone numbers identified in our registration form with regard to billing, collections and other account activities, and for advertisement and telemarketing purposes. I understand that I am not required to provide this call consent and it is not a condition of purchasing healthcare goods or services and I may revoke it at any time.

5. Amendment. You may ask us to amend your child's health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: **Privacy Manager, 1430 N. Arlington Heights Road, Suite 210, Arlington Heights, IL 60004.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of your child's PHI kept by or for the practice; (c) not part of your child's PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

6. Accounting of Disclosures. All of our patients have the a right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your child's PHI for non-treatment, non-payment or non-operations purposes. Use of your child's PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to: **Privacy Manager, 1430 N. Arlington Heights Road, Suite 210, Arlington Heights, IL 60004.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact: **Privacy Manager, (847) 253-3600.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your child's PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your child's PHI for the reasons described in the authorization. Please note, we are required to retain records of your child's care.

9. In Illinois, a specific written authorization is required to disclose or release mental health treatment, alcoholism treatment, drug abuse treatment or HIV/acquired immune deficiency syndrome, (AIDS) information.

Again, if you have any questions regarding this notice or your child's health information privacy policies, please contact: **Privacy Manager, (847) 253-3600.**

POS Reorder # 1603730

North Arlington Pediatrics

1430 N. Arlington Heights Road., Ste 210
Arlington Heights, IL 60004
(847) 253-3600
www.northarlingtonpediatrics.com

Vaccination Schedule

Dear North Arlington Pediatrics Parents:

Below is our vaccination schedule. It is very important that you check with your insurance company to make sure you have coverage for vaccines and well care visits.

Age	Hepatitis B Given in Hospital	No Hepatitis B Given in Hospital
2 Month	Pentacel* Pneumococcal, Rotarix	Pentacel* Pneumococcal, Rotarix
1-3	Hepatitis B	Hepatitis B
4 Month	Pentacel, Pneumococcal, Rotarix	Pentacel, Pneumococcal, Rotarix
4-5		Hepatitis B
6 Month	Pentacel, Pneumococcal, Hepatitis B	Pentacel, Pneumococcal
8 or 10		Hepatitis B
12 Month	Pneumococcal, Hepatitis A, HIB	Pneumococcal, Hepatitis A, HIB
15 Month	MMR, Varicella	MMR, Varicella
18 Month	DTap, Hepatitis A	DTap, Hepatitis A
24 Month	Hepatitis A *(if not given before)*	Hepatitis A *(if not given before)*
4 Year	MMR, Varivax	MMR, Varivax
5 Year	Kinrix (DTap, IPV)	Kinrix (DTap, IPV)

* Pentacel= DTap,HIB, Polio

Vaccines Recommended for children 10 years of age and older:

Age	Vaccine	Recommendation
10	Tdap *(Tetanus, Diphtheria, Pertussis)*	Required for 6th grade entry
11	Meningitis Groups A,C,Y, and W	Required for 6th grade entry; booster at 16 years of age
11-12	Gardasil (*Human Papillomavirus*)	Recommended for middle school adolescents
16	Meningitis Groups A,C,Y, and W	Reqired for 12th grade entry (Booster Dose)
16-18	Meningitis Group B	Recommended 2 dose series at least one month apart
11-18	Hepatitis A	If not yet received 2 dose series 6-12 months apart

North Arlington Pediatrics, S.C.

1430 North Arlington Heights Road, Suite 210
Arlington Heights, IL 60004
tel: (847) 253-3600
fax: (847) 253-3912

David S. Dobkin, M.D.
Beth S. Walsh, M.D.
Timothy Geleske, M.D.
Kristen Brown, M.D.
Andrew Peters, M.D.
Michele Lawhun, M.D.
Nan Walicki, M.D.
Suzanne Alfano, M.D.

PATIENT REGISTRATION FORM

Verified by: _____

Family Last Name _____
(Please print)

Mother's Information (Or Guardian)	Father's Information (Or Guardian)
Name: _____ DOB: _____	Name: _____ DOB: _____
Address: _____	Address: _____
City: _____ ST: ____ Zip: _____	City: _____ ST: ____ Zip: _____
(If different than father's address)	(If different than mother's address)
Phone: Primary: (____) _____ ☐ Home ☐ Cell ☐ Work	Phone: Primary: (____) _____ ☐ Home ☐ Cell ☐ Work
Secondary: (____) _____ ☐ Home ☐ Cell ☐ Work	Secondary: (____) _____ ☐ Home ☐ Cell ☐ Work
E Mail Address: _____	E Mail Address: _____
Occupation: _____	Occupation: _____
Employer: _____ Phone: (____) _____	Employer: _____ Phone: (____) _____
Address: _____	Address: _____
City: _____ ST: _____ Zip: _____	City: _____ ST: _____ Zip: _____
Marital Status: _____	Marital Status: _____

If divorced, which address is the child's (children's) primary address: Mother _____ Father _____ Guardian _____

INSURANCE	INSURANCE
Cardholder's Name: _____	Cardholder's Name: _____
Primary Insurance: _____	Secondary Insurance: _____
Group Number: _____	Group Number: _____
Cardholder ID #: _____	Cardholder ID #: _____

LIST ALL CHILDREN IN FAMILY WHO ARE PATIENTS IN OUR OFFICE:

Name: _____ DOB: _____ M F Name: _____ DOB: _____ M F

Name: _____ DOB: _____ M F Name: _____ DOB: _____ M F

Name: _____ DOB: _____ M F Name: _____ DOB: _____ M F

Emergency Contact: (Not Parent) Name: _____ Phone: (____) _____
Relationship

Address: _____ City: _____ ST: ____ Zip: _____

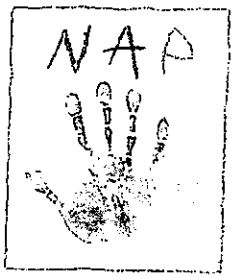
Name of Preferred Pharmacy: _____ **City:** _____

Intersections: _____

Authorization to Treat:
There may be occasions when a parent (guardian) is not available to bring your child(ren) to our office. Your signature below allows us to provide care for your child(ren) in your absence. Otherwise, we need written permission prior to caring for your child(ren) for **each** occurrence.

Signature of Parent/Guardian: _____ **Date:** _____

POS Reorder #1204789



David Dobkin, M.D. · Beth S. Walsh, M.D. · Timothy Geleske, M.D. · Kristen Brown, M.D.
Andrew Peters, M.D. · Michele Lawhun, M.D. · Nan Walicki, M.D. · Suzanne Alfano, M.D.

North Arlington Pediatrics, S.C.
Financial Policy

At North Arlington Pediatrics, SC (NAP), we believe that all patients who are rendered care at our office deserve the best medical care that can be provided. The following information is provided to help you understand your financial responsibilities, as well as the policies and procedures of North Arlington Pediatrics. Please read, sign and date this agreement on the last page to indicate you accept these terms.

Insurance Coverage

It is your responsibility to provide accurate insurance information at the time services are rendered. Our office policy is to request your insurance card at every visit to guarantee that our office staff has the correct information at all times.

NAP will submit claims to your insurance carrier on your child's behalf. It is your responsibility to verify benefits under your plan. ***Your insurance policy is a contract between you and your insurance company.*** We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, co-insurance and non-covered charges. Please contact your insurance carrier, not North Arlington Pediatrics, if you have questions about the insurance coverage or payment. **If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment.** You are responsible for timely payment on your account.

We are required by our insurance contracts to collect all copays at the time of service. Failure to collect applicable copays put both of us in default of the insurance contract. The parent or guardian accompanying the patient is responsible for all copayments and non-covered services at the time of service. **If the copay is not received within 7 business days of the initial date of service, a $10.00 administrative service fee for processing your copayment after your visit will be added to the account.**

Once your insurance company has processed your claim, our business office staff will post any payment it receives to your account. For every charge submitted, the insurance company issues an Explanation of Benefits (EOB) to the policyholder and North Arlington Pediatrics. If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved in writing by the business office, the balance on your statement is due and payable when the statement is issued and is considered past due if not paid within thirty (30) days of issuance. If you have questions regarding the coverage or payment from your insurance carrier please call them with any questions, not North Arlington Pediatrics.

Change of Insurance/Change of Address

Please notify the business office as soon as possible of all insurance and address changes. The responsible party (parent or legal guardian) is responsible for all charges not paid as a result of change in insurance coverage.

Payment Options

Our office accepts Visa, MasterCard, Discover and American Express. We also accept cash or checks. Checks returned unpaid by your bank, regardless of the reason, will be posted back to your account in the original amount of the check in addition to a $25 returned check fee. Once we have a returned check, we may require all future payments be with cash, money order or credit card.

Newborns

It is your responsibility to contact your insurance carrier to have your newborn child added to your insurance within the first week of birth, if not sooner, as dictated by the insurance carrier. You understand that failure to do so will jeopardize your child's ability to be insured. You will provide North Arlington Pediatrics with your child's health care coverage information immediately upon receipt and within thirty (30) days of birth to assure timely billing. You understand that failure to contact your insurance carrier will result in your child not having health care coverage and you will be financially responsible for all medical services rendered by North Arlington Pediatrics.

Uninsured/Self-pay Accounts
We offer a discount to all self-pay patients and payments must be made on the date of service. If you do not make payment on the date of service, full prices will be applied to that visit.

Parental Divorce

The parent who carries the insurance will be responsible for all uncovered services, unless North Arlington Pediatrics is in receipt of a court order or letter stating otherwise from the party requesting financial designation. The parent or guardian accompanying the patient is responsible for providing North Arlington Pediatrics with current demographic and contact information for both parents. If the demographic information for the parent responsible for the insurance cannot be provided, the other parent/guardian will become the responsible party until proper information is received. The parent accompanying the child to the visit will be responsible for copays unless otherwise stated by court order or written agreement by both parents. You will be responsible for the charges accrued by minor children (under age 18) who come into the office unaccompanied, or in the presence of another caregiver (i.e. grandparents, baby-sitter, etc.)

Missed Appointments/No Shows/Late for Appointment
We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Missed appointments are cost to us, to you and to other children who could have used the time set aside for your child. Cancellation or re-scheduling for a Well Visit is required 24 hours in advance and cancellation for a sick visit is required at least 1 hour prior to the scheduled appointment. A charge of $50 will be assessed and must be paid prior to making another appointment. If you are more than 20 minutes late for an appointment, North Arlington Pediatrics may have to re-schedule your appointment. Recurrent missed appointments are ground for dismal from our practice.

Medical Records
Copies of medical records are available to the patient or authorized representative for a fee as allowed by law. You will need to complete the authorization to release records form, which can be obtained from our office. This form needs to be completed in its entirety for us to process the request. Please allow two weeks lead time for records. All patient account balances should be paid in full before records are transferred. Your first set of medical records are processed at no charge, if an additional set is required, you will be charged the allowed fee by the State of Illinois.

Forms
Due to the increasing costs of providing our patients with the highest standards of care, we may impose a charge for certain forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. We will automatically give you a school/camp/sports/daycare form at the time of your child's physical. Please keep the original and photocopy it for anyone requesting a health form. If you require the office to provide an additional form before your next scheduled physical exam, there may be an administration fee of $10.00 to be paid at the time of pick-up or over the phone payment if we are faxing or emailing it. Forms such as FMLA, Disability or Supplemental Insurance forms will be $15.00. Dictated letters, extensive forms with review of medical records may be $25.00 per page.

Assignment of Benefits
I request that payment of authorized Medicaid and commercial insurance benefits be made on my behalf to the name of provider of service (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to Medicaid Services and its agents, or any other insurer and its agents, any information needed to determine these benefits payable for related service.

I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment check(s) direct to North Arlington Pediatrics, SC for medical services rendered to my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

Authorization to Release Information
I hereby authorize North Arlington Pediatrics, SC: (1) release any information necessary to insurance carriers regarding my dependents illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by North Arlington Pediatrics, SC.

Acknowledgement and Acceptance of Financial Policy

I have read and understand the policies of North Arlington Pediatrics, SC Financial Policy. I agree that I am financially responsible for any professional services rendered regardless of insurance coverage. I also agree that if it becomes necessary to forward my account to a third-party collection agency due to nonpayment for medical services rendered, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency and all related collection expenses. By signing below, I acknowledge that I have received a copy of the North Arlington Pediatrics Financial Policy, have read it and agree to its terms.

_____

Name (printed clearly)

_____ _____

Signature of Parent or Legal Guardian Date

Name of children seen at our practice. PLEASE PRINT CLEARLY

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

David Dobkin, M.D. Beth S. Walsh, M.D. Timothy Geleske, M.D. Kristen Brown, M.D.
Andrew Peters, M.D. Michele Lawhun, M.D. Nan Walicki, M.D. Suzanne Alfano, M.D.

Consent for Lactation Consultation-North Arlington Pediatrics, S.C.

I give my consent for the lactation consultant to work with me and my baby during this consultation for my breastfeeding problem/concern. This consent is for face-to-face visits and all follow-up contacts; it includes telephone conversations, and information sent via the Internet, patient portal, fax or regular mail.

I understand the consultation may include but not be limited to a visual examination and manual palpation of my breasts as well as an examination of my infant's mouth and sucking patterns and an observation of a breastfeeding session.

I give my consent for the lactation consultant to discuss my baby's progress with the doctors at North Arlington Pediatrics and my primary health care provider with a report of our consultation, as the ethics of her profession require, and to consult with them in any way she deems appropriate. I agree that she may discuss my case and forward my contact information to a breastfeeding support group counselor.

While the advice given by NAP's Lactation Consultant is effective in most instances, I understand that these recommendations may not completely remedy or prevent adverse symptoms. The success depends, in large part, on my follow through with the recommendations. I understand that my physician is my primary heal care provider and that he/she is responsible for the overall care of my infant/s. I will receive written recommendations at the end of this visit. Your Care Plan can be sent to you through our portal. If you are not web-enabled, please stop by our front desk and they will assist you in setting this up.

I understand that for this lactation consultation and all follow-up, the lactation consultant will protect the privacy of my personal health information as required by the Code of Professional Conduct of the International Board of Lactation Consultant Examiners, the IBLCE Scope of Practice for IBCLCs, the Standards of Practice of the International Lactation Consultant Association, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I have received a copy of the Notice of Privacy Practices of North Arlington Pediatrics.

_____/_____/_____
Mother's name (printed) Signature Date

_____/_____/_____
Lactation Consultant (printed) Signature Date

North Arlington Pediatrics, S.C.
1430 N. Arlington Heights Road Arlington Heights Illinois 60004
tel (847) 253-3600 fax (847) 253-3912

Newborn- 3 months History Questionnaire

(If filling out during your prenatal consult, please fill out as much as possible before delivery a
form during your first visit)

Prenatal Consult: Due Date: _____ Delivering at: _____

Family Last Name: _____

Mom's Name: _____ Mom's Maiden Name: _____

Dad's Name: _____

CHILD'S NAME: _____ | DOB _____

FORM COMPLETED BY: _____

Household

What is the child's living situation?

Lives with:

___ Biological Parents ____ Adoptive Parents

___ Foster Family ____ Joint Custody

___ Single Custody (if so, who do they live with: _____)

___ Other: _____

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

Name:	Relationship to Child:	Birth Date:

Birth History

___ I do not know the birth history

Born at _____ weeks and was delivered by _____ (vaginal or cesarean).

If cesarean, why? _____

Was the baby breech? Yes No

Was the baby conceived by IVF or other forms of assisted fertility? Yes No

If yes, did you use a donor egg or donor sperm? _____

Were there any prenatal or neonatal complications? Yes No

Explain: _____

Any prenatal ultrasound abnormalities? Yes No

Explain: _____

Was a NICU stay required? Yes No

Explain: _____

Infant currently feeding by Formula or Breast Milk

During pregnancy, did mother:

Use tobacco Yes No

Drink alcohol Yes No

Use drugs Yes No

Use Prenatal Vitamins Yes No

Take medication Yes No

Explain: _____

Any other information you feel the pediatrician should know?

_____

Biological Family History ___ I do not know(DK) the birth history

1st or 2nd generation family members (grandparents, parents, aunts, uncles, cousins) with the following?

Does anyone in your family have:	Y	N	DK	If yes, which family member?
Food Allergies				
Nasal Allergies				
Asthma				
Bedwetting (after 6 years old)				
Dental Decay				
Childhood hearing loss				
Eye Disorders/ Congenital Abnormalities/ Retinoblastoma				
Epilepsy/ Seizures				
Migraines or other Neurological Disorder				
Developmental Disabilities				
Autism/ Cognitive Delay				
ADHD				
Immune Problems, HIV, Tuberculosis				
Thyroid Problems or other Endocrine Disease				
Autoimmune Disease				
Anemia				
Genetic or Heritable Disease				
Bleeding or Blood Disorder				
Stomach/ Intestinal Problems				
Liver Disease				
Kidney Disease/ Urologic Malformations				
Heart Abnormalities (congenital heart disease, valve abnormalities, arrhythmias, hypertrophic cardiomyopathy, etc.)				
Hypertension/ High Blood Pressure				
High Cholesterol or takes cholesterol medication				
Heart Attack (before age 60)				
Diabetes				
Obesity				
Cancer (before age 55)				
Depression				
Anxiety				
Eating Disorder				
Other mental illness				
Does either parent smoke cigarettes?				
Is the child exposed to cigarettes on a regular basis?				
Substance/ Drug Abuse				
Are there guns in the house?				
Do your children visit any house where guns are kept?				

Other Medical History:

_____

_____

_____

New Patient 3 month+ History Questionnaire

CHILD'S NAME: _____ | DOB _____
FORM COMPLETED BY: _____

Household

What is the child's living situation?
Lives with:
__ Biological Parents
__ Adoptive Parents
__Foster Family
__Joint Custody
__Single Custody
(if so, who do they live with:
_____
Other: _____

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

Name:	Relationship to Child:	Age:

Birth History ___ I do not know the birth history

Birth weight _____
Was the child born at term? Yes No
If preterm, how many weeks _____
Was the baby conceived by IVF or other forms of assisted fertility? Yes No
If yes, did you use a donor egg or donor sperm? _____
Were there any prenatal or neonatal complications? Yes No
Explain: _____

During pregnancy, did mother:
Use tobacco Yes No
Drink alcohol Yes No
Use drugs Yes No
Take medication Yes No
Explain: _____

Any other information you feel the pediatrician should know?
_____
_____

General Medical History ___ I do not know (DK)

Do you consider your child to be in good health? Yes No DK
Explain:
_____
_____

Has your child had any surgery? Yes No DK
If applies:

Surgery List:	Dates:	Hospital:	Surgeon:

Turn over →

Has your child every been hospitalized? Yes No DK

Dates:	Hospital:	Reason:

Is your child **allergic** to any medication or food? Yes No DK
Explain:

Current Medications:

Any significate past medications the doctor should know about? _____

Past History

___ I do not know (DK) the child's past history

Does your child have, or has your child ever had	Y	N	DK	Explain
Chickenpox				When:
Frequent ear infections/ problems with ears or hearing				
Asthma, bronchitis, bronchiolitis, or pneumonia				
Any heart problems / heart murmur / high blood pressure				
Anemia / bleeding problems / blood transfusions				
Frequent abdominal pain/ intestinal problems/constipation				
Recurrent urinary tract infections				
Kidney disease or urological malformations				
Bed-Wetting (after 6 years old)				
Eye Problems/ Cataracts/ Retinoblastoma				
Metabolic/ Genetic Disorder				
Sleeping problems / snoring				
Chronic or recurrent skin problems (eg, acne, eczema)				
Immune Problem/TB/ HIV				
Autoimmune Disease				
Cancer or Tumor				
Frequent Headaches/ Migraines				
Seizure Disorder				
Obesity/ Eating Disorder				
Diabetes				
Thyroid or other endocrine problems				
History of serious injuries/ fractures/concussions				
ADHD				
Learning Disabilities / Cognitive Delay				
Developmental Delay				
Autism				
Anxiety/ Mood problems/ Depression/ Psychiatric Illness				
History of family violence				

Any other signification problem:

Dr._____
Reviewed: ☐

FILL OUT ONCE A YEAR PER FAMILY
2018 Screening

Family Name_____ DATE_____

Please list all children living in the home:

Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____
Name: _____ DOB: _____

Who do the children live with?

Lives with:

___ Parents ___ Foster Family _____ Joint Custody
_____ Single Custody (if so, who do they live with: _____)
___ Other: _____

Does your child belong to any of the following ethnic groups? (Please Circle)

American Indian African American Hispanic American Asian/South Pacific Islands Caucasian

Respond to the following questions by circling the appropriate answer

TB:

1. Is there a family history of tuberculosis or suspicion of tuberculosis in any family member? YES NO
2. Was this child or his/her parents born in South America, Africa, Central America, Southeast Asia or any other foreign country? YES NO
3. Have any members of the family in close contact been in jail or prison? YES NO
4. Do you live in the city of Chicago or in a neighborhood that is known to have high prevalence of tuberculosis? YES NO
5. Have you or your child traveled out of the country in the last year or have you had visitors from out of the country? YES NO
   If so, where _____

Lead Risk Assessment: (FILL THIS SECTION OUT ONLY FOR CHILDREN UNDER 6 YEARS OF AGE)

1. Is any child in your family eligible for or enrolled in Medicaid, Head Start, All Kids, or WIC? YES NO
2. Does any child in your family have siblings with a blood lead level of 10 mcg/dL or higher? YES NO
3. Does any child in your family live in or regularly visit a home built before 1978? YES NO
4. In the past year, has this child been exposed to repairs, repainting or renovations of a home built before 1978? YES NO
5. Are any of your children a refugee or an adoptee from any foreign country? YES NO
6. Has any child in your family been to Mexico, Central or South American, or any Asian country? YES NO
7. Does any child in your family live with someone who has a job or hobby that may involve lead (for example: jewelry making, construction, plumbing, automobiles, lead solders, leaded glass, lead shots, lead finishing sinkers?) YES NO
8. At any time, has your family lived near a factory where lead is used? YES NO
9. Does your family reside in a high-risk ZIP code area? YES NO
   (Such as, Chicago, Winnetka, River Forest, Evanston, Brookfield, Riverside, Highland Park, Oak Park)

(Please fill out the other side of this form)

Does anyone in your family (1st and 2nd generation) have a history of: *(Mother, Father, Grandparents, Aunts, Uncles, and 1st cousins)*	**Y**	**N**	**DK**	**If yes, who and describe:** *(Which family member and also Maternal or Paternal side of the family)*
Food Allergies				
Nasal Allergies				
Asthma				
Bedwetting (after 6 years old)				
Childhood hearing loss				
Eye Disorders/ Congenital Abnormalities/ Retinoblastoma				
Epilepsy/ Seizures				
Migraines or other Neurological Disorder				
Developmental Disabilities				
Autism/ Cognitive Delay				
ADHD				
Immune Problems, HIV, Tuberculosis				
Thyroid Problems or other Endocrine Disease				
Autoimmune Disease				
Anemia				
Genetic or Heritable Disease				
Bleeding or Blood Disorder				
Stomach/ Intestinal Problems				
Liver Disease				
Kidney Disease/ Urologic Malformations				
Heart Abnormalities (congenital heart disease, valve abnormalities, arrhythmias, hypertrophic cardiomyopathy, etc.)				
Hypertension/ High Blood Pressure				
High Cholesterol or takes cholesterol medication				
Heart Attack (before age 60)				
Diabetes				
Obesity				
Cancer (before age 55)				
Depression				
Anxiety				
Eating Disorder				
Other mental illness				
Does either parent smoke cigarettes, vape or use any tobacco product?				
Is your child exposed to smoke from any tobacco product at home or on a regular basis?				
Substance/ Drug Abuse				
Are there guns in the house?				
Do your children visit any house where guns are kept?				