WESTERVILLE PEDIATRIC SPECIALISTS, INC.
575 Westar Crossing, Suite 101
Westerville, Ohio 43082
614/508-ABCD
FAX 614/508-2233

SUNBURY MILLS PEDIATRICS
700 West Cherry Street, Suite B
Sunbury OH 43074
740/965-6369
FAX 740/965-6371

www.westervillepediatricspecialists.com

WESTERVILLE

Office Hours
Monday: 8 - 7:30
Tuesday: 9 - 4:30
Wednesday: 8 - 4:30
Thursday: 9 - 7:30
Friday: 9 - 4:30
Saturday: 9 - 12:30

SUNBURY

Office Hours
Monday: 8:30 - 4
Tuesday: 9 - 4:30
Wednesday: 9 - 4:30
Thursday: 9:00 – 12:00
Friday: 9:00 – 12:00

(Please note hours and days doctors are available are subject to change)

OUR PROVIDERS

Dr. Leymaster: Graduated from the University of Cincinnati College of Medicine and completed his residency in pediatrics at Case Western Reserve University/Metro Health Medical Center in Cleveland in June 2002. Dr. Leymaster enjoys all areas of pediatrics and has a special interest in sports medicine. He is board certified and a Fellow in the American Academy of Pediatrics (F.A.A.P.) He joined our practice in July 2002. He was Chief of Pediatrics for Mt. Carmel St. Ann's Hospital from 2006-2012. He is a Clinical Assistant Professor of Pediatrics for Ohio University and a Clinical Preceptor for Ohio State University.

Dr. Pottinger: Completed her undergraduate studies at Dartmouth College. She is a graduate of the Columbia University College of Physicians and Surgeons in May 2016. She completed her pediatric residency training at Nationwide Children's Hospital in June 2019. Dr. Pottinger joined our practice July 2019.

Dr. Wodarcyk: Completed her undergraduate studies at The Ohio State University. She is a graduate of the Medical College of Ohio and completed her pediatric residency at the same institution.
Dr. Wodarcyk has been practicing pediatrics in Columbus since 1990. She is a Clinical Instructor at The Ohio State University and is board certified. She's a Fellow in the American Academy of Pediatrics (F.A.A.P.) and joined Westerville Pediatric Specialists in 1997.

Dr.Yaw: Her pediatric training was completed at Wright State University School of Medicine/The Children's Medical Center of Dayton in 1998. She was in private practice for 8 years in the Dayton area. She joined our staff in August 2006. Dr. Yaw is board certified and is a Fellow in the American Academy of Pediatrics (F.A.A.P.) She is an associate professor at Wright State University.

Amanda Jett, R.N., M.S., C.P.N.P.-PC: Completed her undergraduate studies at The Ohio State University in 2002 before returning for her nursing degree and master of nursing in advanced practice, specializing in pediatrics. She is board certified and joined our practice in 2018.

IMMUNIZATION SCHEDULE

1 Week	Office Visit	Weight check (Breastfed babies) or Check up
2 Weeks	Office Visit	Weight check or Check up
1 Month	Office Visit	Check up, HepB
2 Months	Office Visit	DTaP [Diphtheria, Pertussis, Tetanus], IPV, HIB, Pneumococcal, Rota
4 Months	Office Visit	DTaP, IPV, HIB, Pneumococcus, Rotavirus
6 Months	Office Visit	DTaP, IPV, HIB, Pneumococcus, Rotavirus
9 Months	Office Visit	HepB
1 Year	Office Visit	Pneumococcal, Hep A, Lead screening, Hemoglobin
15 Months	Office Visit	MMR (Measles, Mumps, Rubella), Varicella
18 Months	Office Visit	DTaP, IPV, HIB, Hep A, Developmental screening (MChat)
2 Years	Office Visit	Hep A (if not given at 18 months), Lead screening, TB screening
2 ½ Years	Office Visit	Developmental screening (M-Chat)
3 Years	Office Visit	Vision screening
4 Years	Office Visit	Vision & Hearing screening
5 Years	Office Visit	DTaP, IPV, MMR, Varicella (Chicken Pox) Vision & Hearing screening
9 – 11 Years	Office Visit	Lipid Screening (1 time between 9 & 11)
11 Years	Office Visit	TdaP Booster, (Hemoglobin – occasionally female patients), Meningococcal, HPV
12 and older	Office Visit	Completion of HPV series and Meningococcal booster after 16 Years, Lipid screening once between ages 17-21

Revised 2/2022

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Westerville Pediatric Specialists' Vaccine Policy Statement

- We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.
- We firmly believe in the safety of our vaccines.
- We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.
- We firmly believe, based on all available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.
- We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

> *"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox...I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."*

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even discussing whether or not they should be given. Because of vaccines, many have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

Over the past several years, many people in Europe have chosen not to vaccinate their children with the MMR vaccine after publication of an unfounded suspicion (later retracted) that the vaccine caused autism. As a result of under immunization, there have been small outbreaks of measles and several deaths from complications of measles in Europe over the past several years.

Furthermore, those that do not vaccinate their children take selfish advantage of thousands of others who do, which decreases the likelihood that their children will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, **should you have doubts, please discuss these with your health care provider in advance of your visit.** In some cases, we may alter the schedule to accommodate parental concerns or reservations. **Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Westerville Pediatric Specialists.** Such additional visits will require additional co-pays on your part.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

WESTERVILLE PEDIATRIC SPECIALISTS, INC. /SUNBURY MILLS PEDIATRICS

Parent/Guardian Name: _____ M.I._____ Relationship:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ SSN#:_____

Cell Phone:_____ Home Phone: _____ Work Phone:_____

Email Address: _____ Employer: _____

Parent/Guardian Name: _____ M.I._____ Relationship:_____

MailingAddress:_____

City: _____ State: _____ Zip: _____ Date of Birth: _____ SSN#:_____

Cell Phone:_____ Home Phone: _____ Work Phone:_____

Email Address: _____ Employer: _____

PHARMACY Name, Address & Phone Number: _____

I give permission for my medical provider to access pharmacy information from the pharmaceutical clearing house: **Yes** **No**

CHILDREN: **Please circle:**

Name: _____ M/F Date of Birth: _____

Name: _____ M/F Date of Birth: _____

Name: _____ M/F Date of Birth: _____

Name: _____ M/F Date of Birth: _____

Name: _____ M/F Date of Birth: _____

Name: _____ M/F Date of Birth: _____

In order to assist us in meeting Meaningful Use Measures with the U.S. Government, please answer the following questions below regarding your children:

Race: (Please circle one) American Indian or Alaskian Asian Black or African American Native Hawaiian or Other Refuse to Report/Unreportable White

Ethnicity: (Please circle one) Hispanic or Latino NonHispanic or Latino Refuse to Report

Primary Language: (Please circle one) English Hearing Impaired Other _____

INSURANCE INFORMATION (Please present insurance card upon check-in)

1) Name of Insurance Company:_____

Name of person who carries the insurance: :_____ SSN#:_____

Relationship to Patient: _____

2) Name of Insurance Company:_____

Name of person who carries the insurance: :_____ SSN#:_____

Relationship to Patient: _____

Assignment and Release

Payment and/or copayment is required at the time the service is rendered. I hereby authorize my insurance benefits be paid directly to the physician, and I authorize the physician to release any information required to process any claims. I acknowledge that I am financially responsible for any non-covered services. By my signature, I authorize release of immunization records, daycare forms, and medical records to another healthcare provider or daycare/school.

Signature:_____ **Printed Name:**_____ **Date:**_____

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Child's Name _____

Date of Birth _____

Drug Allergies _____

Current Medications	**Dosage**	**Times/Day**

Social History (circle all that apply)
Child lives with: Both parents Mom Dad Step Mom Step Dad Adoptive Parents
Foster Family Maternal Grandparents Paternal Grandparents Guardian
Other (specify) _____

Birth History
Term or Preterm (<37 weeks):
Type of Delivery (vaginal or c-section):
Complications at delivery or shortly after birth:

Hospitalizations if your child has been in the hospital overnight – state the year- illness/operation

Year	**Illness/Operation**

Past Medical History
Has your child ever had the following (circle yes or no, leave blank if uncertain).

ADD/ADHD	Y	N	Intellectually Challenged	Y	N
AIDS or HIV	Y	N	Intestinal Disease	Y	N
Anemia	Y	N	Jaundice	Y	N
Asthma	Y	N	Kidney Disease	Y	N
Allergies	Y	N	Learning Disability	Y	N
Apnea	Y	N	Liver Disease	Y	N
Arthritis	Y	N	Mental Illness	Y	N
Bladder infections	Y	N	Menstrual Abnormalities	Y	N
Bleeding Tendency	Y	N	Pneumonia	Y	N
Bone or Joint Disease	Y	N	Rheumatic Fever	Y	N
Bronchitis	Y	N	Seizure Disorder	Y	N
Bronchiolitis	Y	N	Sleep Disturbance	Y	N
Cancer	Y	N	STD	Y	N
Cerebral Palsy	Y	N	Thyroid Disease	Y	N
Chicken Pox	Y	N	Transfusions	Y	N
Constipation	Y	N	Tuberculosis	Y	N
Developmental delay	Y	N	Ulcer	Y	N
Diabetes	Y	N	Whooping Cough	Y	N
Gastroespheal Reflux	Y	N			
Genetic Disease	Y	N			
Heart Murmur	Y	N			
Headaches	Y	N			
Hypertension	Y	N			

Comments (please give details of your child's medical condition such as onset of illness, treatment and outcomes)
_____
_____
_____

Child's Name _____

Family History

This includes child here today, parents, brothers, and sisters

	Relative	Explain
Alcohol-drug abuse		
Allergies (hay fever, asthma)		
Anemia (low blood, blood disease, sickle cell)		
Bone or joint disease (arthritis)		
Congenital anomalies (birth defects)		
Cystic fibrosis		
Heart Disease or Stroke (before age 50, high cholesterol)		
Hypertension (high blood pressure)		
Inborn errors of metabolism (PKU, thyroid)		
Infectious disease including (TB)		
Intellectually Challenged		
Intestinal disease (ulcer, ulcerative colitis, Crohn's Disease)		
Juvenile Diabetes (onset less than 18 years)		
Kidney Disease including (urinary tract infection)		
Seizures		
Other		

_____ **No significant history**

_____

Signature of Parent/Guardian **Date**

Office Use Only

Reviewed by:

_____

Physician/Nurse Practitioner Signature **Date**

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PRIVACY CONSENT

Consent for care: I, with my signature, authorize Westerville Pediatric Specialists, Inc. and Sunbury Mills Pediatrics, and any employee working under the direction of the physicians, to provide medical care for this patient for which I am the legal guardian. This medical care may include services and supplies related to this person's health and may include (but not limited to) preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.

Consent for release of information: for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice's privacy notice.

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts deemed to be my responsibility by the payment sources, as required by the contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

Consent related to the Privacy Statement: I have had a chance to review the Practice Privacy Statement as part of this registration process. I understand that the terms of the Privacy Statement may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

I understand that this practice may refuse services to me if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time.

Parent/Guardian Signature _____ Date _____

Printed Name _____ Relationship _____

Copy of Practice Privacy statement signed or initiated with parent/guardian on:_____

Effective, April, 2003

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PRIVACY STATEMENT

Effective April 1, 2003
Revised 4/2009, Revised 6/2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- This is a formal notification, as defined by CMS (Centers for Medicare and Medicaid Services) and Federal and State laws concerning the privacy policy of this practice and reporting requirement regarding identity theft and fraud. It is important that all patients and staff members understand the importance of guarding patient information.

- Medical records and personal health information, by law, must be maintained in the strictest of confidence. We cannot release such information to others without your written consent, including conversations, reminder calls, test results and any other information that may be of confidential nature. Patient information about health care is identified as "PHI" or protected health information.

- This policy requires that you, the parent or legal guardian, identify who we may talk to, how we can leave information on your child(s)behalf, and the process of ongoing continuity of medical care at the time of registration with this practice.

- Your protected health information (PHI) can be used or disclosed with your written consent as follows:
  - For treatment in this practice and other locations under the physician's immediate care. This may include any referral for services such as labs, x-rays or other diagnostic testing or treatment related to your medical care needs. This may also include conversations with other physicians.
  - For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes, or procedure notes. This would include eligibility verification, prior authorization and claim submission.
  - For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting, and compliance with federal and state laws and regulations.
  - Appointment reminders and health related benefit services only with your consent identified on the registration form.
  - Disclosure, concerning any related health care information, with family and friends indicated on the registration form. This list may be modified at any time orally, followed by written consent.
  - **Consent is not required for emergency care and treatment.** An emergency is considered a medical condition that, in the judgment of the physician or medical entity, requires immediate and full information for care.
- Certain disclosures can be made without your consent. They are as follows:
  - Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds and any suspected victims of abuse or neglect.

- Information used for public health purposes, medical examiners or related to a person's death, or for the health department for disease tracking.
- Information used for health care oversight, such as a site review by an insurance program
- Information related to organ donation
- Information related to certain research procedures. The majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to avoid harm if there is a threat to the patient's or other's safety.
- Specific governmental functions.
- Workers compensation review.

- Your rights with respect to your protected health information
  - The right to request limits on the uses and disclosure at registration or any time during your care
  - The right to choose how we send this information to you, including an alternate address
  - The right to see and obtain copies of this information, but you may expect copy and postage fees
  - The right to obtain a listing of those to whom we have made disclosures to regarding your PHI
  - The right to correct and update your file through an amendment process, if appropriate
- Westerville Pediatric Specialists, Inc. reserves the right to modify or change this Privacy Statement and process at any time. Revisions to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.
- If you have a concern or complaint about how your protected health information is being used, you should first contact our office to see if we can resolve your concerns. You may contact the Office of Civil Rights or the Ohio Medicare Carrier, GBA Palmetto.
  - Contact the office manager, Teri Campbell, and complete a complaint form for review and discussion.
  - If you are not satisfied with this response, you may report the practice to:

    Office of Civil Rights
    Regional Manager
    Department of Health and Human Services
    233 N. Michigan Ave, Suite 240
    Chicago, Illinois 60601
    (312)886-1807

    or the local Medicare Part B Intermediary

    GBA Palmetto
    Part B Operations – HIPAA Compliance Concern
    PO Box 182957
    Columbus, OH 43218

_____

Parent/Legal Guardian Signature Date

This confirms receipt of Privacy Notice & copy given to Parent/Legal Guardian

----------**OFFICE USE ONLY**----------

Refused to sign – witness _____

Scanned to EMR _____

Date Patient(s) name(s)

Westerville Pediatric Specialists, Inc. and Sunbury Mills Pediatrics
Missed Appointments/Late Cancel/Reschedule Policy

Here at Westerville Pediatric Specialists, Inc., it is our goal to provide quality care to our patients and families. It is important to recognize the length of the appointment time slot varies to allow the physician or nurse practitioner enough time to spend with your child.

Please call our office 2 hours prior to cancel a sick appointment. Call at least 24 hours prior to your child's well check-up or recheck appointment. We ask this of you so that another patient who needs an appointment can use a cancelled appointment time slot.

We have implemented the following **non-cancelled** Missed Appointments Policy therefore, your account will be subject to the following:

- $40 charge for each non-cancelled missed appointment per child
- No longer be able to schedule early morning, evening, or Saturday appointments for well child or rechecks (only sick will be scheduled)

Please be advised that excessive, **non-cancelled** missed appointments will result in review of your account and in possible dismissal from our office.

We appreciate your understanding and will be happy to answer questions that arise. Thank you.

Print name Signature Date

8/19 This policy is subject to change without notice at the discretion of management.

Westerville Pediatric Specialists, Inc., and Sunbury Mills Pediatrics Financial Policy

Thank you for choosing us as your child's healthcare provider. It is our goal to provide quality care to our patients and their families. Your understanding of our office policies is important to our professional relationship.

Child/Children's Name_____ **Date of Birth**_____

Required at Check-In

- Provide current personal information at each visit
- Provide a current insurance card at each visit
- Payment of your co-pay, co-insurance, or any deductible
- Payment of any outstanding balance
- Payment of today's visit if you do not have insurance

Insurance Plans

Your insurance plan is a contract between you, your employer, and the insurance company; we are not a party to that contract. Please understand that we will bill for all services rendered according to approved CPT Coding Guidelines. This may result in a co-pay/co-insurance/or deductible amount that becomes your responsibility, even for a preventive visit. We will be happy to file your claim(s) with the primary insurance company; all charges are your responsibility from the date that services are rendered. **For us to file a claim, you must present a current copy of your insurance card at each visit and let us know of any changes in your personal information.**

Miscellaneous Charges

- **Returned Check Charge** - Non-Sufficient Funds (NSF) checks are subject to a $45 fee (in addition to fees from your bank).
- **Medical Records/Shot Record Charge** - There is a $40 fee per patient if you would like a copy of your medical records/shot records sent to a non-physician entity, yourself, or another physician. However, if a collaborating physician or specialist requests portions of your chart to assist in your child's care, there is no charge.
- **Correspondence/Forms Charge** - There is a $20 fee per patient per correspondence/form i.e., letters, Life Insurance applications, F.M.L.A. and Social Security Disability applications, etc.
- **Collection Fee** - If your account balance becomes 90 days past due, you will be given a 30-day notice. At the end of the 30 days, all portions due (not including insurance pending) will be sent to an outside collection agency. Please note that an additional 30% collection fee will be applied to your balance at this point, and we will be unable to see your children. You agree, for us to provide services for you and your account and/or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.
- **Non-Payment of Co-pay Fee** - Nonpayment of your co-pay by the end of the business day on the date of service will result in an additional $30 charge.
- **Missed Appointment/Late Cancel/Reschedule Fee** - A $40 fee will be billed when there is a failure to provide a 24-hour cancellation notice of well child appointment and recheck appointment or a failure to provide a 2-hour cancellation notice for a same day scheduled appointment per child. This charge is not covered by insurance and you will be responsible for payment. Our office provides reminder calls for appointments scheduled in advance; this is a courtesy only and has no effect on the financial obligation for missed appointments.
- **Missed Appointment Fee that requires Interpreting Services** - If an interpreter is scheduled and you miss your appointment or fail to cancel 24 hours before the appointment time, your missed appointment fee is subject to the Interpreting Company's fee we incur.
- **Telehealth/Medicine Convenience Fee**-$60

_____

Printed Name Signature Date

3/2022

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INFORMATION REGARDING YOUR CHILD'S PHYSICAL APPOINTMENT

Today, we will be addressing routine topics of growth and development, nutrition, and social and emotional health at your child's well child check-up (physical).

If medical issues that are either chronic in nature or if your child is sick today, the physician/nurse practitioner MUST address your child's medical issues. We will then have two options on how to handle both the physical and medical concerns.

1. We will complete both the physical and treat the medical issue at the same time. We will charge for BOTH services and your insurance company will most likely require you to pay a copay and/or deductible amount.

2. If your child is too sick or the chronic condition too significant to complete during the physical we will treat the medical issue and bring the child back for the physical.

We are required to follow standard billing guidelines and codes and are following standard billing when we charge for all our services. **We have always charged for services provided and have not changed our billing practices.**

Your insurance carrier may have made changes to your plan and, although they will cover both services at one appointment, they may require you to pay a copay or deductible for the additional services. This is out of our control and you should speak to your insurance company or human resources department if you have any questions or concerns.

Child's name:_____ Date of Birth: _____

Child's name:_____ Date of Birth: _____

Parent/Legal Guardian signature: _____ Date: _____

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AUTHORIZATION TO SEEK MEDICAL CARE

Patient(s) name(s): _____

_____

_____

The following individuals named below and their relationship to the patient(s) are authorized to schedule appointments and seek care for illness or injury for the above named patient(s) with the physicians and nurse practitioners of Westerville Pediatric Specialists, Inc. Please be advised the individuals named below are people who will have access and knowledge of private health information:

1) _____
Relationship

2) _____
Relationship

3) _____
Relationship

4) _____
Relationship

Please note: We understand that grandparents, baby sitters, or otherwise might render care for your children. However, if the visit with Westerville Pediatric Specialists, Inc. is for a well child routine visit, it is the policy of Westerville Pediatric Specialists, Inc. not to perform such services unless a parent, or legal guardian is present. **Additionally, immunizations must be authorized by the parent or legal guardian by federal law.**

I _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individuals to seek medical care in my absence.

_____
Printed Name Signature Date

Notary: _____ **Witness:** _____

County: _____ **State:** _____ **Expires:** _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name, Address & Fax number of previous doctor: _____

_____

The undersigned understands and acknowledges that:

- He/she has the right to end the authorization by submission of a written request to the doctor or medical group listed above. Uses and discloses (releases) made between the authorization date and the date of ending or expiration date are permitted and approved by the undersigned.
- The doctor or medical group listed above is prohibited from conditioning treatment, payment, or enrollment upon giving of this authorization.
- The information released may be subject to re-disclosure (release) by the recipient and may no longer be protected by Federal privacy law.

_____ Date: _____

Signature of parent or legal guardian

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

CIRCLE THE LOCATION THAT RECORDS SHOULD BE MAILED TO:

Westerville Pediatric Specialists, Inc .
575 Westar Crossing, Suite 101
Westerville OH 43082
614/508-2223

or

Sunbury Mills Pediatrics
700 West Cherry Street, Suite B
Sunbury OH 43074
740/965-6369

IMMUNIZATION RECORD *ONLY* MAY BE FAXED TO:

Westerville
614/508-2233

Sunbury
740/965-6371

Description of information to be released/disclosed (circle all that apply):

All medical records Immunization record

Other: _____

Purpose or need for release (circle applicable purpose):

Continuation of medical care Payment of insurance claim Legal

Personal Other: _____

This authorization is in effect for six (6) months from date of signature, or until: ____/____/____

Printed Name: _____

A copy of this authorization will be made available upon request to the individual granting the authorization.