Atrium Health Levine Children's –Vaccine Statement

Dear valued patients and families,

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of our vaccines. We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all available literature, evidence and current studies, that vaccines do 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 can perform as health care providers, and that you can perform as parents/caregivers.

We want to emphasize the important of vaccinating your child. We recognize that the choice may be a very emotional one, and, for some parents, even controversial. 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 healthcare provider in advance of your visit. Please be advised that delaying or "breaking up 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 Atrium Health Levine Children's.**

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. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness, disability, and even death.

Thank you for your time in reviewing this information, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

Sincerely,
Your HealthCare Partners at
Atrium Health Levine Children's

Atrium Health
Levine Children's

Older Child Vaccine Statement

Dear valued patients and families,

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 vaccinating children and young adults may be the single more important health-promoting intervention we perform as health care providers and parents/caregivers.

Vaccines are so effective at preventing illness that many parents have never seen a child with bacterial meningitis or chicken pox or known a friend or family member whose child died of one of these diseases. Unfortunately, such success at preventing disease can make us complacent about vaccinating. But such an attitude, if it becomes widespread, can lead to tragic results and the re-emergence of preventable diseases.

In the pre-adolescent years, ages 10-12, it is recommended by the medical community and schools to give booster doses of varicella vaccine (if not done earlier), Tdap (pertussis and tetanus) and an initial booster dose of MCV4 (meningococcal meningitis). In addition, it is recommended, but not required, to initiate and complete the HPV vaccine series (human papillomavirus) between the ages of 9 and 26.

For new patients who are not vaccinated or incompletely vaccinated, we expect them to catch up on their complete vaccine series within the recommended time period of 12 months. By not vaccinating your child and boosting them in their pre-adolescent years, parents are putting their child and other children at unnecessary risk for life threatening illness, disability and even death as these diseases – varicella, meningococcal meningitis and pertussis – do occur each year in unvaccinated and under-vaccinated older children.

As medical professionals, we feel very strongly that vaccinating children and adolescents on schedule with current available vaccines is absolutely the right thing to do for all children and teens. If you do not comply with the require childhood and adolescent vaccines, we will request that you find another health care provider. Thank you for your time in reviewing this information and please feel free to discuss any questions or concerns you may have about vaccines with your provider.

Sincerely,

Your HealthCare Partners at
Atrium Health Levine Children's

Pre-Visit Forms and Vaccine Schedule for Well Checks

Age/Visit	Screenings (Complete Forms Prior to Visit)	Vaccines
Newborn	PHQ-2(mom)	Hepatitis B (if not done in nursery)
1 month	PHQ-2 (mom), TB	
2 month	SWYC	PEDIARIX, Hib, Prevnar, RotaTeq
4 month	SWYC	PEDIARIX, Hib Prevnar, RotaTeq
6 month	SWYC	PEDIARIX, Prevnar, RotaTeq
6 months+		Annual Flu vaccine
9 month	SWYC	
12 month	SWYC	Varivax, MMR, Hep A, Prevnar
15 month	SWYC	DTaP, Hib
18 month	SWYC (includes Autism screening)	Hep A
24 month	SWYC (includes Autism screening)	
30 month	SWYC	
3 year	SWYC, 5210	
4 year	SWYC, 5210	Kinrix and ProQuad
5 year	SWYC, ACT (4-11), 5210, KG	
6 year	PSC-17 parent, FL/Lead/TB/Anemia, ACT (4-11), 5210	
7 year	PSC-17 parent, FL/TB/Anemia, ACT (4-11), 5210	
8 year	PSC-17 parent, FL/TB/Anemia, ACT (4-11), 5210	
9 year	PSC-17 parent, FL/TB/Anemia, ACT (4-11), 5210	
10 year	PSC-17 parent, FL/TB/Anemia, ACT (4-11), 5210	
11 year	FL/TB/Anemia/Lead, ACT 12+, 5210	Tdap/ Menveo/ HPV
12 year	FL/TB/Anemia, ACT 12+, 5210	HPV (if not completed)
12+ years		COVID-19 vaccine
13 and 14 year	FL/TB/Anemia, ACT 12+, 5210	HPV (if not completed)
15 year	FL/TB/Anemia, ACT 12+, 5210	HPV (if not completed)
16 and 17 year	FL/TB/Anemia, ACT 12+, 5210	Menveo/ HPV if needed
18 year	TB/Lead/Anemia, 5210	Menveo (if not completed)

Term	Description	Term	Description
5210	Healthy Weight and Activity Screen	MMR	Measles, Mumps, Rubella combination vaccine
ACT	Asthma Control Test, for asthmatics only	PEDIARIX	Diphtheria, Tetanus, Acellular Pertussis, Inactivated Polio & Hepatitis B combination vaccine
DTaP	Diphtheria, Tetanus & Acellular Pertussis combination vaccine	PHQ-2	Maternal Well-Being Screen
Hep A	Hepatitis A vaccine	ProQuad	Measles, Mumps, Rubella & Varicella vaccine
Hep B	Hepatitis B vaccine	Prevnar	Pneumococcal Conjugate (PCV13) vaccine
Hib	Haemophilus Influenzae Type B (HIB) vaccine	PSC-17	Mental Health Screen
HPV	Human Papillomaviruses vaccine	Rotateq	Rotavirus vaccine
KG	Kindergarten Health Assessment	Tdap	Tetanus, Diphtheria & Acellular Pertussis combination vaccine
Kinrix	Diphtheria, Tetanus, Acellular Pertussis & Inactivated Polio combination vaccine	Varivax	Varicella (Chicken Pox) vaccine
Menveo/Menactra	Meningococcal Groups A, B, C, Y & W135 vaccine		

Please know that there is a range of acceptable ages for each vaccine, so your individual practice schedule may vary slightly.

Your practice may send pre-visit paperwork via email prior to your well-child exam. You can also find the pre-visit forms at **LevineChildrens.org/PatientForms**

Atrium Health Levine Children's

Dear Valued Patient/Parent,

Thank you for choosing Atrium Health Levine Children's for your child's healthcare needs. We practice comprehensive medical care focused on prevention as well as evaluation and management of your child's complaints and concerns.

Insurance companies are now dictating how physicians bill for these services.
There are **two** definitions that you need to be aware of that define office visits:

1. **Preventative or "Well Child" Exam**

   This visit is designed to review your child's growth and development. This visit is not designed to address specific complaints or to manage known medical problems. This is usually a visit to review preventative health issues such as:

   - Growth and development
   - Immunizations
   - Physical Exam
   - Activities of healthy living
   - Patient Family History

2. **Office Visit or "Sick Visit"**

   This visit is designed for the evaluation and management of a single or multiple complaints such as:

   - Ear infections
   - Allergies
   - Chronic medical conditions that are flaring or require follow-up
   - Respiratory infections
   - Complex behavioral issues

During your child's preventative or "well child" exam today, other concerns/issues/forms/labs/vaccines may be addressed or performed that are not considered part of your preventative care benefits by your insurance carrier and could be considered an office visit. Please be aware that there is a possibility that these concerns/issues/forms/labs/vaccines will not be covered by your insurance carrier (depending on your individual insurance coverage) and could therefore be applied to your deductible/coinsurance. You may also be assigned responsibility by your insurance company for a sick visit co-pay/co-insurance, in addition to, one for the well visit.

Should you have additional questions regarding this information and/or the billing of your child's visit today, please contact your insurance company to ask questions specific to your coverage.

Thank you again for choosing Atrium Health Levine Children's.

Atrium Health
Levine Children's

Atrium Health Levine Children's –Billing and Insurance

Please bring your insurance card to every appointment. If your insurance changes at any time please inform our staff at check-in.

You are responsible for all copays, deductibles, and services not covered by your insurance carrier. Payment is accepted via cash, checks, debit, or credit card

What insurances do you accept?

Atrium Health Levine Children's is willing to file with any type of insurance; however with the Affordable Care Act and usage of the Health Insurance Marketplace bringing so many new policies into effect, it is imperative that you check with your insurance company to determine if we are considered in-network with your policy.

If you have questions about the Marketplace, please visit www.healthcare.gov.

Unfortunately, at this time, we are cannot accept Tricare Prime, BCBS NC Blue Value, United Healthcare Compass, Cigna HealthSpring, and select SC Medicaid plans (Absolute Total Care, Select Health, Blue Choice and WellCare).

Do I have to pay any charges up front?

We collect all copays at the time of service, and they vary between the many health insurance policies on the market. Please check your policy details to determine the deductibles, coinsurance and copayments you will owe for services rendered. If you have a plan where you must meet a deductible before services are covered in full, and have not met your deductible, we ask that you pay $50 at the time of service. For our patients that are uninsured, we offer a 30% discount, and ask that you pay at least $50 at the time of service.

Why am I getting a bill for services completed a while ago?

Once we have received a response from your insurance carrier, and if we confirm that there is a patient liability, we then bill you for the services. Also, insurance carriers sometimes require additional information which delays the processing of the claim.

Atrium Health
Levine Children's

Why wasn't my insurance carrier billed?

If the information in our billing system is inaccurate at the time of service we will be unable to bill your insurance carrier. Please provide us with your correct health insurance information when you register with the office. If at any time your coverage changes, please inform us.

Why was my claim denied?

If you have active coverage and a claim is denied, contact your insurance carrier immediately for an explanation of how your claim was processed and why it was denied. Most of the time it is denied only because they need more information from the subscriber or there is an error with the spelling of the child's name or date of birth. Once your carrier has been contacted, you will have to ask them to reprocess the claim. We cannot re-file it once it has been denied.

Did my insurance carrier pay for services rendered?

Reimbursement from your insurance carrier will be reflected on your statement. Most carriers send an explanation of benefits notice explaining how the medical claim was processed.

- Information on what was paid
- Any non-covered, deductible, or denied amounts
- The balance owed by you

Why does my Medicaid card have my pediatric office on it?

A primary care provider must be listed on your child's card. If it does not say the name of the pediatric office, we are unable to file it for your visit without prior authorization. To change the provider listed on your card, please call 704-353-1500.

Does my insurance carrier cover my child's prescriptions?

Contact your insurance carrier for information regarding coverage of prescriptions, or consult your prescription benefits card.

Do I need to wait a full year between well child visits for insurance to cover them?

This depends completely on your policy. Some plans require you wait 365 days between well visits, while others will cover one per calendar or policy year, and some will only cover them every two years. The only way to find out is to contact your insurance carrier directly.

I just had a baby- what do I need to do?

Newborns are considered self pay patients when first seen because their insurance is not yet active. You are only allowed 30 days after birth to add a child to your insurance policy, and we recommend that you call as soon as possible. Insurance carriers will not make exceptions, and the child will not be able to be insured until the next open enrollment if not done on time. When insurance does become active, it should retroactively cover any visits since birth.

You will receive a bill as a self pay patient for doctor visits prior to your newborn's insurance becoming active and being entered into our system. As soon as you receive the insurance card with your newborn's information you can do one of two things:

1. Call the central business office at 704-512-7171. They will be able to enter your information and file any outstanding claims.
2. Bring your insurance card to your next appointment, as we require that you bring your card to each visit. We will scan your insurance card into our system and input the information, then file any previous claims. Please ask the registrar to have all previous claims filed.

If you have not yet received an insurance card for your newborn by the time you come in for your two month well visit, please contact the central business office to prevent outstanding claims from being turned over to collections. We also recommend that you follow up with your insurance carrier to find out the status of your policy if you have not receive the insurance card within four weeks of adding your newborn.

Once the claims have been filed to your insurance company, you will then be billed only for copays and any coinsurance or deductibles that you are responsible for per your policy.

What happens if I am sent to collections?

Atrium Health utilizes the collection agency PMAB for delinquent accounts. You have 90 days from the day your insurance processes your claim to pay, or get set up on a payment plan, for any remaining amount

deemed patient liability by your carrier. After 90 days, if no payment is received, and no arrangement made, the computer will automatically roll your account to collections. We are willing to work with you and your ability to pay. The business office can get you set up on a payment plan that fits your budget. If you have invoices due, or in collections, please contact us as soon as possible. We want to help! If you fail to contact us and have multiple invoices turned over to PMAB, it may result in dismissal from the practice.

Who do I contact with questions?

You can call the central business office customer service line Monday- Friday from 8a-5p at 704-512-7171. They have the ability to answer any questions regarding billing questions, even if your outstanding balance has been forwarded to PMAB.

Glossary of Insurance Terms

Benefit: The amount paid for covered medical services or events.

Claim: Your request to the insurance company for benefits. The claim is submitted to the insurance company for medical services you've received or events that make you eligible for payments.

Coinsurance: A percentage of your medical bill that is shared by you and your insurance company after your deductible has been met.

Copay: A predetermined fee that you pay for health care services in addition to what's covered by your insurance. Not every type of health insurance plan requires a copay.

Deductible: The predetermined amount of your medical bills that you pay before your insurance benefits begin.

Network: A group comprised of participating doctors, hospitals, and facilities. Depending upon your type of health insurance, you can use any doctor or facility that you like, but your costs will be substantially lower if you choose a provider that's within the network.

Policy: Contract between you and your insurance company that provides specific coverage details for the health plan you selected.

Premium: Amount that you pay for health coverage, usually monthly. If you have health insurance through an employer this is typically deducted from your salary every pay period.

Patient Intake Form
(For new patients only)

Atrium Health Levine Children's

Patient Name	Date of Birth	Preferred Name/Nickname
Parent/Guardian Name	Relationship to Patient	Mobile Phone
Parent/Guardian Name	Relationship to Patient	Mobile Phone

Parent relationship status: ☐ Married ☐ Separated ☐ Divorced ☐ Neither

Sibling names: _____

Step-siblings / half-siblings (if applicable): _____

Other household members: _____

Language(s) spoken in home: _____

What school does your child attend? _____

Do you have any concerns about your child's school performance, behavior or sleep? If so, please describe:

_____

Past Medical History

Was your child adopted? ☐ Yes ☐ No If yes, is your child aware? ☐ Yes ☐ No

Birth History: ☐ Full Term ☐ Premature If premature, how many weeks? _____

Has your child been diagnosed with a developmental delay? ☐ Yes ☐ No

Has your child received:
- Speech therapy? ☐ Yes ☐ No
- Occupational therapy? ☐ Yes ☐ No
- Physical therapy? ☐ Yes ☐ No

Has your child ever been diagnosed with any medical problems such as allergies (seasonal or food), asthma, breathing problems, autism, ADHD, learning disability, diabetes, seizures, headaches, intestinal problems, arthritis, depression, anxiety, or any other diagnosis that required medications or surgery? ☐ Yes ☐ No

If so, please list/describe: _____

_____

Has your child ever been hospitalized? ☐ **Yes** ☐ **No** **If yes, please describe:** _____

_____

Has your child ever had surgery? ☐ **Yes** ☐ **No** **If yes, please list:** _____

_____

Please list any medications your child is currently taking: _____

_____

Is your child in need of refills for any medications? ☐ **Yes** ☐ **No** **If yes, please list:** _____

_____

Does your child have any allergies to medications? ☐ **Yes** ☐ **No** **If yes, please list:** _____

Does your child see any specialty doctors? ☐ **Yes** ☐ **No** **If yes, please list:** _____

_____

Has your child received all recommended vaccines / immunizations? ☐ **Yes** ☐ **No**

Does your child have any reasons (exemptions/ beliefs/ medical problems) that have resulted in vaccines not being given? ☐ **Yes** ☐ **No** **If yes, please describe:** _____

_____

Name of previous pediatrician(s) and practice location (City, State): _____

_____

Please list the names of anyone whom you have authorized to bring your child to the pediatrician and consent for treatment, including vaccinations, on your behalf:

Name	Relationship to Patient	Mobile Phone
Name	Relationship to Patient	Mobile Phone
Name	Relationship to Patient	Mobile Phone

Atrium Health Levine Children's

Annual Patient Update

(for established patients only)

Patient Name	Date of Birth	Preferred Name/Nickname
Parent/Guardian Name	Relationship to Patient	Mobile Phone
Parent/Guardian Name	Relationship to Patient	Mobile Phone

Parent relationship status: ☐ Married ☐ Separated ☐ Divorced ☐ Neither

Sibling names: _____

Step-siblings / half-siblings (if applicable): _____

Other household members: _____

Language(s) spoken in home: _____

What school does your child attend? _____

Do you have any concerns about your child's school performance, behavior or sleep? If so, please describe:

_____

_____

Past Medical History

In the past 2 years, has your child been hospitalized? ☐ Yes ☐ No **If yes, please describe:** _____

_____

In the past 2 years, has your child had any surgeries? ☐ Yes ☐ No **If yes, please describe:** _____

_____

Please list any concerns you may have about your child that you wish to discuss: _____

_____

_____

Please list any pertinent updates in your family history over the past 2 years: _____

Please list the names of anyone whom you have authorized to bring your child to the pediatrician and consent for treatment, including vaccinations, on your behalf:

Name	Relationship to Patient	Mobile Phone
Name	Relationship to Patient	Mobile Phone
Name	Relationship to Patient	Mobile Phone

All patients need to complete this form.

RISK ASSESSMENTS

Anemia Risk Assessment	Yes	No
Has your child been previously diagnosed with anemia?		
Is your child on a vegetarian or vegan diet?		
TB Risk Assessment: Does your child have . . .	Yes	No
Close contact with someone who has been diagnosed with tuberculosis?		
Close contact with anyone who has moved to the US within the past 5 years from Africa, Latin America, or the Middle East? Has your child visited any of these areas?		
Close contact with anyone who is HIV positive, homeless, an IV drug user, a migrant worker, employed by or resides in a correctional facility, homeless shelter, long-term care facility, or group home?		
ANY of the following medical conditions: History of TB, HIV infection, Diabetes, Leukemia, Lymphoma, Chronic Renal Failure, Severely Underweight, or is taking Immunosuppressive therapy?		
Fluoride Assessment:		
Do you have well water?		
Do you exclusively use bottled water in your child's formula or for drinking?		

asthma.com

Complete only if your child has Asthma

Name: _____ **Today's Date:** _____

ASTHMA CONTROL TEST™

Know your score.

Parent or Guardian:

The Childhood Asthma Control Test is a way to help your child's healthcare provider determine if your child's asthma symptoms are well controlled.

Does your child have asthma, reactive airway disease or chronic wheezing? Yes or No

In the past 2 years, has your child ever used an inhaler or nebulizer? Yes or No

If your answer is yes to either of these 2 questions, then please complete the ACT below:

					SCORE
1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?	All of the time **[1]**	Most of the time **[2]**	Some of the time **[3]**	A little of the time **[4]**	None of the time **[5]**	.....
2. During the past 4 weeks, how often have you had shortness of breath?	More than Once a day **[1]**	Once a day **[2]**	3 to 6 times a week **[3]**	Once or twice a week **[4]**	Not at all **[5]**	.....
3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	4 or more nights a week **[1]**	2 to 3 nights a week **[2]**	Once a week **[3]**	Once or twice **[4]**	Not at all **[5]**	.....
4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	3 or more times per day **[1]**	1 to 2 times per day **[2]**	2 or 3 times per week **[3]**	Once a week or less **[4]**	Not at all **[5]**	.....
5. How would you rate your asthma control during the past 4 weeks?	Not Controlled at All **[1]**	Poorly Controlled **[2]**	Somewhat Controlled **[3]**	Well Controlled **[4]**	Completely Controlled **[5]**	.....

TOTAL: .....

This material was developed by GSK.

Only complete if your child is being assessed for or has been diagnosed with ADD/ADHD.

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

Patient Request for Access/Copy of Medical Records

Did you know you can view most of your medical record online via MyAtriumHealth? Go to www.atriumhealth.org and click on MyAtriumHealth. If you would like a copy of your medical record please complete the form below.

I am a patient of Atrium Health and my information is listed below:

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip:_____

Telephone: _____ Email address: _____

By providing your email address, you acknowledge and accept the risks outlined in Guidelines for E-mail with Patients, posted on carolinashealthcare.org.

I would like for _____ **to (choose one):**

(list name of facility or practice)

- ☐ **give me a copy of my health information**
- ☐ **send a copy of my records to OR share my health information with:**

_____

(Name of Facility, Person, Company) (Street Address or PO Box, City, State, Zip Code)

_____

(Phone Number) (Fax Number)

_____

(E-mail Address)

I would like these dates of service to be sent/shared: _____

I want the parts of my record checked below sent/shared:

Facility (check all that may apply):	**Office/Clinic/Home Care (check all that may apply):**
☐ Facility Summary (includes items in **bold**)	☐ Office/Clinical Summary (includes items in bold)
☐ **Discharge Summary** ☐ **Emergency Record**	☐ **Office/Home Visits**
☐ **History and Physical** ☐ **Operative Reports**	☐ **Physical Exam**
☐ **Laboratory reports**	☐ **Laboratory Reports**
☐ **Radiology/X-Ray Reports**	☐ **Radiology Reports**
☐ Therapy Notes	☐ Therapy Notes
☐ Other_____	☐ Other_____
☐ Entire record	☐ Entire Record
☐ Itemized Bill	☐ Itemized Bill

I want these records as a/an (choose one):

- ☐ **CD**
- ☐ **E-mail**
- ☐ **Paper copy**
- ☐ **Other:** _____

I want you to (choose one):

- ☐ **Mail them**
- ☐ **Send them secure e-mail**
- ☐ **Fax them to:** _____
- ☐ **Prepare them to be picked up by:** _____
- ☐ **Share my health information verbally**

As an alternative you may schedule an appointment with your healthcare provider's office to see your record in person. Please note it may take up to 30 days to schedule the appointment or provide copies.

Signature: _____ **Print Name:** _____

Relationship to Patient: _____ **Date:** _____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written proof may be requested.)

Date records given/sent to patient: _____via ☐Mail ☐Fax ☐Other_____ ☐**ID Verified** ☐**DL/OtherID**_____

Atrium Health Teammate Name & Department_____**Date:**_____ **# of Pages** _____

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Atrium Health

Patient Request for Access/Copy of Medical Records

Place Patient Label Here