PATIENT REGISTRATION FORM
WEE PEDIATRICS, INC.

THERESA Y. WEE, M.D. | JORDAN ARAKAWA, M.D. | MYRTLE PAREL, APRN

Patient: *Last Name:* _____ *First Name*: _____ *MI*: _____

D.O.B: ___/____/_____ *Gender*: _____ *Primary Language*: _____

Ethnicity: Hispanic / Non-Hispanic / Unknown *Race*: Asian / Black or African American / Hawaiian / White

Primary Phone (_____) _____- _____ PHONE NUMBER FOR REMINDER CALLS/TEXT

PARENT/LEGAL GUARDIAN #1 (NOTE: this parent is the RESPONSIBLE PARTY who is responsible for payments and receiving billing statements)

Name: _____ Mother or Father/Genetic or Adoptive *Date of Birth*: ___/____/_____

Lives with patient? Yes / No

Mailing Address (must be a Hawaii address):

_____

Street City State & Zip

Mobile Phone: (____) _____-_____ *Email*: _____

Occupation: _____ *Work Phone*: (____) _____-_____

PARENT/LEGAL GUARDIAN #2

Name: _____Mother or Father/Genetic or Adoptive *Date of Birth*: ___/____/_____

Lives with patient? Yes / No (if NO, please fill out address)

Mailing Address:

_____

Street City State & Zip

Mobile Phone: (____) _____-_____ *Email*: _____

Occupation: _____ *Work Phone*: (____) _____-_____

NOTE: By providing your contact information above, you are also consenting to receive messages from our office about the patient (s) (such as appointment reminders, lab results, and billing inquiries) via text, phone (voice messages), and/or email.

Emergency Contact (other than parents): *Name*: _____*Relationship*: _____

Phone number: (____) _____-_____

SEE OTHER SIDE if parents are divorced or separated.

PLEASE PROVIDE PICTURE ID AND INSURANCE CARD FOR VERIFICATION AT EVERY VISIT

If parents are divorced or separated, please fill out this section:

Who has custody? _____
Are there any legal restrictions that will restrict the non-custodial parent from consenting to medical treatment for the child or from obtaining information about the child's medical treatment? Yes / No

If yes, please explain and provide a copy of any legal paperwork that supports this restriction.

Step-Parent: *Name*: _____

Lives with patient: Yes / No *Date of Birth*: ___/____/_____

Mobile Phone: (____) _____-_____

Occupation: _____ *Work Phone*: (____) _____-_____

Step-Parent: *Name*: _____

Lives with patient: Yes / No *Date of Birth*: ___/____/_____

Mobile Phone: (____) _____-_____

Occupation: _____ *Work Phone*: (____) _____-_____

Staff note: Any legal documentation must be given to front office administrator for systems updates.

INSURANCE INFORMATION

_____ _____/_____/_____

Patient Name DOB

Primary Insurance: _____

Policy Holder: _____

Policy Holder DOB: _____

ID Number: _____

Group Number: _____

Secondary Insurance: _____

Policy Holder: _____

Policy Holder DOB: _____

ID Number: _____

Group Number: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby assign my insurance benefits to be paid directly to Wee Pediatrics, Inc ("Provider") for services rendered. I further agree and acknowledge that my signature on this document authorizes my Provider to submit claims for services rendered on this and subsequent visits without obtaining my signature on every claim to be submitted. I understand that this signature will bind me as though I personally signed the particular claim. I also authorize the Provider, staff of Wee Pediatrics or its representative Akamai PM to release any Medical Records or other information necessary or required for the processing of insurance claims. I understand that Wee Pediatrics, Inc. is submitting claims on my behalf as a courtesy. I understand that all applicable co-payments, deductibles, and co-insurance are due at the time of service. I understand that I am financially responsible for non-covered services and that I am fully responsible should insurance not exist.

I have read and understand the assignment of benefits and authorization to release medical records. My signature below confirms my acceptance of the above assignment of benefits and release of medical records.

_____ _____/_____/_____

Parent/Legal Guardian Signature Date

_____ _____

Parent/Legal Guardian Name Relationship to patient

CONSENT FOR TREATMENT

Patient Name: _____ DOB: _____/_____/_____

- I hereby give consent to Wee Pediatrics, Inc. to perform any medical or surgical treatment, EKG or lab testing, or other clinical services, including the use of telemedicine, examination and anesthetic rendered to my child under the care by a licensed physician, as well as any nurse practitioner or medical assistant on the staff of Wee Pediatrics, Inc. to the minor named above.
- My consent is given in advance of any specific medical diagnosis, treatment or hospital care being required. And is given to encourage each Physician, nurse practitioner as well as any assistant, or any designee, or employee of Wee Pediatrics, Inc. to exercise his/her best judgment in ordering tests or treatments appropriate to the child's medical needs.
- The consent is effective on the date below and will remain in effect until revoked in writing by a parent/legal guardian or if the parent/legal guardian changes.

I have read and understand the Consent for Treatment policy and agree to have Wee Pediatrics treat my child.

Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Parent/Legal Guardian Name: _____

Relationship to patient: _____

CONSENT TO PARTICIPATE IN TELEMEDICINE SERVICES

Telemedicine refers to the use of video visit technology to deliver healthcare services when the healthcare provider and patient are not in the same physical location. Electronically transmitted information may be used for diagnosis, therapy, follow-up, and/or patient education. Our platform is HIPAA compliant, and the laws that protect the privacy and the confidentiality of healthcare information apply to telemedicine services. Telemedicine provides the following services:

- The same standard of care applies to a telemedicine visit as an in-person visit.
- There are potential risks to using technology, including services interruptions, interception, and technical difficulties.
- If the videoconferencing equipment and/or connection is not adequate, the provider or I can discontinue the visit and make other arrangements to continue.
- If the Provider determines the telemedicine visit is inadequate for treatment, the patient may need to be seen in-person.
- I have the right to refuse to participate or decide to stop participating in a telemedicine visit.
- I will be responsible for any out-of-pocket costs such as copayments, deductibles or coinsurances that apply to my telemedicine visits. Health plan payment policies for telemedicine visits may be different from policies for in-person visits.

_____ _____/_____/_____

Parent/Legal Guardian Signature Date

WEE PEDIATRICS, INC
94-1388 Moaniani Street, Suite 207
Waipahu, HI 96797
(808) 677-9988
www.weewellnesscenter.com

NOTICE OF PRIVACY PRACTICES

Effective September 18, 2023

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU OR YOUR CHILD MAY BE USED AND DISCLOSED AND YOUR RIGHTS WITH REGARD TO YOUR OR YOUR CHILD'S HEALTH INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Wee Pediatrics, Inc. ("Provider") is devoted to protecting our patient's health information. Provider is required by law to maintain the privacy of Protected Health Information (PHI), to provide you adequate notice of your rights and our legal responsibilities and privacy practices with respect to PHI and to notify affected individuals following a breach of unsecured PHI. PHI is defined to include past, present, and future information created or received by Provider. It also includes demographic information that may identify the patient that relates to their past, present or future medical condition (physical or mental), the providing of health care to the patient, or payment for health care treatment.

Table of Contents for this Notice:

USES AND DISCLOSURES- PERMITTED AND REQUIRED

Information about the patient must be used and disclosed to other parties for purposes of treatment, payment, and health care operations. Examples of information that must be disclosed:

- Treatment: We may use the patient's health information to provide, coordinate or manage his/her medical treatment or services. We may disclose their medical information to doctors, nurses, technicians, health care students, or other provider employees or contractors who are involved in providing health care to your child. For example, we may share your child's health information with another provider for a consultation or referral for further treatment.

- Payment: We may use and disclose the patient's information to bill for medical treatment and services and receive payment from you, insurance companies, or third parties. For example, we may need to give information to your health plan about treatment the patient received so that the health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment the patient is going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- Health Care Operations: We may use and disclose information about the patient for our health care operations. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your child's PHI to accrediting agencies as part of an accreditation survey. We may also call your child by name while you are at our facility.

USES AND DISCLOSURES- ADDITIONAL PERMITTED

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We are permitted to use or disclose information about the patient without consent or authorization in the following circumstances:

- Appointment Reminders: We may use your information to contact you with reminders about an appointment.

- Emergency: If the patient requires emergency treatment, or we are required by law but are unable to get your consent, we will attempt to obtain consent as soon as practical after treatment.

- Required by law: We may disclose the patient's information where the use or disclosure of medical information about the patient is required by federal, state, or local law.

- Public health: Prevent or control disease (Communicable Diseases), injury or disability; report child abuse or neglect; report reactions to medications or problems with products; provide notice of recalls of products your child may be using; provide notice to person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (if you agree or when required or authorized by law)

- Health care oversight: Audits, investigations, inspections, and licensure by a government health oversight agency as authorized by law to monitor the health care system, government programs and compliance with civil rights laws.

- Business associates: Contractors provide services to Provider. These include electronic health record software vendors, IT vendor, accountants, attorneys, consultants, and collection agencies. We may disclose information to those contractors for the purposes of providing services to Provider. The contractors must enter into contracts with Provider agreeing to appropriately safeguard the health information and not use or disclose the information except as permitted under the contract or by law.

- Lawsuits or disputes: If the patient is involved in a lawsuit or a dispute, we may disclose medical information about the patient in response to a court or administrative order, a subpoena, discovery request or other lawful process by someone else involved in the dispute.

- Law enforcement: Subject to certain restrictions, we may disclose information needed or requested by law enforcement officials.

- Workers' compensation: For workers' compensation claims and investigations.

- Deceased: To coroners, medical examiners, and funeral directors to identify a decease person, determine the cause of death or to assist in carrying out their duties.

- Organ or tissue donation: If the patient chose or the parent chooses their child to be an organ donor, we may disclose information to organizations involved in procuring, banking or transplanting organs and tissues.

- Avert a serious threat to health and safety: We may use or disclose the patient's information when necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public. Disclosure must be limited to someone able to help prevent or lessen the threat.

- Disaster Relief: We may disclose information about the patient to disaster relief entities to notify family or friends of their location, general condition, or death.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, tell us what you want us to do, and we will follow your instructions:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.
- Provide proof of immunization to a school that is required by state or other law to have such proof with agreement to disclosure from you or your child's guardian.
- We may communicate with you by encrypted mail or text unless you object.

OTHER USES AND DISCLOSURES

In the following cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Psychotherapy notes

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of your rights with respect to the patient's protected health information:

- Right to request restrictions. You have the right to request, in writing, a restriction on uses and disclosures of the patient's health information made for payment or health care operations. Our office is not required to agree to the restriction that you may request, and we may say "no" if it would affect your care. If in the provider's professional judgement, is believed it is in the best interest to permit use and disclosure of the patient's protected health information, the patient's health information will not be restricted. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

- Right to request confidential communications. You may request to receive communications from us in an alternative method or at an alternative location. For example, you may request that we contact you only at work, by email or by mailed paper. If you request the patient's medical information to be transmitted directly to another person chosen by you, your written request must be signed and clearly identify the designated person and where the copy of Protected Health Information is to be sent. We will say "yes" to all reasonable requests.

- Right to access, inspect and obtain copies of health information. You have the right to access, inspect and receive an electronic or paper copy of the patient's health information, including billing records, except for psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil,

criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

- Right to request amendment. You have the right to request, in writing, an amendment of the patient's record and include the reason for your request. We may say "no" to your request, but we will tell you why in writing within sixty days.

- Right to receive an accounting of disclosures. You have the right to request an accounting of the disclosures we have made for your child's health information for up to the past six (6) years. We will include all the disclosures, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve months.

- Right to receive notice of a breach. We are required to provide you with notice of any acquisition, access, use or disclosure of unsecured PHI by Provider, its business associates and/or subcontractors. Unsecured health information is information that is not secured by an electronic method specific by the government. Notice must be given within 60 days of the breach and will include a brief description of the breach and your child's information involved, steps you may take to protect your child's information, steps we are taking to investigate the breach, mitigate loss and protect against future breaches, and contact information where you may ask questions.

- Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

- Choose someone to act for you/your child. If you have given someone medical power of attorney for you or your child, or if someone is yours or your child's legal guardian, that person can exercise yours or your child's rights and make choices about health information. We will make sure the person has this authority and can act for you or your child before we take any action.

COMPLAINTS

If you believe that the patient's privacy rights have been violated, you may complain to Provider or to the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf. There will be no retaliation against you for filing a complaint.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THIS NOTICE

This notice is effective September 18, 2023. We are required to abide by the terms of the notice currently in effect, but we reserve the right to change these terms as necessary. We reserve the right to amend this notice of privacy practices at any time. You have the right to request a current copy of the Notice at any time by contacting Provider or view a current copy on the Provider's website.

If you require further information about matters covered by this notice, please contact our office.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that the Department of Health and Human Services has established a "Privacy Rule" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I acknowledge that Wee Pediatrics, Inc.'s (the "practice") Notice of Privacy Practices has disclosed how the practice may use and disclose my child(ren)'s protected health information (PHI). I understand that the necessary or required medical information can and will be used and disclosed for treatment, payment, and health care operations, and that the terms of the practice's notice may change. I also understand that I may request a current copy of the practice's notice at any time by contacting the practice.

I have been informed that I am entitled to access to my child(ren)'s personal medical records, and that I may request in writing, certain restrictions as to how this information may be used and disclosed. I do acknowledge that the practice is not required to agree with my request, but if the practice does agree, it is bound to abide by my requested restrictions.

I acknowledge that I am in receipt of the practice's Notice of Privacy Practices and have been given the right to review the practice's Notice of Privacy Practices prior to signing this acknowledgement. I agree to the practice's use and disclosure of protected health information regarding my child(ren) for treatment, payment, and healthcare operations.

Patient Name: _____

This Acknowledgement was signed by (print name): _____

Signature: _____ Date: _____

Relationship to Patient: _____

Witnessed by: _____(Practice Representative) Date: _____

OFFICE USE

I attempted to obtain a signature in acknowledgement of this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date: _____ Practice Representative: _____

Reason:

_____

_____

PRACTICE AND FINANCIAL POLICIES

Mahalo for choosing Wee Pediatrics, Inc. as the health care provider for your child(ren). We are committed to providing you with the best care possible. We believe in providing and maintaining a positive and communicative relationship with our families. The goal is best achieved if everyone is aware of the practice and financial policies. Your clear understanding of these policies is important to our professional relationship.

Please read each section carefully and initial.

PAYMENTS/BILLING POLICY

- The parent/legal guardian or any authorized caregiver who is accompanying a child to the office is responsible for payment in full for all co-pays, deductibles and/or co-insurance amounts, that are due at the time of service. Payment for any non-covered services is also due at the time of service.

- Divorce: In case of divorce or separation, the accompanying parent/caregiver is responsible for full payment at the time of service. Divorce has no bearing on the responsibility for payment of medical services in our office. Please, do not place our office in the middle of martial disputes. Our office is not a party to any court orders that you may have regarding payment responsibilities. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the accompanying parent/caregiver's responsibility to collect from the other parent.

- Your account becomes delinquent if not paid within 90 days. Any further delinquency may warrant the balance being assigned to a collection agency as well as being dismissed from the practice. Unless payment arrangements have been made.

- A $30.00 fee will be charged for all returned checks and your account will be placed on a "cash-only basis". We will accept payments only by cash or credit card until the balance is cleared.

INITIAL: _____

INSURANCE PLAN POLICY

- It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designated is incorrect, you will be responsible for payment of the visit.** Once we are reimbursed by the correct insurance company, a refund will be provided.

- **For Newborns**: Not all insurances offer automatic coverage for new babies. However, some plans give a 30–31-day grace period for you to add your newborn under your plan.
    - We recommend you check with your insurance carrier, HR department or member services to understand your health plan and to start the process of adding your baby to your insurance plan.
    - If the newborn coverage period has ended, and your baby is not showing up as active under your insurance plan, you will be financially responsible for the visit(s). This may also lead to a lapse of coverage for your child.

- For HMO/Quest and Tricare Prime plans: If we are your primary care physician, ("PCP"), please make sure one of our provider's names appears on your card. If your insurance company has not been notified that we are your PCP, you may be financially responsible for your current visit.

- It is your responsibility to understand your benefit plan:

    - Not all plans cover annual well exams/physical, sports physicals, or hearing or vision screening. If it is not covered, you will be responsible for payment.
    - For children younger than 2 years of age, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company with not pay; you will be responsible for payment.

INITIAL: _____

APPOINTMENT POLICY

- Patients in our office are seen by *Appointments only.* We recommend calling us as early as possible when an appointment is needed for same day appointments.

- **If you choose not to complete the "Consent by Proxy" form, you (parent/legal guardian) will need to provide a letter authorizing a designee (18 years and older) to accompany your child to their visit and to give consent for medical treatment(s) and/or sign for vaccinations for both sick visits and well exams. This letter would be required for each visit.**

- As a courtesy, we will remind you of your child's scheduled appointment date and time by calling or sending a text/email. If we are unable to speak to you directly, we will leave a message. In the event your mailbox is full or not set up, or your line is busy, our efforts to contact you may not be successful.

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate 24-hour notice as **there is a charge of $25.00 for the missed appointment.**

- We require our patients to check-in at their designated check-in time:
    - 30 minutes before for New Patients and Well Exam Visits.
    - 15 minutes before follow-up and sick visits.

This allows adequate time to fill out forms, health screeners, updating information, collecting payments and time with the Medical Assistant to perform any necessary/required tests to be completed for a Well Exam prior to your visit with the Provider.

- If you are running late for your appointment, please give the office a call immediately to determine if we are able to accommodate you or need to reschedule you for another day.

- Frequent No Shows or Same Day Cancellations, may result in your child(ren) being dismissed from the practice.

INITIAL: _____

WELL CHILD EXAM POLICY:

- We highly recommend a parent/legal guardian be present at their child's well child exam visits to help us provide the most complete and comprehensive exam. This is to ensure consistency and communication between providers and families.

INITIAL: _____

VACCINE POLICY

- SEE FULL VACCINE POLICY

- If consent (verbal/written) is provided and later withdrawn after vaccine doses have been prepared for your child, you will be responsible for paying the full cost of the vaccines.

INITIAL: _____

REFERRAL POLICY

- If a referral is being generated by one of our providers, please allow 5-7 business days for our office to contact you with referral/specialist details. Please note, appointments with a specialist can range from 4-6 months out or longer.

- In general, we will not provide or agree to a referral for a problem we were not consulted about first.

- Referrals for specialists/procedures may be delayed if authorization is required by your insurance company.

INITIAL: _____

FORMS/LETTER POLICY

- Forms and letters require significant staff and provider time to prepare and complete. Please allow 5-7 business days for completion.

- A Student Health Record (Form 14/ DHS 908) form can be completed at the time of your child's well check up at no charge.
    - Forms given at a later time will be charged a $10.47 fee ($10.00 + tax).

- FMLA forms will incur a charge of $25.00 and require 7-10 business days for completion.

INITIAL: _____

MEDICAL RECORDS

- Transferring care: A ROI (Release of Information) consent form is required in order for us to send the medical records to the new provider.
    - There is no charge when transferring records directly to the new provider.
    - There is a charge of $0.25 per page if requesting records to be released to you.
    - Please clear any outstanding balance you may have on your account.

Note: please allow up to 30 days to process the request of medical records

INITIAL: _____

MEDICATION/REFILL POLICY

- REFILLS: We require 48-72 hours for all refills requests to be processed. Contact the pharmacy or our office to request refills at least one week prior to your medication running out to ensure you have enough medication while waiting for your refill.

- ANTIBIOTICS: We do NOT prescribe antibiotics over the phone and patients are required to be seen by a provider to determine if antibiotics are the right form of treatment.

INITIAL: _____

DISMISSAL POLICY

- If you are "dismissed" from our practice it means that you can no longer schedule appointments, get medication refills, or consider us to be your provider. You must find another provider.

  Common reasons for Dismissal are as follows:

  - Failure to keep appointments and/or frequent No-Shows.
  - Non-compliance- which means you disregard and/or choose not to follow the provider's medical advice about an important health issue.
  - Abusive to providers and staff.
  - Failure to pay your bill.

  Dismissal Process:

  We will send a letter to your last known address, via certified mail, notifying you that you are (patient) being dismissed. If you (patient) have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another provider (call your insurance company to inquire about a list of providers who are accepting new patients). We will forward a copy of your medical record to your new provider once they send us a signed Release of Information form. You may also request a Release of Information form from our office.

INITIAL: _____

I have read and understand the practice and financial policies for Wee Pediatrics, Inc. My signature below confirms my acceptance of the above policies.

_____ _____

Patient Name DOB

_____ _____

Authorized Signature Patient, Parent or Legal Guardian Date

_____ _____

Printed Name of Parent or Legal Guardian Relationship to patient

VACCINE POLICY STATEMENT

Theresa Y. Wee, MD. Jordan Arakawa, M.D Myrtle Parel, APRN

- At Wee Pediatrics, Inc. we firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. Vaccinating children and adolescents may be the single most important health-promoting intervention we perform as healthcare providers, and that you can perform as parents/caregivers. When you don't vaccinate, you take a significant risk with your child's health and the health of others around them.

- We follow the Center for Disease Control (CDC) Immunizations Schedule, which has been validated to be the most effective and is also endorsed by the American Academy of Pediatrics (AAP). The recommended vaccines and the vaccine schedule are the result of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

- We recognize that the choice may be a very emotional one for some parents. Should you have doubts please discuss this with our providers. In some cases, we may alter the schedule to accommodate parental concerns or reservations. Please be advised however, that delaying or spreading out the vaccines to give one or two at a time over two visits go 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 Wee Pediatrics, Inc. Such additional visits will require additional co-pays on your part. Please realize that you may also be required to sign a "refusal to Vaccinate" acknowledgment in the event of lengthy delays.

- We'll always offer the flu vaccine in our office, and we highly recommend them. But it is currently optional in our office. You can decline for your child, but we'll offer it again to you next year, just in case you change your mind.

- The Covid Vaccine is optional.

- Because we are committed to protecting the health of your children through vaccination, *with a few exceptions*, we require all our patients to be vaccinated. Infants will receive all age-appropriate recommended vaccines by 6 months of age, with additional recommended vaccines and booster doses by 2-years of age. Children will receive additional recommended booster doses by the time they are 7-years old. They will be given recommended 10–12-year preteen vaccines by the time they are 13-years old. We will complete 16-year teen vaccinations before each child's 18th birthday.

- Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will respectfully ask you to find another healthcare provider who shares your views. We do not keep a list of such providers. 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 taking the time to read this policy. Our intention is to make you fully aware and understand the importance of vaccinating your child. Please feel free to discuss any questions or concerns you may have about vaccines with any of our providers.

Please sign below to acknowledge that you read and understand our Vaccine Policy.

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____ Date: _____