



## 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 required 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

Age/Visit	Screenings (Complete Forms Prior to Visit)	Vaccines
Newborn	PHQ-2 (mom)	Hep B (if not done in nursery)
1 month	PHQ-2 (mom), TB	
2 month	SWYC	Pediarix, Hib, Pevnar, Rotateq
4 month	SWYC	Pediarix, Hib Pevnar, Rotateq
6 month	SWYC	Pediarix, Pevnar, Rotateq,
9 month	SWYC	
12 month	SWYC	Varivax, MMR, Hep A, Pevnar
15 month	SWYC	DTaP, Hib
18 month	SWYC	Hep A
24 month	SWYC	
30 month	SWYC	
3 year	SWYC	
4 year	SWYC	Kinrix and Proquad
5 year	SWYC, ACT (4-11)	
6 year	PSC-17 parent, FI/Lead/TB/Anemia, ACT (4-11)	
7 year	PSC-17 parent, FI/TB/Anemia, ACT (4-11)	
8 year	PSC-17 parent, FI/TB/Anemia, ACT (4-11)	
9 year	PSC-17 parent, FI/TB/Anemia, ACT (4-11)	
10 year	PSC-17 parent, FI/TB/Anemia, ACT (4-11)	
11 year	FI/TB/Anemia/Lead, ACT 12+	Tdap/ Menveo/ HPV
12 year	FI/TB/Anemia, ACT 12+	HPV (if not completed)
13 and 14 year	FI/TB/Anemia, ACT 12+	HPV (if not completed)
15 year	FI/TB/Anemia, ACT 12+	HPV (if not completed)
16 and 17 year	FI/TB/Anemia, ACT 12+	Menveo/ HPV if needed
18 year	TB/Lead/Anemia	

Term	Description	Term	Description
5210	Health Weight and Activity Screen	MMR	Measles, Mumps, Rubella combination vaccine
ASQ	Ages & Stages Questionnaire/Developmental Screenings	NBS	Newborn Screen
DTaP	Diphtheria, Tetanus, & acellular Pertussis combination vaccine	Pediarix	Diphtheria Tetanus, acellular Pertussis, Inactivated Polio & Hepatitis B combination vaccine
Hep A	Hepatitis A vaccine	PHQ-9	Maternal Well-Being Screen
Hep B	Hepatitis B vaccine	Proquad	Measles, Mumps, Rubella & Varicella combination vaccine
Hib	Haemophilus influenzae type B (HIB) vaccine	Pevnar	Pneumococcal Conjugate (PCV13) vaccine
IPV	Human Papillomavirus vaccine	PSC-17	Mental Health Screen
IPV	Inactivated Polio vaccine	Rotateq	Rotavirus vaccine
KG	Kindergarten Health Form	Safety	Adolescent Safety Screen
Kinrix	Diphtheria, Tetanus, acellular Pertussis & Inactivated Polio combination vaccine	Tdap	Tetanus, Diphtheria, & acellular Pertussis combination vaccine
M-CHAT	Modified Checklist for Autism in Toddlers	Varivax	Varicella (Chicken Pox) vaccine
Menveo/Menactra	Meningococcal Groups A, C, Y, & W 135 vaccine		

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



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.



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## 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, credit or HSA card.

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### 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](http://www.healthcare.gov).

Unfortunately, at this time Tricare Prime\*, BCBS NC Blue Value, United Healthcare Compass, and select SC Medicaid\*\* plans are out of network.

\*Unless referred to one of our providers.

\*\*Absolute Total Care is considered in network for Rock Hill Pediatrics only.

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### 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.

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### 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.

### 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.

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### 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. To request to have a claim re-filed, please contact Customer Service at 704-512-7171.

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### 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
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### 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 Charlotte Pediatric Clinic, 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.

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### 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.

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### 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 received 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.

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### 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.

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### 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 have 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 is 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 is 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)

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Occupational therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Annual Patient Update

*(for established patients only)*

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Patient Name

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Date of Birth

---

Preferred Name/Nickname

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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:

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### 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: \_\_\_\_\_

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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:

_____	_____	_____
<b>Name</b>	<b>Relationship to Patient</b>	<b>Mobile Phone</b>
_____	_____	_____
<b>Name</b>	<b>Relationship to Patient</b>	<b>Mobile Phone</b>
_____	_____	_____
<b>Name</b>	<b>Relationship to Patient</b>	<b>Mobile Phone</b>

All patients need to complete this form.

Child ID#: \_\_\_\_\_

Child age \_\_\_\_\_

Caregiver: \_\_\_\_\_

Date: \_\_\_\_\_

## Pediatric Symptom Checklist-17 (PSC-17)

**INSTRUCTIONS:** Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child’s behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

	Please mark under the heading that best fits your child			<i>For Office Use</i>		
	Never	Sometimes	Often	I	A	E
1. Feel sad.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2. Feel hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. Feel down on him/herself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4. Worry a lot.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5. Seem to be having less fun.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6. Fidget, is unable to sit still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7. Daydream too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
8. Distract easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
9. Have trouble concentrating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10. Act as if driven by a motor.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
11. Fight with other children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
12. Not listen to rules.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
13. Not understand other people’s feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
14. Tease others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
15. Blame others for his/her troubles.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
16. Refuse to share.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
17. Take things that do not belong to him her.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<b>TOTAL</b>						

**To Score:**

Fill in the unshaded box on the right: “Never” = 0, “Sometimes” = 1, “Often” = 2.

Sum the columns.

PSC17-Internalizing score is the sum of column I.

PSC17-Attention is the sum of column A

PSC17-Externalizing is the sum of column E.

PSC-17 Total Score is the sum of PSC17-I + PSC17-A + PSC17-E.

**Positive Scores:**

PSC17-I        ≥ 5

PSC17-A        ≥ 7

PSC17-E        ≥ 7

Total Score    ≥ 15

**RISK ASSESSMENTS**

Anemia Risk Assessment	Yes	No
Has your child been previously diagnosed with anemia?		
Is your child on a vegetarian or vegan diet?		
<b>TB Risk Assessment: Does your child have . . .</b>		
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?		
<b>Fluoride Assessment:</b>		
Do you have well water?		
Do you exclusively use bottled water in your child's formula or for drinking?		

# Childhood Asthma Control Test for children 4 to 11 years

## 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:

### Have your child complete these questions.




1. How is your asthma today?

 <b>0</b> Very bad	 <b>1</b> Bad	 <b>2</b> Good	 <b>3</b> Very good
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2. How much of a problem is your asthma when you run, exercise or play sports?

 <b>0</b> It's a big problem, I can't do what I want to do.	 <b>1</b> It's a problem and I don't like it.	 <b>2</b> It's a little problem but it's okay.	 <b>3</b> It's not a problem.
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3. Do you cough because of your asthma?

 <b>0</b> Yes, all of the time.	 <b>1</b> Yes, most of the time.	 <b>2</b> Yes, some of the time.	 <b>3</b> No, none of the time.
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4. Do you wake up during the night because of your asthma?

 <b>0</b> Yes, all of the time.	 <b>1</b> Yes, most of the time.	 <b>2</b> Yes, some of the time.	 <b>3</b> No, none of the time.
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### Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

<b>5</b> Not at all	<b>4</b> 1-3 days	<b>3</b> 4-10 days	<b>2</b> 11-18 days	<b>1</b> 19-24 days	<b>0</b> Everyday
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6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

<b>5</b> Not at all	<b>4</b> 1-3 days	<b>3</b> 4-10 days	<b>2</b> 11-18 days	<b>1</b> 19-24 days	<b>0</b> Everyday
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7. During the last 4 weeks, how many days did your child wake up during the night because of the asthma?

<b>5</b> Not at all	<b>4</b> 1-3 days	<b>3</b> 4-10 days	<b>2</b> 11-18 days	<b>1</b> 19-24 days	<b>0</b> Everyday
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\*The Childhood Asthma Control Test was developed by GSK.

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SCORE







TOTAL

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

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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

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American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality





## 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](http://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](http://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:

<b>Facility (check all that may apply):</b> <input type="checkbox"/> Facility Summary (includes items in bold) <input type="checkbox"/> <b>Discharge Summary</b> <input type="checkbox"/> <b>Emergency Record</b> <input type="checkbox"/> <b>History and Physical</b> <input type="checkbox"/> <b>Operative Reports</b> <input type="checkbox"/> Laboratory reports <input type="checkbox"/> <b>Radiology/X-Ray Reports</b> <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Other _____  <input type="checkbox"/> Entire record <input type="checkbox"/> Itemized Bill	<b>Office/Clinic/Home Care (check all that may apply):</b> <input type="checkbox"/> Office/Clinical Summary (includes items in bold) <input type="checkbox"/> <b>Office/Home Visits</b> <input type="checkbox"/> <b>Physical Exam</b> <input type="checkbox"/> <b>Laboratory Reports</b> <input type="checkbox"/> <b>Radiology Reports</b> <input type="checkbox"/> Therapy Notes <input type="checkbox"/> Other _____  <input type="checkbox"/> Entire Record <input type="checkbox"/> Itemized Bill
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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 \_\_\_\_\_

