

MOUNTAINSIDE PEDIATRICS NEW PATIENT PACKET

PATIENT INFORMATION:

Race: White African-	DOB:	Gender: \square M \square	F
	-American □ Asian □ Hispanic □	Multi-Racial □ Other	
Address:	City: Alternative Phone: ry □ Alternative □ Both Email	State: Zip:	
Primary Phone:	Alternative Phone:	· · · · · · · · · · · · · · · · · · ·	6.
Leave messages at: ☐ Prima	ry 🗆 Alternative 🗀 Both Email	i:	
	The man element		. 14 21 1
PARENT'S INFORMATION:			
Parent #1:			
Name:	S.S.# (required) City:	DOB:	_
		State: Zip:	Seed of
(If Different from Patients)			
Mother's Maiden Name:			-
	8°4'		
Parent #2:			
Name:	S.S.# (required) City:	DOB:	-
Address:	City:	State: Zip:	10
(If Different from Patients)	N. 15 P		
	No If divorced, who has custody?		-
Please provide legal docume	entation		
Patient Consent Form:			
The second second			
As our patient we want you to know tha	t we respect the PRIVACY of your personal medically belongers to protect your privacy. When it		
As our patient we want you to know tha privacy. We strive to always take reasons	t we respect the PRIVACY of your personal medicable precautions to protect your privacy. When it it are operations, in order to provide health care that	is appropriate and necessary, we provide minimu	m informat
As our patient we want you to know tha privacy. We strive to always take reasona about treatment, payment, or health car support full access to your personal med	able precautions to protect your privacy. When it is re operations, in order to provide health care that lical records. We may have indirect treatment rela	is appropriate and necessary, we provide minimu is in your best interest. We also want you to kno ationships with you and may have to disclose pers	m informat w that we onal healti
privacy. We strive to always take reasons about treatment, payment, or health car support full access to your personal med	able precautions to protect your privacy. When it is re operations, in order to provide health care that	is appropriate and necessary, we provide minimu is in your best interest. We also want you to kno ationships with you and may have to disclose pers	m informat w that we onal healti
As our patient we want you to know tha privacy. We strive to always take reasona about treatment, payment, or health car support full access to your personal medinformation for purposes of treatment, paymay refuse to consent to the use of	able precautions to protect your privacy. When it is a operations, in order to provide health care that lical records. We may have indirect treatment relay bayment, or health care operations. These entitles disclosure of your personal health information, but	is appropriate and necessary, we provide minimu is in your best interest. We also want you to kno ationships with you and may have to disclose per s are most often not required to contain patient o ut this must be written, under HIPPA Law, we hav	m informate we that we conal health onsent.
As our patient we want you to know that privacy. We strive to always take reasonat about treatment, payment, or health car support full access to your personal medinformation for purposes of treatment, produced to the use of	able precautions to protect your privacy. When it is a operations, in order to provide health care that lical records. We may have indirect treatment related by the provide health care operations. These entitles	is appropriate and necessary, we provide minimu is in your best interest. We also want you to kno ationships with you and may have to disclose per s are most often not required to contain patient o ut this must be written, under HIPPA Law, we hav	m informate we that we conal health onsent.
As our patient we want you to know that privacy. We strive to always take reasonat about treatment, payment, or health car support full access to your personal medinformation for purposes of treatment, programmed to the use of refuse to treat you should you chose to signed consent.	able precautions to protect your privacy. When it is a operations, in order to provide health care that lical records. We may have indirect treatment relapsyment, or health care operations. These entitles disclosure of your personal health information, but disclose your PHI. You may not revoke actions that	is appropriate and necessary, we provide minimule is in your best interest. We also want you to kno ationships with you and may have to disclose persone most often not required to contain patient of this must be written, under HIPPA Law, we have thave already been taken which relied of this or	m informat w that we onal health onsent. e the right a previous!
As our patient we want you to know that privacy. We strive to always take reasonal about treatment, payment, or health car support full access to your personal medinformation for purposes of treatment, provided to the use of refuse to treat you should you chose to signed consent.	able precautions to protect your privacy. When it is a operations, in order to provide health care that lical records. We may have indirect treatment relay bayment, or health care operations. These entitles disclosure of your personal health information, but	is appropriate and necessary, we provide minimule is in your best interest. We also want you to know ationships with you and may have to disclose persone most often not required to contain patient of this must be written, under HIPPA Law, we have thave already been taken which relied of this or incer. You have the right to review our policy notice.	m informat w that we onal health onsent. e the right a previous!
As our patient we want you to know that privacy. We strive to always take reasonal about treatment, payment, or health car support full access to your personal medinformation for purposes of treatment, provided to the use of refuse to treat you should you chose to signed consent.	able precautions to protect your privacy. When it is to operations, in order to provide health care that lical records. We may have indirect treatment related anyment, or health care operations. These entitles disclosure of your personal health information, but disclose your PHI. You may not revoke actions that lease ask to speak with our HIPPA Compliance Office.	is appropriate and necessary, we provide minimule is in your best interest. We also want you to know ationships with you and may have to disclose persone most often not required to contain patient of this must be written, under HIPPA Law, we have thave already been taken which relied of this or incer. You have the right to review our policy notice.	m informat w that we onal health onsent. e the right a previous!
As our patient we want you to know that privacy. We strive to always take reasonal about treatment, payment, or health car support full access to your personal medinformation for purposes of treatment, provided to the use of refuse to treat you should you chose to signed consent.	able precautions to protect your privacy. When it is to operations, in order to provide health care that lical records. We may have indirect treatment related anyment, or health care operations. These entitles disclosure of your personal health information, but disclose your PHI. You may not revoke actions that lease ask to speak with our HIPPA Compliance Office.	is appropriate and necessary, we provide minimule is in your best interest. We also want you to know ationships with you and may have to disclose persone most often not required to contain patient of this must be written, under HIPPA Law, we have thave already been taken which relied of this or incer. You have the right to review our policy notice.	m informat w that we onal health onsent. e the right a previous!
As our patient we want you to know that privacy. We strive to always take reasonat about treatment, payment, or health care support full access to your personal medinformation for purposes of treatment, provided the support full access to your personal medinformation for purposes of treatment, provided to the support full access to your personal medinformation for purposes of treatment, provided to the support full access to your personal medinformation for purposes of treatment, provided to the support full access to your personal media.	able precautions to protect your privacy. When it is to operations, in order to provide health care that lical records. We may have indirect treatment related anyment, or health care operations. These entitles disclosure of your personal health information, but disclose your PHI. You may not revoke actions that lease ask to speak with our HIPPA Compliance Office.	is appropriate and necessary, we provide minimule is in your best interest. We also want you to know ationships with you and may have to disclose persone most often not required to contain patient of this must be written, under HIPPA Law, we have thave already been taken which relied of this or incer. You have the right to review our policy notice.	m informat w that we onal health onsent. e the right a previous!
As our patient we want you to know that privacy. We strive to always take reasonat about treatment, payment, or health care support full access to your personal medinformation for purposes of treatment, provided to the use of refuse to treat you should you chose to disigned consent.	able precautions to protect your privacy. When it is to operations, in order to provide health care that lical records. We may have indirect treatment related anyment, or health care operations. These entitles disclosure of your personal health information, but disclose your PHI. You may not revoke actions that lease ask to speak with our HIPPA Compliance Office.	is appropriate and necessary, we provide minimule is in your best interest. We also want you to know ationships with you and may have to disclose persone most often not required to contain patient of this must be written, under HIPPA Law, we have thave already been taken which relied of this or incer. You have the right to review our policy notice.	m informat w that we onal health onsent. e the right a previous!
As our patient we want you to know that privacy. We strive to always take reasonat about treatment, payment, or health care support full access to your personal medinformation for purposes of treatment, provided to the use of refuse to treat you should you chose to disigned consent.	able precautions to protect your privacy. When it is to operations, in order to provide health care that lical records. We may have indirect treatment related anyment, or health care operations. These entitles disclosure of your personal health information, but disclose your PHI. You may not revoke actions that lease ask to speak with our HIPPA Compliance Office.	is appropriate and necessary, we provide minimule is in your best interest. We also want you to know ationships with you and may have to disclose persone most often not required to contain patient of this must be written, under HIPPA Law, we have thave already been taken which relied of this or incer. You have the right to review our policy notice.	m informat w that we onal health onsent. e the right a previous!

Mountainside Pediatrics Medical/Family History Questionnaire

Patient Name:			Date of Birth:	Sex: (circle)	
					Female
Form Completed By:	Toda	y's Date	Relationship:		
PREGNA'NCY AND BIF	RTH HIS	TÖRY	" PSYCHOSOCIAL HTS	TORY	
Name of Hospital:			Who lives in household?		
Name of Hospital:	No [] Yes □			
Medications during pregnancy	? No 🗆] Yes □	How many?		
Alcohol/Drug Abuse?	No 🗆			Shelter?	
Problems at birth?	No E] Yes □	Who cares for child?		
Describe:			Date of Birth? Mother		
Type of delivery?	al 🗀	C-section	Father		
Birth Weight Dis Did baby receive Hepatitis B va	charge	Weight	Are parents working? Mother	No 🗆 Yo	es 🗆
Did baby receive Hepatitis B va	accine?	No □ Yes □	Father Father	No 🗆 Y	es 🗆
Date of Hepatitis B immunization			Foster Care? Dates	:	
Newborn Hearing Screen?	No E] Yes □	Father Foster Care? Dates Other Languages?		
FAMILY HIST			MEDICAL HISTO	RY	
Has anyone in the family (pare		nd-parents,	Has your child ever had:		
aunts/uncles, sisters/brothers)	had:		 	–	
A!!:	N - C	Who?	Allergies (List)	_ No □	Yes □
Allergies (List)	ио П	res ⊔	Asthma	- N- (7	V 🗆
Acthro	No □	Yes □		No □ No □	Yes □ Yes □
Asthma		Yes □	Chicken Pox (Year) Frequent Ear Infections		Yes 🗆
TB/Lung Disease HIV/AIDS	No □ No □		Vision/Hearing Problems		Yes □
Suicide Attempts	No 🗆	Yes □	Skin Problems/Eczema	No 🗆	Yes □
Heart Disease	No 🗆	Yes □	TB/Lung Disease	No 🗆	Yes 🗆
High Blood Pressure/Stroke	No 🗆	Yes 🗆	Seizures/Epilepsy	No □	Yes □
High Cholesterol	No 🗆	Yes □	High Blood Pressure	No 🗆	Yes 🗆
Blood Disorders/Sickle Cell	No 🗆	Yes □	Heart Defects/Disease	No 🗆	Yes □
Diabetes	No 🗆	Yes □	Liver Disease/Hepatitis	No 🗆	Yes □
Diabetes Seizures	No 🗆	Yes □	Diabetes	No □	Yes 🗆
Mental illness	No 🗆	Yes 🗆	Kidney Disease/Bladder Infection		
Cancer	No 🗆	Yes □	Physical or Learning Disabilities	No □	
Birth Defects	No 🗆	Yes □	Bleeding Disorders/Hemophilia		Yes □
Hearing Loss		Yes □	Sexually Transmitted Diseases		Yes □
Speech Problems	No 🗆	Yes □	Emotional or Behavioral Problem		Yes □
Kidney Disease	No 🗆	Yes □	Depression/Suicidal Thoughts	No 🗆	Yes □
Alcohol/Drug Abuse	No 🗆	Yes □	Hospitalizations/Surgeries	No □	Yes □
Hepatitis/Liver Disease	HO L	1 cs Cl	Physical/Emotional/ Sexual Abus		Yes □
Thyroid Disease	No □	Yes □	Bone or Joint Injuries	No 🗆	Yes □
Learning Problems/Attention	No 🗆	Yes □	Obesity/Eating Disorders	No 🗆	Yes □
Deficit Disorder	No 🗆	Yes □	Other:		Yes □
Family Violence	No 🗆	Yes 🗆			.00 🗅
Other:			Current Medication(s): (<i>List</i>)		
Reviewed by:			Date of Review:	Pa	ge 2 of 7



With this consent, the Office of Mountainside Pediatrics, LLC may:

- Call my home or other locations that I specify; and leave a message regarding appointment reminders, insurance items, financial information, and any call pertaining to my child's clinical care, including labs and imaging results.
- Use and/or disclosure certain protect health information (PHI) about my child for school, camps, or sports, on a form that I submit for completion.
- Provide immunization records or forms by fax to my child's school.

,,			- ('		- '>
Please indicated how you pr	ofor to be cont	acted regarding	the following (ch	ack one for e	each item):
Medical Issues:	Home	□ Cell			
		Cell			
Appointment Reminders:	Home				
Appointment Recalls:	Home	Cell	Phone #:		
Optional:					
give permission to the office		The treatment of the second of			
hat I am unable to accompar					
parent present to obtain med			14		
child with a caregiver or by se	ending my adol	escent child alo	ne, I am giving ad	vance conse	nt to any medical
procedure the physician deer	ns necessary.				
Persons other than a parent of	or legal guardia	n authorized to	accompany my cl	nild to an app	pointment include
Name:		_ Relationship: .		Phone#: _	
Signature of Parent/Guardian	ĺ	Print Paren	t/Guardian		Date
Patient Financial Policy:					
All patients must present a vi	alid proof of insurance	e each time of service	3		
All patients previous balance					
 All balances should be cleare 	d in full with in 30 da	ys or the balance will	be forwarded to the co	llection agency.	
 After presenting one NSF che 			ayment will be accepted	í.	
\$25.00 will be charged in add			weeks beautiful from the London		
 Balances aged 60 days will be All patients' dues and balance 		이 집에 되었다. 이 반에 어떻게 되었다면 그 이 사람들이 되었다.		business office.	
If patient would be non-com				rics. LLC reserve t	he right to discharge pati
from practice.	sidine to pay may ner	balance within 50 day	o, mountainistae realian	,	ne ngara sa sasana ga pasa
All copayments are due at tir	ne of service.				
have read the financial policy and/or it	has been explained	to me Lagree to the t	erms and conditions of	this policy	
nave read the initialitial policy and/or it	nas seen explained	ine. rugice to the t	es and conditions of	poney.	
Name (signature)	Nam	e (print)		Date	



Well Visits & Additional Charges:

The providers at Mountainside Pediatrics, LLC agree strongly with the AAP and Bright Future recommendations that your child should receive regularly scheduled checkups, which may include routine labs and testing of hearing and vision.

Insurance companies have recently changed what they will cover during a well check. Our billing office receives many calls from parents with questions regarding their bills for changes incurred during a "checkup" that are not covered under routine wellness benefits.

Depending on the age of your child, their visit may include the following:

- Age-appropriate questionnaires to assess proper development and/or detect delays.
- · Adolescent depression screenings
- Various lab tests: lead, urine, remoglobin, and lipids
- Edinburgh postnatal depression screening
- · Hearing and Vision testing
- · Filling out forms for sports
- Refill medications

Other concerns that are more complicated and involve more time such as chronic headaches, stomach pains, ear pains, wheezing, psychological or unusual school problems, or other medical issues usually require a separate code and charge in addition to the checkup. Your insurance companies may consider these additional codes and/or charges as two separate visits and they <u>MAY</u> require additional patient out-of-pocket (copay, co-insurance, or deductible). We practice medicine based on the guidelines from the American Academy of Pediatrics. Occasionally, some things such as blood work, other labs, and hearing and vision are not covered by your insurance and/or are put towards your deductible. These billing issues are between <u>you and your insurance company</u>, and we always suggest you check with your insurer or HR Department <u>BEFORE</u> coming to the doctor to know what is covered by <u>YOUR</u> plan. Mountainside Pediatrics, LLC is not responsible for knowing your individual plan details and files your claim for you as a courtesy.

The amount of time required to "check in" for a well visit appointment is substantially longer than that of a sick visit. This is due to the varying number of questionnaires that are given according to the Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Please be here at least 10 minutes prior to your appointment.

Your signature below verifies the	nat you agree to the above.		
Patients Name	Patients D.O.B.		
Parent Signature	Parent Print Name	Date	

Mountainside Pediatric Notice:

Welcome to Mountainside Pediatrics. We strive to give you the best care you and your children need. We aim to be your pediatrician as long as your family wants us to be. If there is anything we can do to improve your experience, please let us know.

- We're committed to nurturing the future generation and preparing the next wave of healthcare heroes! Sometimes you might spot our eager students buzzing around and soaking up wisdom from our legendary Dr. Mahmood. We kindly ask for your patience during these moments of educational excitement. Think of it as helping future health care providers, your understanding and patients are truly appreciated.
- 2. For our **WebMD** explorers: while we appreciate your detective skills, let's remember that it is not always a reliable diagnosis tool. Your case is one-of-a-kind, and that is where our healthcare expertise comes in. We're here to provide you accurate assessments, appropriate care, and save you from unnecessary anxiety caused by Dr. Google. So please tell us your symptoms, share your concerns, and let us handle the rest. We have your covered with the best care possible.
- 3. In this era of instant gratification, we get that waiting can be a real buzzkill. Our doctors are on a mission to give each patient personalized car, which might mean they take a little extra time with you and the other patients. So, while there might be occasional delays, we want to make sure every child, including yours, has our undivided attention. We appreciate your patience and if you have any questions or concerns during the wait feel free to reach out.
- 4. No Shows: If you miss your appointment, there is no penalty to you. However, there might be another child in need of care that we are unable to see because you've taken their spot. If you think you might miss your appointment, please give us a call and let us know as soon as you can so we can work with you to get you and your child rescheduled.
- 5. Stay awesome, and keep rolling with us.

I have read and agree to the notice	above:		
Parent Signature	Parent Print	 Date	

PRACTICE POLICIES AND GUIDELINES AGREEMENT:

Welcome. We are glad that you have decided to become a part of our practice. Our goal is to provide you with excellent healthcare in a friendly and compassionate environment. Please take a moment to become familiar with our office's policies and guidelines, then sign the acknowledgement at the bottom of this page and return to our office. Our treatment relationship is a partnership and we look forward to helping you achieve the best health outcomes possible.

<u>First Time Visit</u>: Please arrive at least 10-15 minutes prior to your appointment time. A nurse will go over your past medical history. Please bring all of your medications in their original containers. If you have a copay or have not yet met your deductible, please be prepared to pay it when you check in the front desk. If you do not have insurance coverage, payment will be collected after you see the doctor. Payment is due at the time of service.

<u>Follow-Up Visit:</u> Please arrive 5-10 minutes before your scheduled appointment time. It is our goal for you to be ready to see your physician on time. Notify us if you have any changes in your insurance or contact information. Please make us aware of any significant updates in your medical history, such as hospital or urgent care visits, and any changes in your medications by another healthcare professional.

<u>Follow-Up Care</u>: Your treatment plan may involve a follow-up care. As such, we may schedule you for diagnostic tests, follow-up appointments with us or other providers. If you do not keep the appointment, it is important that you contact us to discuss alternatives. Likewise, if you decide to seek care from another provider, please let us know.

It is our policy to inform you of your test results, however, <u>if you have not received your test results within the expected time, please contact our office.</u> Some patients may make an appointment for a mammography exam and receive the follow-up report without doctor's referral. This is known as "self-referral". In these cases, we may not be aware of your test results. Please provide us with a copy of your results and make us aware of any recommendations for follow-up care.

<u>Late Arrivals</u>: We all run late sometimes. In the event that you are late for your appointment, we will try our best to work you back in to the schedule. Depending on how busy we are, you may be required to reschedule your appointment.

Appointment Cancellations: We understand that sometimes plans change. We ask that you reschedule your appointment at least 24 hours in advance so that we may give that appointment time to someone else. Although unexpected events may necessitate missing an appointment, if you miss 2 appointments without following the cancellation protocol then you will be charged \$25.00. If you miss 3 appointments without following the cancellation protocol, you may be dismissed from the practice. You will receive a written notification if you miss 2 appointments.

<u>Sick Visits</u>: Established patients who need acute care should call as early in the day as possible so that we can accommodate you. Patients are seen by appointment only. Depending on the availability of your physician, you may be asked to go to urgent care.

Medication Refills: For non-emergency and routine medication refills, please allow 48 hours and ask your pharmacy to send us a refill request. Also, please let a nurse or physician know if you need a 90-day prescription. Narcotic medications will only be written for a 30-day supply at a time. Additional refills to the original prescription will be at the doctor's discretion. Early refills will not be given. You may be requested to contact your pharmacy to ask them to fax a refill request to our office to assure that exact fill dates are documented accurately. You may also be asked for a follow-up appointment for certain refill request.

After Clinic Hours and Weekends: You may reach the on-call physician by calling 706-253-9898 and following the instructions as given. After clinic hours is for medical advice about your child current conditions. If it is an emergency, please take your child to an urgent care or emergency room. All other questions please call back during our business hours.

<u>Audio or Video Recording</u>: In the interest of your privacy, as well as that of our workforce, unauthorized audio or video recording by patients, family members, and/or visitors is strictly prohibited. Personal devices with an audio and/or video recording function should not be used or be visible in the office and must be stored accordingly. To the extent a member of our workforce is aware of any unauthorized attempt to photograph or record a patient and/or workforce member, the workforce member will take reasonable steps to ensure the patients and/or workforce embers are not photographed within the office.

We respectfully request that your turn off or silence your phone cell phone during your office visit.

<u>Parents Living Apart</u>: The parents shall communicate with each other about the children, and shall use good faith efforts in attempts to resolve differences of opinion regarding any major decisions concerning the child with primary emphasis being on arriving at a solution



which will be in the best interest of the child. The practice will not be in any position to act as an intermediary between the parents. On matters of billing and financial responsibility, accounts of minor children of separated or divorced parents are the responsibility of the parent who consents to treatment.

<u>Chaperones</u>: Our practice is committed to providing a safe and comfortable environment for all patients. We provide formal chaperones for all intimate exams; however, you have the right to have a formal chaperone present for any examination, procedure, or treatment. Please notify a staff member that you want a chaperone.

Non-Parent Accompanying a Child: If you the parent are unable to accompany your child to their appointment, please make sure that the person accompanying your child is on the authorized list located on page 3 or that we have a HAND WRITTEN NOTE WITH THE PARENTS SIGNATURE on it before the arrival to the appointment. Email approval or over the phone approval will not be accepted.

<u>Unsolicited Text Messages</u>: Please refrain from sending unsolicited text to our providers or staff. You may use our secure portal to communicate with our staff.

ent Signature	Parent Print	Date
---------------	--------------	------

Vaccine Policy Statement:

We strongly believe in the effectiveness and safety of vaccines to prevent serious illness and to save lives.

We firmly believe that all children and young adults should receive all the recommended vaccines according to the schedule published by the Centers of 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 perform as healthcare providers, and that you can perform as parents/guardians. The recommended vaccines and their schedules given are the results of years and years of scientific study and date gathering on millions of children by thousands of our brightest scientists and physicians.

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

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

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

We are making you aware of these facts not to scare you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be very emotional one for some parents. We will do everything we can to convince you that vaccinating accordingly to the schedule is this the right thing to do. However, should you have doubts, please discuss these with your health care provider in advance of your visit. Please be advised, however, that delaying or "breaking up" these 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.

Finally, if you should absolutely refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in riding this policy, and please feel free to discuss any

questions or concerns you may have about vaccines with any one of us. Sincerely, K.R. Mahmood, MD, FAAP Associate Professor of Pediatrics CEO Mountainside Pediatrics, LLC I have read the vaccine policy and/or it has been explained to me. I agree to the terms and conditions of this policy. Parent Signature Parent Print Date Acknowledgment: have received a copy of the office procedures, Bill of Rights, and HIPPA promise to Privacy practice. Parent Signature Parent Print Date Relationship to Patient

Patient D.O.B.

Patient Name