New Patient Registration Form

PATIENT DEMOGRAPHICS

Today's Date: ___/___/_____ Last Name: _____ First Name: _____
Nickname (goes by): _____ Date of birth: ___/___/_____ Sex: Male / Female
Home Address: _____ **PRIMARY location: HODGES / NOCATEE**
City: _____ State: _____ Zip: _____
Home Phone: (_____)_____-_____ Cell: (_____)_____-_____ Primary email: _____
BEST phone number to reach parents: 1.) Name:_____ (_____)_____-_____ home/cell
Race: Asian / African American / Caucasian / American Indian / Native Hawaiian / Hispanic / other: _____
Ethnicity: Non-Hispanic / Hispanic / Refused to report Language preference: English / Spanish / Other:_____
Pharmacy Name: _____ Address: _____ Phone:_____
How did you hear about us? _____
Do you agree to receive periodic messages from the practice (appointments, labs results, Rx) Voice: Y/N Text: Y/N

FATHER

Last Name: _____ DOB: ___/___/_____
First Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Best Phone #: (_____)_____-_____ cell / work / home
Alternate Phone#: (_____)_____-_____ cell/work/home
Email:_____
Occupation: _____
Employer:_____

MOTHER

Last Name: _____ DOB: ___/___/_____
First Name: _____
Address: _____
City: _____ State: _____ Zip:_____
Best Phone #: (_____)_____-_____ cell / work / home
Alternate Phone#: (_____)_____-_____ cell/work/home
Email:_____
Occupation: _____
Employer:_____

Biological Parents Marital Status: Married / Single / Divorced / Widowed Other:_____
If divorced, who has custody of child? _____ Who does the child Primarily live with: _____
Any court documents documenting custody of this child? YES / NO If yes, please provide copies for our records
If Step Parents please list names Step-Mom: _____ Step-Dad:_____

INSURANCE

Primary Insurance: _____
Full name of Insured:_____
Subscriber ID:_____
Group#:_____
Subscriber DOB:___/___/_____ Effective date: _____
Relationship to Patient:_____ Co-pay $:_____

EMERGENCY CONTACTS

Name:_____
Relationship: _____ Phone:_____
May this person seek medical care for your child? YES / NO
Name:_____
Relationship: _____ Phone:_____
May this person seek medical care for your child? YES / NO

Does your child have any communication needs? Vision impaired / hearing impaired / Cognitive Issues
Does your child receive therapy / counseling /services (speech, ENT, allergy) from any other providers? YES / NO
If yes, please complete below:

Reason:_____ Provider:_____ Office Phone(_____)_____-_____
Reason:_____ Provider:_____ Office Phone(_____)_____-_____
Reason:_____ Provider:_____ Office Phone(_____)_____-_____

RAINBOW PEDIATRIC CENTER

Authorized Consent to Seek Medical Care

I am providing my current insurance information along with my copayment or full payment for the services rendered. I also understand if Rainbow Pediatric Center is unable to obtain payment from my insurance company I am responsible for payment in full for services rendered to my child/children while under the care of the above named person.
**Copay must be paid by the authorized adult bringing the child in for services or a $5 fee will be charged.

_____ _____/_____/_____
Patient Name Patient's date of birth

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

For patients 16 years and older ONLY: Patient listed above may present and be treated unaccompanied by an adult. Yes____ No____ (parent, please initial one)

□ I Do NOT authorize anyone other than the parents stated on the New Patient Questionnaire to seek medical care for my child. (Only mom or dad may bring patient to office)

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

If you are allowing someone other than the parents to bring in the child (grandparents, nanny, aunt/uncle, etc. in case parents are at work or out of town), please complete and sign below

I (Parent / legal guardian), _____ am hereby giving permission for the following person to bring my child/children to Rainbow Pediatric Center and to receive medical treatment and advise during my absence.

Name:_____ DOB: ___/___/_____ Relationship:_____
Name:_____ DOB: ___/___/_____ Relationship:_____
Name:_____ DOB: ___/___/_____ Relationship:_____

Please specify dates: From _____/_____/_____ to _____/_____/_____ (ex. 18th birthday or the week you will be out of town and child with grandparents)

We will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify Rainbow Pediatric Center of a divorce, legal separation, change in custody arrangement, or any other circumstances which may alter this authorization.

OFFICE FINANCIAL AGREEMENT:
AUTHORIZATION OF ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF MEDICAL RECORDS

Please read carefully and sign stating that you understand and agree with our policies
**** Please note both parents have access to child's information, unless a court order is on file****

I understand payment of all medical care is due at the time of service. We accept cash, check, visa, master card and discover. In case of divorced parents, responsibility and payment shall be that of the guardian bringing the child in for treatment. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance not paid by my insurance company. I understand that if my account is not paid in full by my insurance within 60 days of the date of service, I am responsible for payment in full. I understand that, in case of default, I am responsible for any costs incurred in the collection of patient account, as well as reasonable attorney fees and court costs**.**

There is a **$5** billing fee when co-pay is not paid on date of visit. *Your insurance requires you to pay your co-pay at every visit* and we incur an expense in billing for these small balances. Therefore, we find it necessary to charge this fee.

Returned checks are subject to a service charge of **$40.00** and you will lose your privilege to write checks in our office**.**

Missed appointments: **Rainbow Pediatric Center** requires 24-hour advance notice for all cancellations. Failure to notify our office will result in a **$30.00** fee. Emergencies will be considered on a case-by-case basis for waiver of this fee. After the third no show, the patient will be discharged from the practice.

Medical Records: There will be a charge of **$1.00** per page for the first 25 pages and **$.25** thereafter for the copying of medical records. For FMLA or military forms there will be a $20 fee. Physical and immunization forms are provided free of charge at your child's annual well visit. There will be a $5 fee per form for records requested after your child's well visit. These records require a minimum of 24hrs to complete. If you need these sooner you may pay an additional $5 fee per form to get the form completed in <4hrs. For sports physicals, in order to complete forms, your child MUST have had a well visit in our office in the last 3 months or a sports physical visit must be completed.

Medical Forms: Physical and Immunizations forms are PROVIDED FREE at your child's yearly well visit. If needed after that visit, there is a $5 fee per form and require 3 business days to complete. One sheet forms (sports physical, camp, medication) fee of $5 per form. >1 sheet form $10. ALL forms require 3 business days to complete. If a rush is needed (forms needed in <24hrs notice, other than FMLA) than $10 fee. FMLA paperwork is $20 and takes 5 business days to complete. FMLA rush fee is $30 for forms needed < 24hrs.

Newborns: *If you are enrolling your baby to an insurance policy please be sure to do so within 30 days of birth*. As a courtesy we will hold claims for 30 days prior to submitting to the insurance allowing you this time to add the baby. Please note: Our office visits are not billable under mother's coverage. Baby must be added as an individual policy holder.

Rainbow Pediatric Center only bills **ONE** insurance policy. If your child/children are covered by two policies, we will only bill the primary insurance.

Deliquent Bills: On a case-by-case basis Management will work with Responsible Party to address delinquent accounts. **If unresolved, the account will be assigned to external collection agency. I will also be responsible for all additional financial charges levied.**

Guarantor Name: _____ Patient Name:_____

Signature: _____ **Date:** _____

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

"Notice of Privacy Practices"

I hereby give consent to Rainbow Pediatric Center, P.A. and all health care providers furnishing care within the practice to use and disclose health information for the purposes of treatment, payment and health care operations.

I further authorize Rainbow Pediatric Center, P.A. to furnish information from my medical records as requested by other physicians or medical care facilities, hospitals or home health agencies for my continued care and treatment or for peer review activities.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe information may identify me.

I understand that I have a right to request Rainbow Pediatric Center, P.A. to restrict how they use and disclose my protected health information for the purposes of treatment, payment or health care operations. Rainbow Pediatric Center, P.A. is not required to grant my request, but if they do, the restriction will be binding on Rainbow Pediatric Center, P.A.

I acknowledge that I have received the Notice of Privacy Practices for Rainbow Pediatric Center, P.A., which provides more detailed information about how Rainbow Pediatric Center, P.A. may use or disclose by protected health information.

_____	_____
Father's Printed Name	Mother's Printed Name
_____	_____
Father's Signature	Mother's Signature
_____	_____
Date	Date

Medical Records Release Authorization

To whom it may concern:
I hereby authorize the release of my child's medical records, or copies of such, and request that they be transferred from your office to Rainbow Pediatric Center at the contact information below as soon as possible.

Rainbow Pediatric Center
4788 Hodges Blvd. B-108 Jacksonville, FL 32224 Ph: 904.223.9100 Fax: 904.223.9282

Previous Provider Information
Office Name: _____

Address: _____ City: _____

State: _____ Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____

Check the reports to be disclosed:

□ **Complete Records**	□ **Immunizations**	□ Lab Results	□ Growth Charts
□ Radiology Reports	□ Operative Reports	□ Consultations	□ Summary of Visits

Below is my child's information for the records that I am requesting: ONLY ONE CHILD PER FORM

Name: _____DOB: _____ / _____ / _____

Reason for Requested use or Disclosure: □Change in Healthcare Provider □Legal □Personal use □2nd Opinion □Other:_____ This authorization expires in 6 months from the date signed or earlier if needed: ___/___/___

□ DAYCARE / SCHOOL RELEASE: I authorize Rainbow Pediatrics to fax my child / children's medical information to:

Name: _____ Fax number: (_____)_____-_____

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- The practice will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely and under no pressure from any individual to do so.
- Information disclosed under this authorization might be re-disclosed by the recipient & this re-disclosure may no longer be protected by federal/state law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
- This authorization may include disclosure of information relating to alcohol and drug use, and confidential HIV related information only if I check this box and write my initials beside □ _____
- If I am authorizing the release of HIV related, alcohol, or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV relation information without authorization.

Parent's Name : _____**Relationship to child**: _____

Parent's Signature: _____ **Date**:___/___/_____ **Phone**:_____