Rainbow Pediatrics

153 West Main St., Suite 200
New Albany, OH 43054

6905 Hospital Dr., Suite 100
Dublin, OH 43016

Circle Location Where the Patient is/will be established: Dublin Office New Albany Office

Today's Date: _____
How were you referred to our office? _____

Please complete for the patient being seen today:
Last Name: _____
First Name: _____
Nick/Preferred Name: _____
Child lives with _____
Date of Birth: _____
Sex: Male Female
Languages spoken at home: _____
Preferred E-mail address: _____
Name/DOB/Sex of Siblings:
_____
_____
_____

Insurance Information: (Please be ready to show card at each visit)
Primary Insurance Name: _____
Primary Insurance ID Number: _____
Primary Insurance Group Number: _____
Mailing Address for Claims: _____
_____
Policy Holder Name: _____
Policy Holder Date of Birth: _____
Emergency contact:
Name: _____ Relation to Patient: _____
Preferred Contact Number: (_____) _____

Authorization: Provided proper photo identification is shown, I give the following person/people authority to make medical decisions for my child(ren) in my absence.
_____
_____

Did you attend our prenatal class? _____ Date of class: _____
Physician your child would like to see primarily: _____

Guardian: Please complete the following information for the parent/guardian who does NOT hold the primary insurance.
Last Name: _____
First Name: _____
Relationship to Patient: _____
Address: _____
City: _____State:_____ Zip:_____
Cell Phone: (_____) _____ ☐ Preferred Contact Number
Home/ Land Line Phone: (_____) _____ ☐ Preferred Contact Number
SSN:_____ Date of Birth:_____
Employer: _____
Occupation / Skill / Trade: _____

Guarantor: Please complete the following information for the parent/ guardian who holds the primary insurance.
Last Name: _____
First Name:_____
Relationship to Patient: _____
Address_____
City: _____State:_____ Zip:_____
Cell Phone: (_____) _____ ☐ Preferred Contact Number
Home/ Land Line Phone: (_____) _____ ☐ Preferred Contact Number
SSN:_____ Date of Birth:_____
Employer: _____
Occupation / Skill / Trade: _____

I certify the above is correct: _____ Date:_____
Signature of Parent/Guardian completing form

EDC: _____ OB/GYN:_____ Hospital:_____ _____ Initials of Rainbow Employee Entering Demo. Information
Prenatal class:_____ Initials: _____ _____ Date Entered
Shared files/ Front Desk Blank Forms/Demographic Information Sheet with Authorization Updated 11.16.15/bjt/11.16.15/ed/7.14.17/

Rainbow Pediatrics

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe program also includes:

- **Formulary and benefit transactions**- Gives the healthcare provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification**- Allows the healthcare provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- **Medication history transactions** – Provides the healthcare provider with information about your current and past prescriptions. This allows healthcare providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate : compliance with prescribed regimens; therapeutic interventions; drug –drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medications history information would include medication prescribed by your healthcare provider at Rainbow Pediatrics, as well as other healthcare providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases***. As part of this consent form, you specifically consent to the release of this and other sensitive health information.***

Consent

By signing this consent form you are agreeing that your provider at Rainbow Pediatrics, may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an affect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Rainbow Pediatrics, Inc. to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name _____ Patient DOB _____

Signature of Patient or Guardian _____ Today's Date _____

Relationship to Patient _____

Rainbow Pediatrics

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Rainbow Pediatrics may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Rainbow Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to, and have been provided the opportunity to, review the Notice of Privacy Practices prior to signing this consent. Rainbow Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Rainbow Pediatrics Privacy Officer at 153 W Main Street, Suite 200, New Albany, Ohio 43054.

With my consent, Rainbow Pediatrics may call my home or other designated location
and leave a message on voice mail, or in person, in reference to any items that assist the practice in carrying out TPO, including, but not limited to; insurance items, patient statements, laboratory results, referral reminders, and RX information.

Preferred Voice Call Option:

_____

With my consent, Rainbow Pediatrics may mail to my home, or other designated location, any
items that assist the practice in carrying out TPO, including, but not limited to; insurance items, patient statements, laboratory results, referral reminders, and RX information.

Preferred Mailing Address:

_____

With my consent, Rainbow Pediatrics may send an e-mail to my designated e-mail address any
items that assist the practice in carrying out TPO, including, but not limited to; insurance items, patient statements, laboratory results, referral reminders, and RX information.

Preferred E-Mail Address:

_____

With my consent, Rainbow Pediatrics may send a text to my designated cell phone any
items that assist the practice in carrying out TPO, including, but not limited to; insurance items, patient statements, laboratory results, referral reminders, and RX information.

Preferred Text Number:

_____

Rainbow Pediatrics will not be responsible for any additional charges for the above mentioned methods of contact. If your individual plan does not allow for such reminders you are responsible for asking our office to update your consent form.

By signing this form, I am consenting to Rainbow Pediatrics' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Rainbow Pediatrics may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Account #

_____ _____
Print Name of Legal Guardian Date

HIPPA Form updated 8.22.16/bjt

Rainbow Pediatrics

Office Financial Policy

Parents are required to pay for their child's health care at the time services are provided. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, MasterCard and Visa credit and debit cards. For your convenience, we also offer the option of keeping a credit card on file.

It is your responsibility to bring your most current insurance card with you to every office visit. You will be asked to present the card upon arrival along with any applicable co-payment. If you have changed insurance since the previous visit, please obtain the expiration date of the old policy and the effective date for the new coverage prior to your appointment. If this information is not provided, you will be expected to pay at the time of service.

Managed Care Policyholders: Co-payment and deductible are payable in full at the time of service. If you do not have an active/ valid insurance card, payment is expected at the time of service. Please check with your plan to verify that we are a participating provider. Any services received and later denied by your insurance carrier are your responsibility.

Referrals: Some insurance companies require a referral if your child needs to see a specialist for any reason. It is your responsibility to call your insurance company to determine if a referral is needed. If a referral is required, please let us know and we will arrange it for you. Referrals ***MUST*** be completed at least 36 hours in advance. Any referrals required with less than 24 hours notice will be subject to an additional fee.

Lab/X-ray Procedures: Often we need to order lab or x-rays and other procedures. We use Nationwide Children's Hospital as our lab/x-ray facility. If your insurance policy does not include Nationwide Children's Hospital as a preferred provider, please obtain the name of the alternative facility and inform the physician in advance. If we do not obtain the alternative facility information and lab/x-ray procedures are not covered, we cannot be responsible for payment.

Billing: Account balances not paid after 2 statements have been sent will be forwarded to our collection agency and a collection preparation fee of $15.00 will be charged to the account.

No Show Policy: A "no-show" charge of $50.00 will be billed when there is a failure to provide a 24 hour cancellation notice or failure to arrive for a same day scheduled appointment. This charge is not covered by insurance and you will be responsible for payment. Every attempt is made to provide reminder calls for appointments scheduled in advance; this is a courtesy only and has no effect on fees for missed appointments.

Copay Policy: Per the contract you have with your insurance company, copays must be made at the time of service. If copayment is not made and treatment is rendered, a $15.00 charge will be added. This charge is not billable to your insurance company and will be your responsibility.

Covered/Non-Covered Services: **Rainbow Pediatrics is not responsible for knowing your insurance policy coverage. You must contact your insurance company to determine what your policy will cover.** I understand the billing staff of Rainbow Pediatrics will file all claims for covered services with my insurance company if the physician is a contracted provider. I understand I am responsible for any balances that may be due to the physician as a result of:

- **co-insurance or co-payments**
- **annual deductible amounts**
- **non-covered services**
- **out-of-network charges**
- **terminated coverage**
- **exhausted benefits**
- **no insurance coverage**
- **failure to respond to insurance company correspondence or inquiries**
- **failure to list our physician as your primary care physician**
- **failure to notify in advance that Children's Hospital lab/x-ray facility is not a preferred provider**

Release of Information and Payment Authorization:

All Insurance Companies and Third Party Payers: I hereby authorize Rainbow Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize my insurance carrier or its intermediaries to issue payment directly to Rainbow Pediatrics and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Medicare and Medicaid: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers, any and all information needed for this or a related Medicare or Medicaid claim. I authorize and request that payment be made directly to Rainbow Pediatrics.

Guarantee of Payment: I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Rainbow Pediatrics to me or the patient indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Workman's Compensation and/or claims due to personal injury accidents/illnesses. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I understand that I will receive a statement for any balance due after the claim has been processed by the insurance company. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days. If the balance is not paid within 30 days, I understand that a late fee of $25.00 per month will be added and I may be turned away for non-emergent services until the balance is paid.

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 years of age **Date**

Rainbow Pediatrics

We ask that you realize that we don't work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

Advanced **B**eneficiary **N**otice

The following is a list of services that will *NOT* be billed to your insurance carrier. The fact that your insurance carrier does not cover a particular service does not mean you should not receive that service.

Service	
Complex Telephone Consultation	$50.00
Call placed to After Hours (10pm-7am)	$25.00
Standard Form Fee (unless completed during the preventative visit)	$10.00 per page
Complex Form Fee (unless completed during an office visit)	$40.00
Complex Pre-Authorizations	$50.00
Travel Consultation via Visit or Telephone	$75.00
Synagis Co-ordination/Authorization	$50.00
Emergency Referral	$50.00
Complex Medical Management	$75.00 annually

Parent/guardian will also be financially responsible for any/all services performed and denied by your insurance carrier. It is your responsibility to verify any/all services with your insurance carrier.

Signature of Understanding: I have read and understand that I will be held financially responsible for the above mentioned service, as well as any other services performed by Rainbow Pediatrics and denied by my insurance carrier. I agree to provide Rainbow Pediatrics the most current insurance card at every visit.

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 years of age **Date**

_____ _____

Signature of Witness **Date**

Rainbow Pediatrics

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With my consent, Rainbow Pediatrics may use and disclose protected health information (PHI) about me and my child to carry out treatment, payment and healthcare operations (TPO). Please refer to Rainbow Pediatrics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to, and have been provided the opportunity to, review the Notice of Privacy Practices prior to signing this consent. Rainbow Pediatrics reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Rainbow Pediatrics Privacy Officer at 153 W Main Street, Suite 200, New Albany, Ohio 43054.

With my consent, Rainbow Pediatrics may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and among others.

With my consent, Rainbow Pediatrics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Rainbow Pediatrics may send an e-mail to my designated e-mail address any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Rainbow Pediatrics may send a text to my designated cell phone any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. Rainbow Pediatrics will not be responsible for any additional charges incurred as a result of your individual mobile phone plans.

By signing this form, I am consenting to Rainbow Pediatrics' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Rainbow Pediatrics may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Account #

_____ _____
Print Name of Legal Guardian Date

Rainbow Pediatrics

Records Transfer Request

Please complete this form and return to our New Albany office either in person or by mail to:

Rainbow Pediatrics; Attn: Medical Records; 153 West Main St., Suite 200; New Albany, OH 43054

Your records will be sent to you on a USB flash drive. The drive will contain all of the records for one child. Our charge for the transfer is **$30 per patient** and we ask that you pay in advance with a credit card provided on this request form.

If you prefer a copy of the **Vaccine Record ONLY** we will send that at **NO CHARGE**, please check here: ❑

Date of Request:_____ Name of Parent/Legal Guardian: _____

Best contact number: _____E-mail Address: _____

Patient(s) & Date of Birth(s):_____

Requested Records can take 30 days to process and will be mailed to your address.
Please provide your current address:

_____

Please Identify Reason(s) for Transfer:

____Age (over 22; therefore seeking services other than Pediatrician)
____Change of insurance carrier to:_____
____For specialist review; not transferring out of practice
____Moving out of the area
____Other (please elaborate):_____

_____
Signature Parent/Legal Guardian

Please provide payment information below:

Cardholder Name (Printed): _____

❑ Mastercard ❑ Visa ❑ American Express ❑ Discover

Card Number: _____

Exp. Date: _____ Security Code: _____ Amount to be charged: _____

Cardholder's Signature: _____

Billing Address for the card: _____

_____