Rainbow Pediatrics

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:

Athena ID (to be assigned by Rainbow)

Medical Record Number: _____

Last Name: _____

First Name: _____

Nick/Preferred Name: _____

Sex: Male Female

Date of Birth: _____

Address: _____

City: _____State:_____Zip:_____

Land / Home Phone: (_____) _____ ☐ Preferred Contact Number

Languages spoken at home: _____

Biological parents marital status: _____

Preferred E-Mail Address: _____

Name/DOB/Sex of Siblings:

_____

_____

_____

_____

_____

_____

Insurance Information: (You may be required 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: _____

Policy Holder SSN: _____

Is there a secondary insurance in place? _____ (We do not bill secondary)

If yes, please list the name of the secondary:_____

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 insurance.

Last Name: _____

First Name: _____

Relationship to Patient: _____

Address: _____

City: _____State:_____Zip:_____

Cell Phone: (_____) _____ ☐ Preferred Contact Number

SSN:_____ Date of Birth:_____

Employer: _____

Employer Phone: (_____) _____

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

SSN:_____ Date of Birth:_____

Employer: _____

Employer Phone: (_____) _____

Occupation / Skill / Trade: _____

Emergency contact:

Name: _____ Relation to Patient: _____

Home Phone: (_____) _____ ☐ Preferred Contact Number

Cell Phone: (_____) _____ ☐ 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.

_____

_____

_____

I certify the above is correct: _____ Date:_____

Signature of Parent/Guardian completing form

Shared files/ Front Desk Blank Forms/Demographic Information Sheet/bjt/5.6.10

EDC: _____ OB/GYN:_____Hospital:_____

Prenatal Class: _____ Initials:_____

_____Initials of Rainbow Employee Entering Demographic Information

_____ Date Entered

Rainbow Pediatrics

Office Financial Policy Effective 11.01.15

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. We require a valid credit card be kept on file at all times.

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: If your credit card on file is declined, 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 $25.00 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.** The billing staff of Rainbow Pediatrics will file all claims for covered services with your insurance company, if the physician is a contracted provider. You are 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
Declined charge on credit card	$10.00 per occurance

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**

Credit Card on File Is MANDATORY
Authorization to Charge Credit Card

Today's Date: _____ **Patient Name(s):** _____

I authorize Ann M. Rogers, MD and Associates, dba Rainbow Pediatrics to charge my credit card for any outstanding balance that is incurred for visits and treatments. Rainbow Pediatrics will provide me with a receipt for all payments made with this credit card. I understand that I will be required to provide updated credit card information either annually or whenever it becomes necessary . I understand that I must keep a valid credit on file at all times to remain a patient at Rainbow Pediatrics.

I understand that Rainbow Pediatrics will keep this information in a secure location only allowing access to designated personnel. I understand that I may cancel this at any time with written authorization.

X_____ _____

Signature ***Visa/MasterCard Number***

_____ _____

Name as it appears on credit card ***Expiration Date***

_____

Security Code

Rainbow Pediatrics

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU and YOUR CHILD (as a patient of this practice) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in regard to your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Practice Administrator
614-791-2000
6905 Hospital Drive, Suite 100
Dublin, Ohio 43016

C. WE MAY USE AND DISCLOSE INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

7. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

7. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

9. Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI: You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the **Practice Administrator** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to the **Practice Administrator** and include:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Practice Administrator** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the **Practice Administrator**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the **Practice Administrator.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the **Practice Administrator**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the **Practice Administrator**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

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 6905 Hospital Drive, Suite 100, Dublin, Ohio 43016.

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.

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 Chart #

_____
Print Name of Legal Guardian

_____
Date

Rainbow Pediatrics

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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.

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_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Chart #

_____
Print Name of Legal Guardian

_____
Date

Rainbow Pediatrics

Records Release

Date of Request:_____

Chart #:_____

Name of Parent/Legal Guardian: _____

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

_____

Request Records to be forwarded to:

_____ 6905 Hospital Drive
Suite 100
Dublin, Ohio 43016
614.791.2000

_____153 W. Main Street
Suite 200
New Albany Ohio 43054
614.939.2200

Request Records to be forwarded from:

Name:_____

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):_____
_____
_____

If moving, please provide us with your new address:

_____

_____
Signature Parent/Legal Guardian