Patient Registration

Patient ______________________ Sex: ❑ M ❑ F DoB___/___/___ SS#__________

Language __________ Race __________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling ______________________ Sex: ❑ M ❑ F DoB___/___/___ SS#__________

Language __________ Race __________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling ______________________ Sex: ❑ M ❑ F DoB___/___/___ SS#__________

Language __________ Race __________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Patient/Sibling ______________________ Sex: ❑ M ❑ F DoB___/___/___ SS#__________

Language __________ Race __________ Ethnicity: ❑ Not Hispanic ❑ Hispanic ❑ Latin

Mother/Guardian ______________________ DoB___/___/___ SS#__________

Address ______________________ Home Phone __________

Email __________

City/State/Zip ______________________ Work Phone __________

Employer ______________________ Occupation __________

Father/Guardian ______________________ DoB___/___/___ SS#__________

Home Phone __________

Address ______________________ Email __________

City/State/Zip ______________________ Work Phone __________

Employer ______________________ Occupation __________

Children live with: ❑ Mother ❑ Father ❑ Guardian ______________________

Emergency Contact:

Someone that does not live in home: ______________ Relation __________ Phone __________

What Pharmacy do you use/Location: *(Kroger on Madison)* ______________________

INSURANCE INFORMATION

Primary__________ Policy #__________ Insured Name __________

Secondary__________ Policy #__________ Insured Name __________

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

I authorize Rainbow Kids Clinic to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Rainbow Kids Clinic for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care of immunizations cannot be given unless my child is accompanied by one of the following:______________________

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

Parent/Guardian's signature ______________________ Relation __________ Date__________

OVER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Rainbow Kids Clinic
111 Otis Smith Drive
Clarksville, TN 37043
931-553-6666
Fax 931-553-4006

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to Patient ______________________________________

Signature ____

Date ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason

RAINBOW KIDS CLINIC OFFICE POLICIES

APPOINTMENTS

Due to HIPPA requirements we are required to have each patient accompanied by a parent or legal guardian unless the parent has listed any other individual on initial paperwork. If your child is accompanied by a listed person from paperwork he or she must present picture ID.

- Scheduling: You can schedule appointments by calling our office or submitting a request on our website along with the date and time that works best for you. However, online scheduling is only for Well checks. Urgent appointments we ask that you please call our office directly.

- Rescheduling and Cancellations: In order to reschedule or cancel an appointment, please do so at least 24 hours before appointment time for well exams/physicals, ADHD and follow up appointments. We want to give all patients an opportunity to make an appointment if needed. If you are more that **10 minutes** late for an appointment it may have to be rescheduled (exceptions may be made for sick children on a case by case basis).

- No Shows: If you fail to show for an appointment that has been scheduled, it is considered a NO SHOW. Our office does not tolerate NO SHOW'S, we have the right to terminate you from our office.

- Well Checkups and Physical: All patients scheduled for a physical/well checkup should have a parent or legal guardian accompany the child so that the doctor or nurse practitioner can give your child the best possible care. We can only see **two siblings** at one given appointment time a day for well checkups/physicals.

VACCINATIONS

The providers at Rainbow Kids Clinic believe in the safety and efficacy of all routine vaccinations. We require full participation in obtaining required vaccinations on schedule. By signing below you agree to discuss your questions or concerns with a provider today if you have any hesitations regarding vaccinations. Exceptions will be made on a case by case basis ONLY for existing families. **A parent or legal guardian must be present to sign for vaccinations before they can be given.**

PATIENTS IN WAITING ROOM AND EXAM ROOMS

Parents must watch their children in the waiting area. Please do not allow children to run or climb on the furniture. Children cannot be left alone in the waiting area or exam rooms. Children over the age of 13 can be seen in exam room without a parent **IF** they can answer history questions and relay information, but we ask that a parent be available in the lobby or by phone. Children must also be kept off the rolling stool in the exam rooms. Children are not to be left unattended on the exam tables. Due to HIPAA requirements, we cannot allow parent and patients to walk outside the exam rooms prior to the doctor or nurse practitioner entering the room. Please remain in the exam room with the door closed until the doctor or nurse practitioner has completed the examination of your child.

REQUESTS FOR PRESCTIPTION REFILLS OR FORMS

Requests for refills, forms for school, daycare or WIC can be submitted by telephone or on our website. **Please allow 24-48 hours to complete.**

MESSAGES FOR YOUR PCP

Messages can be submitted on our website of by calling our office directly. All telephone calls or messages of non-emergency will be answered by the end of the business day. If the matter is urgent PLEASE CALL OUR OFFICE IMMEDIATELY!

By signing these policy statements, I acknowledge that I have read all policies and practices of Rainbow Kids Clinic and agree to follow according to above policies.

Signature:________________________________ Date:________________

INITIAL PATIENT RECORD

(To be filled out by parent)

PATIENT'S NAME: ______________________________ DATE: ______________

PAST MEDICAL HISTORY

1) Who has been child's doctor until now? ______________________________
2) Has your child had allergic reactions to any medications, foods, insect bites? ☐No ☐Yes, Which ones?
____
3) Has your child had reactions to immunizations? ☐No ☐Yes, Which ones? ______________
4) Any hospitalizations other than for birth? ☐No ☐Yes, For what? ______________
____
5) Has your child had any surgeries? ☐No ☐Yes, What? ______________
____
6) Has your child had any serious injuries? ☐No ☐Yes, What kind? ______________
7) Does your child see any specialists? ☐No ☐Yes, What kind/Who? ______________
____
8) Has your child had frequent ear infections? .... ☐No ☐Yes
9) Any eye problems .... ☐No ☐Yes
10) Has he/she had any problems with teeth? .... ☐No ☐Yes
11) Has he/she had any problems with asthma, used inhalers, or had nebulizer treatments? ☐No ☐Yes
12) Has he/she had pneumonia? If Yes, how many times?_______ .... ☐No ☐Yes
13) Does he/she have a heart murmur or any heart problems? .... ☐No ☐Yes
14) Any problems with urination? .... ☐No ☐Yes
15) Any problems with diarrhea or constipation? .... ☐No ☐Yes
16) Have there been any seizures or other problems with the nervous system? .... ☐No ☐Yes
17) Any eczema, hives, or other skin conditions? .... ☐No ☐Yes
18) Has your child ever been anemic? .... ☐No ☐Yes
19) Has your child ever had high lead levels in blood? .... ☐No ☐Yes
20) Does your child have any developmental concerns? .... ☐No ☐Yes
21) Does your child have any discipline/behavior problems? .... ☐No ☐Yes
22) Other concerns? ______________________________
____

IMMUNIZATION RECORD

Do you have a record of immunizations? ☐No ☐Yes, Please give copy to receptionist.

LIST MEDICATIONS TAKEN BY CHILD AT PRESENT

Name and Dosage (if dose unknown, please list pharmacy where prescription was filled so we may call if needed)
Please include all oral, inhaled, nasal, injectable, herbal, vitamins, and over-the-counter medications

____

____

____

PATIENT'S NAME: ______________________________ DATE: ____________

SOCIAL HISTORY

1) Who lives in household with your child?

- ☐ Biological mom
- ☐ Biological dad
- ☐ Step mom
- ☐ Step dad
- ☐ Grandmother
- ☐ Grandfather
- ☐ Siblings, How many? ________
- ☐ Others: ______________________________

2) Does anyone in the household smoke? ☐No ☐Yes; If yes, where? ☐Inside home ☐Outside home ☐Vehicle

3) Do you have any pets? ☐No ☐Yes, What type(s)? ______________________________

Where do pets stay? ☐Inside home ☐Outside home

4) What type of home do you live in? ☐ Private ☐ Apartment ☐ Condo

5) What type of heating is used in your home? ☐ Electric ☐ Gas ☐ Wood

6) Does your child attend school/daycare? ☐ No ☐Yes, Name: ____________________

FAMILY HISTORY

	Biological Mother	Biological Father	Siblings	Grandparents	Other
ADHD					
Anemia					
Asthma					
Autism / Asperger's					
Bipolar Disorders					
Bleeding Disorders					
Cancer (if yes, what type?)					
Celiac Disease					
Crohn's / Ulcerative Colitis / IBS					
Cystic Fibrosis					
Diabetes					
Eczema					
Hearing Loss					
Heart Attack / Stroke before age 55					
Hepatitis					
High Cholesterol					
High Blood Pressure					
Irregular Heart Beats					
Kidney Reflux					
Kidney Stones					
Lupus					
Mental Retardation					
Migraine					
Neurofibromatosis					
Obesity					
PTSD					
Schizophrenia					
Seizure / Epilepsy					
Sickle Cell Anemia / Trait					
Sleep Apnea					
TB					
Thyroid Problem					
Other genetic disorders (If yes, what?)					

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Rainbow Kids Clinic
111 Otis Smith Drive
Clarksville, TN 37043
Phone (931) 553-6666, Fax (931) 553-6681

I, ____

Address: ____

City: ____________________________ State_____________ Zip_________

Phone: _____________________________ Cell/Wk: ___________________

Hereby authorize Rainbow Kids Clinic to: ____Release Copies ____Obtain Records

Protected Health Information of:

____ DOB: ______________

____ DOB: ______________

____ DOB: ______________

____ DOB: ______________

This request and authorization applies to:

____ Immunization Records ____ Other _____________________________

____ All Records: All of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, ADHD, autism, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released:

___Substance abuse ___ Psychological or psychiatric treatment __HIV/AIDS/STD

Send Records to/Get Records From: ____

Address: ____

City: _________________________ State____________ Zip____________

Phone: ______________________ Fax: ___________________________

Reason for Release of Records: ☐Selecting New Physician ☐Consult ☐Personal
☐Relocating Out of Town (if relocating, please provide forwarding address/phone)

☐Other____

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that my protected health information, which is disclosed with this release, may be subject to re-disclosure by the recipient and no longer protected by law. Rainbow Kids Clinic is not responsible for any alterations made on its medical record copies, which have been released to any party.

I understand that I have a right to a copy of this authorization after I sign it and that Rainbow Kids Clinic will not condition any provision of treatment on my signing this authorization.

This authorization expires one year after the date I sign it. I understand that this authorization may also be revoked at any time with my written statement.

____ ________________

Parent or Guardian Signature Date

IDENTIFICATION OF PERSONAL REPRESENTATIVES

Patient ____ Date of Birth________________

State laws provide access to protected health information by biological parents regardless of marital status, unless there is a court order restricting parental access, or a parent has legally relinquished parental rights. To assure privacy and protection of a child's protected healthcare information please list the biological parents below:

Print name of Mother	Date of birth	Social Security Number	Phone #
Print name of Father	Date of birth	Social Security Number	Phone #
Print name of Legal Guardian	Date of birth	Social Security Number	Phone #

- ***If your child has been adopted by you or spouse, please provide a copy of the official adoption decree***
- ***If your child is under joint custody, please provide a copy of the official Custody Order***
- ***If a child is under guardianship, please provide the court documents citing who is the child's legal guardian***

OTHER PERSONAL REPRESENTATIVES

I am aware that my child may require medical treatment when I am not able to be present. In my absence, I hereby grant the individual(s) named below access to my child's protected health information and authorize any and all medical treatment(s) for my child. This individual may receive and act upon information received from Rainbow Kids Clinic. This information may include clinical information about my child's care, as well as billing information related to my child's health insurance coverage and payment activity for services rendered by Rainbow Kids Clinic. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child's care.

- **I understand I may revoke this authorization at any time**
- **I understand the protected health information released to my personal representative(s) may be further disclosed by the recipient. Rainbow Kids Clinic cannot guarantee the further safeguarding of the health information after disclosure.**

Below are My Personal Representative(s):			This request and authorization applies to:
Name of Personal Representative	Date of birth	Phone #	All medical records Billing/insurance Authorize medical treatment including vaccinations Any behavioral/psychiatric treatment/information/medications Specific records/dates/information ONLY:
Name of Personal Representative	Date of birth	Phone #	All medical records Billing/insurance Authorize medical treatment including vaccinations Any behavioral/psychiatric treatment/information/medications Specific records/dates/information ONLY:
Name of Personal Representative	Date of birth	Phone #	All medical records Billing/insurance Authorize medical treatment including vaccinations Any behavioral/psychiatric treatment/information/medications Specific records/dates/information ONLY:

I hereby grant my personal representative(s) to have access to my child's protected health information from Rainbow Kids Clinic.

______________________________ __________

Parent/Legal Guardian Signature **Date**