Rainbow Pediatrics

99 Court Street, Suite 1,

Middlebury, VT, 05753

Phone: (802)-388-1338 Fax: (802)-388-8244

*Tawnya Kiernan, MD *Lauren Young, FNP *Angela Brisson, FNP *Kara Pool, FNP

Thank you for choosing Rainbow Pediatrics for your child's medical care! Please complete the enclosed documents and return them to our office:

- General Consent for Treatment
- Payment Policy
- Initial History Questionnaire
- Release of Records
- Registration Form

We have also enclosed the practice brochure for your review.

At Rainbow Pediatrics, we strive to be as accessible as possible. Our office hours are Monday through Friday from 8:00 am – 5:00 pm, and Saturday from 8:00 am – 12:00 pm. Please note that the office closes daily from 12:00 pm – 1:00 pm for lunch. Outside our office hours, there is always a provider on call to address your concerns 24/7. If you need to reach a provider outside regular business hours for a concern, call the office at (802)-388-1338. Our answering service will have the on-call nurse or provider return your call.

For routine visits, we endeavor to maintain a continuity of care by helping you select a primary care provider for your child to see for routine health maintenance visits. If you would like more information on our providers, please feel free to visit our website at www.rainbowvt.com, or ask any member of our team. We also provide a nurse triage line during regular business hours to aid patients and parents in deciding the best way to address the concern, as well as address other medical questions that may not require an office visit.

We understand that life happens, and you may not always be able to make your scheduled appointment. If that is the case, please do your best to give our office a twenty-four hours' notice of cancellation. If you do or call and cancel ahead of time, we will label your missed appointment as a no call/no show. After three of these no-show appointments within one year,

you may be dismissed from the practice. Missed appointments leave time open in our schedule that could be optimized for another patient.

To refill medications, you should first call your pharmacy. This also applies if you have no refills left on your bottle(s). Your pharmacy will contact us with your medication needs. Refill requests take 12-24 hours to process. Requests made on a Friday will be processed the next business day. Unfortunately, we cannot process requests over the weekend. Please note that no prescriptions can be filled before your first scheduled appointment and controlled substances will be prescribed at the time of your first visit or later based on the provider's discretion.

If you have any questions or concerns, we invite you to call and chat with us. Our nurses and providers have a wealth of knowledge and are always ready to advise and provide reassurance. They can also help you decide if your child needs to be seen in the office and assist in setting up appointments. We invite you to explore our website for general questions where you will find office forms, staff biographies, and so much more.

If you have any questions regarding the enclosed forms or our office policies, please feel free to contact our office.

Lisa Ryan, Practice Manager

99 Court Street, Suite 1

Middlebury, VT, 05753

Phone: (802)-388-1338 Fax: (802)-388-8244

Lryan@rainbowvt.com

RAINBOW PEDIATRICS
99 Court Street, Suite 1, Middlebury, VT, 05753
Phone Number: (802)-388-1338 Fax Number: (802)-388-8244
Staff@rainbowvt.com

PATIENT CONTACT INFORMATION

Please note: This information may be used to contact you in an emergency regarding your child. **Please give us as complete information as possible.** Thank you!

PATIENT NAME: _____ DOB: _____ SEX: _____

SEXUAL ORIENTATION: (Please check one):

____ Lesbian/Gay/Homosexual
____ Straight/Heterosexual
____ Bisexual
____ Something else, please explain: _____
____ Choose not to disclose

PATIENT'S CELL PHONE # (IF APPLICABLE): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PARENTS AND RELATIONSHIP TO CHILD (IF APPLICABLE) (e.g.: biological, adoptive, step, foster, guardian, grandparent, etc)
#1_____

HOME PHONE: _____WORK PHONE: _____ CELL PHONE: _____

#2 _____

HOME PHONE: _____WORK PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ **EMERGENCY PHONE**: _____
(OTHER THAN PARENTS)

RELATIONSHIP TO PATIENT: _____

_____ _____
Signature of Parent or Guardian Date

PAYMENT POLICY

Thank you for choosing us as your primary care provider. Please read our payment policy, ask any questions you may have. Your signature tells us that you understand and agree to abide by these guidelines.

1. **Insurance.** We participate with most insurance plans. (If you are uninsured, ask us about setting up a payment plan that you can afford.) Insurance plans change, so we ask that you verify your insurance with us at each visit. If your Medicaid/Dr. Dino/Primary Care Plus has lapsed, please let us know. We can help so you are not charged for the visit. (If you reapply promptly, there is a 90-day grace period during which charges may be paid.)

2. **Co-payments.** Please – it is your obligation to pay your co-payment at the time of service.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered by your insurance company. You will be responsible for payment.

4. **Claims submission.** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. Please do so promptly. However, any unpaid balance is your responsibility.

5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. **Non-payment.** Times are hard, we understand. Please talk to us about setting up a payment plan that you can afford. If your account is over 60 days past due, we will contact you by phone. If your account is 90 days past due and no payment has been made, you will receive a letter requesting payment. If your account still remains unpaid, we must refer your account to a collection agency, and you may be discharged from our practice. Should this happen, you will be responsible for any collection and court fees that are attached to your delinquent account, and you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will provide only emergency care.

NOTE: Divorce has no bearing on the responsibility for medical care as it affects third parties. Whoever brings the child is expected to pay the charges due for the service rendered that day. Rainbow Pediatrics does not participate in payment disputes between parents.

Rainbow Pediatrics is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

_____ _____

Signature of patient or responsible party **Date**

MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN, OR IF THE PATIENT IS 18 YEARS OR OLDER.

PLEASE INITIAL FOR EACH CONSENT

_____ I give permission for physicians of Rainbow Pediatrics or persons designated by them, to interview, examine, and perform necessary laboratory/radiological procedures and to provide appropriate treatment to the above-named minor.

_____ I herby authorize Rainbow Pediatrics to furnish and/or obtain necessary information concerning my named child above, to my insurance carriers, school nurses, to other medical personnel to whom physics of Rainbow Pediatrics have referred my child for treatment, and to the admitting hospital should my child be admitted for treatment. I also give consent for Rainbow Pediatrics to enter OAE screening results into VTEHDI database. I authorize Rainbow Pediatrics to communicate with community partners for integrative services related to my child's care.

_____ I understand that all professional charges are charged to the patient. Patients covered under contracted insurance plans are required to pay any copayment at the time of the service. **I understand that insurance cards should be presented at EVERY visit.**

_____ I understand if I **'no show'** for 3 appointments within a year, I may be dismissed from the practice.

CONSENT FOR IMMUNIZATIONS

_____ I give permission for Rainbow Pediatrics to administer all standard immunizations as recommended by The American Academy for Pediatrics scheduled for immunizations at the time of administrations. I understand that I will be advised in writing the benefits and risks associated with each immunization at the time of administration. I also give consent for Rainbow Pediatrics to enter said immunizations into the Vermont Immunization Registry.

PLEASE NOTE: This document will remain in effect as long as custody of the child remains the same. In the event of a custodial change or reaching the age of 18, a new consent form will need to be signed.

Authorization for assignment of benefits request that payment of authorized medical benefits be made on my behalf to Rainbow Pediatrics for any services furnished to me including physician services. I authorize any holder of medical information about me to release to my insurance carrier or its intermediaries any information for this or related claims.

_____ _____

Signature of Patient or Legal Guardian **Date**

Rainbow Pediatrics

99 Court Street, Suite 1, Middlebury, VT, 05753

Phone Number: (802)-388-1338 Fax Number: (802)-388-8244

Medical Records Contact Person: Lynn Paquette

Staff@rainbowvvt.com

AUTHORIZATION for the RELEASE of PROECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Address: _____

Phone Number: (____) _____

I hereby authorize Rainbow Pediatrics to:

___ Release health information to:

(if you are transferring **from RAINBOW PEDIATRICS** to another provider)

___ Receive health information from:

(if you are new **to RAINBOW PEDIATRICS** and need medical records from your previous provider)

Practice/ Provider: _____

Phone Number: (___) _____ Fax Number: (____) _____

Reason for requesting this information:

___ Transferring to an adult/family practice.

___ Transferring due to change of insurance.

___ Transferring, moved out of the area.

___ Other, please specify: _____

- The information to be released by Rainbow Pediatrics shall be all pertinent records and will be released to the above-named practice/provider by mail or courier (when applicable).
- The information released will include information relating to AIDS or HIV infection, treatment for substance and/or alcohol abuse or dependency, and psychotherapy notes or other information relating to mental health or psychiatric care. If you wish to EXCLUDE this information from the records being released, please initial here ___
- This information is being disclosed to the above person, organization, or agency from the records whose confidentiality may be protected by the Vermont Drug and Alcohol Abuse Control Act, the Vermont Mental Health Procedures Act, and/or the Vermont Confidentiality or HIV Related Information Act. My signature below authorizes the release of information protected by these Vermont statues, unless initialed above.
- I understand that I may revoke this authorization at any time in writing, except to the extent that action based on this authorization has been taken. However, I also understand that health information disclosed pursuant to this authorization may be subject to re-disclosure because it is no longer protected by federal privacy laws. I fully understand the contents of this authorization and voluntarily consent to the release of the information stated. Rainbow Pediatrics, its employees, officers and clinical staff are released from legal responsibility or liability for the releasee of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to a copy o this authorization from Rainbow Pediatrics upon request.

THIS AUTHORIUZATION SHALL EXPIRE 90 DAYS FROM THE DATE BELOW, UNLESS OTHERWISE NOTED.

_____ _____ _____

Patient (18 years or older) or Parent/Guardian Date Relationship to Patient

If patient is under the age of 18 years old

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____ DATE COMPLETED _____

BIRTH DATE _____ AGE ☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____ DATE COMPLETED _____

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Birth History ☐ Don't know birth history

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Were there any prenatal or neonatal complications?
☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

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Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)