Rainbow Pediatrics
99 Court Street Suite 1
Middlebury, Vermont 05753
P: (802) 388-1338 F: (802) 388-8244
www.RainbowVT.com
Gussie Belisle, FNP Tawnya Kiernan, MD Lauren Young, FNP Dayna Stimson, 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
- Release of Records
- Registration Form

Please remember to bring in your most up-to-date insurance card and photo ID.

We also have enclosed the following for your review:

- Immunization and Physical Exam Schedule
- Practice Brochure

At Rainbow, we strive to be as accessible as possible. For sick visits, we offer walk-in hours Monday through Friday from 8 to 8:45 a.m. and weekend hours by appointment. Outside of our office hours, there is always a provider on call to address your concerns. We provide 24-hour coverage for our patients for emergencies and illnesses that cannot wait for normal office hours. If the office is closed and you have a concern, call the office number: 802-388-1338. Our answering service will have the on-call nurse or doctor return your call. Weekend visits are available by appointment from 9 am until 12 pm. Please call at 8 am to schedule an appointment or to speak with a nurse. At this time, we share coverage with the pediatricians at Middlebury Pediatric and Adolescent Medicine for evening and weekend call.

For routine visits, we endeavor to maintain continuity of care by helping you to select a primary care provider and then to schedule routine health maintenance visits with your chosen provider. If you would like more information on our providers please feel free to visit our website or to ask any member of our team. We also provide a nurse triage line during our office hours to aid patients and parents in deciding the urgency of the concern and also to answer other medical questions that may not require an office visit.

We understand life happens and you may not always be able to make your scheduled appointment. If that is the case, please give our office 24 hours' notice of your cancellation. If you do not 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 used by 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 to 24 hours to process. Requests made on a Friday will be processed the next business day. Unfortunately,

we cannot process refill requests over the weekend. Please note that no prescriptions can be refilled before your first scheduled appointment and controlled substances will be prescribed at the time of your first visit or later based on provider discretion.

Other services available in our office include our Community Health Team, which is comprised of a registered dietician, a behavioral health counselor, and a care coordinator. Meeting with any of these team members is completely free. We also perform medical ear piercing using Blomdahl products which consists of little or no nickel. The cost is $25.00. We offer bike helmets (Bell – True Fit) in sizes starting with toddler through adults. The cost is $9.90 (our cost). There is also a community bookshelf in our waiting room that we hope you and your child will explore each time you visit us, and leave with a new book.

If you have questions or concerns, we hope you will call us. Our nurses and providers have a wealth of knowledge and are always ready to advise and reassure worried parents. They can also help you decide if your child needs to be seen in the office and assist in setting up an appointment. For general questions, we highly recommend visiting our website. There you can find forms, staff bios, and the Child and Adolescent Health Library. If you have any questions regarding the enclosed forms or our office policies, please feel free to call our office.

Lisa Ryan, Practice Manager
99 Court Street Suite 1
Middlebury, Vermont 05753
P: (802) 388-1338 F: (802) 388-8244
lisaryan@sover.net

Rainbow Pediatrics
99 Court Street, Suite 1, Middlebury, VT 05753
Phone: 802-388-1338 Fax: 802-388-8244
Medical Records Contact: Judith Walker

AUTHORIZATION for the RELEASE of PROTECTED HEALTH INFORMATION

Patient Name _____ Birth Date _____

Address _____ Phone (_____)_____

I hereby authorize Rainbow Pediatrics to:

❑ Release health information to:
(If you are transferring **from RAINBOW** to another provider)

❑ Receive health information from:
(If you are **new to RAINBOW** needing records from your previous provider)

Practice/Physician _____

Address _____

Phone Number (_____) _____ Fax Number (_____) _____

Reason for requesting this information:

❑ Transfer to adult/family practice
❑ Transfer due to change of insurance
❑ Transfer, moved out of 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/physician 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 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 of HIV Related Information Act. My signature below authorizes the release of information protected by these Vermont statutes, 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 as stated. Rainbow Pediatrics, its employees, officers and clinical staff are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. Finally, I understand that I am entitled to obtain a copy of this authorization from Rainbow Pediatrics upon request.

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

_____ _____ _____

Patient (18 years or older) or Parent/Guardian if patient is under age 18 | Date | Relationship to Patient

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.)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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RAINBOW PEDIATRICS
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: _____

PATIENT'S CELL PHONE # (over 13 years of age if available): _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

****

911 ADDRESS _____

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: _____

#3 (IF APPLICABLE): _____ PHONE: _____

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

RELATIONSHIP TO PATIENT: _____

_____ _____
Signature of Parent or Guardian Date

RAINBOW PEDIATRICS

MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN, OR IF PATIENT IF OVER 18 YRS OLD

PLEASE INTIAL 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. Permission for evaluation and treatment granted whether child presented by parent, other family member, unrelated third party, or unaccompanied.

_____I hereby authorize Rainbow Pediatrics to furnish and/or obtain any necessary information concerning my child named above, to my insurance carriers, school nurses, athletic directors, and to other medical personnel to whom physicians 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 the VTEHDI data base.

_____I understand that all professional charges are charged to the patient. Patients covered under a contracted insurance plan are required to pay any co-payment at the time of service. I understand that **Insurance/Medicaid 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 of Pediatrics schedule for immunizations. 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 my consent for Rainbow Pediatrics to enter said immunizations into the VT Immunization Registry.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

_____I have received, or have been given the opportunity to receive, a copy of the HIPAA Notice of Privacy Practices for Rainbow Pediatrics. Copies are available at the front desk.

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 on reaching age 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 SEVICES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER OR ITS INTERMEDIATRIES ANY INFORMATION FOR THISOR RELATED CLAIM.

_____ _____

Signature (Patient or Legal Guardian) **Date**

_____

Printed Name (Patient or Legal Guardian)

RAINBOW PEDIATRICS

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**

_____ _____

Guarantor's S.S. # **Guarantor's D.O.B.**