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Middlebury, Vermont 05753  
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[www.RainbowVT.com](http://www.RainbowVT.com)

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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

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

At Rainbow, we strive to be as accessible as possible. Our business hours are 8:00 am to 5:00 pm and Saturday hours by appointment. Because of the pandemic, we are no longer offering walk – in hours. 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 provider 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.

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. Please know there may be times when you schedule an **acute visit**, that your preferred provider may not be available. 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  
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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 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. 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.**

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### **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 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 90day 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 30day 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.**

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**Signature of patient or responsible party**

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**Date**

---

**Guarantor's S.S. #**

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

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

M

## 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

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

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

## Past History DK = don't know

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

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

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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