RAINBOW
CHILDREN'S CLINIC

Dr. Ruth Bernardez-Tan

# GENERAL OFFICE POLICIES/CONSENTS/INFORMATION

Welcome to RAINBOW CHILDREN'S CLINIC, P.A., where caring for children is what we do best! Thank you for choosing our clinic as your child's Primary Care Provider (PCP). Our staff is committed to providing you with the best medical care in a professional, child-friendly, and caring environment. Outlined below are our office policies and other important information. In order to better serve you, please take the time to read and understand them. If you have any questions, please approach any of our office staff.

**APPOINTMENTS:** As a courtesy to our patients, we will call to remind you of your appointment. However, it is your primary responsibility to make sure that every appointment is kept. You must call at least 24 hours in advance to cancel your appointment, so that your space may be given to another patient. You may be discharged from the clinic because of repeated "no shows". A patient who is more than 15 minutes late may need to reschedule or wait to be seen until the schedule allows.

**MEDICAL RECORDS:** When requesting medical records or other information to be released to you, you must be listed as a responsible party and submit a valid picture identification card. There is a $25 fee for medical records and a $10 fee for immunization cards. However, records can be sent directly to a requesting facility free of charge, provided you have completed and signed a records release form. Please fill out the "AUTHORIZATION TO RELEASE HEALTH INFORMATION" form in case your provider would like to obtain your records from or share with another facility.

**CONDUCT**: Please watch your children closely making sure that they are safe always. Please make sure that they do not destroy any of the clinic's properties and play with our instruments and medical supplies. Please avoid use of foul or threatening language and display of inappropriate behavior.

**PHYSICIAN-PATIENT RELATIONSHIP:**

**THE CLINIC RESERVES THE RIGHT TO REFUSE TO PROVIDE SERVICE OR TERMINATE THE PHYSICIAN-PATIENT RELATIONSHIP AT ANY TIME.**

**HIPPA:** Your signature below acknowledges that you have read the Notice of Privacy Practice for RCC which was either given to you or posted in the waiting room.

**CLIENT ACKNOWLEDGEMENT STATEMENT:** I understand that the services or items that I may request or receive for the patient may not be deemed medically necessary by the Medical Provider, and may not be approved or paid by the insurance company. In this event, I understand that I will be responsible for the payment of such items and services.

**CONSENT FOR TREATMENT:** I have read and understood all the forms on the new patient packet and give permission for the patient to receive services at Rainbow Children's Clinic and be treated by its medical providers and staff.

**Name of Patient:** _____ **D. O. B.** _____

_____ _____

**Parent/Guardian Signature** **Date**