RAINBOW CHILDREN'S CLINIC

1915 E. Mayfield Rd, Suite115
Arlington, TX 76014
☐ Phone (682) 276-6700

1900 Ballpark Way, Suite 106
Arlington, TX 76006
☐ Phone (817) 704-7339

PATIENT INFORMATION

Patient's Name:_____ D.O.B._____ Social Security # :____-_____-_____
Address:_____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Sex: _____ M _____ F
Race:____Caucasian ____Black ____Asian ____American Indian ____Hispanic ____Pacific Islander ___Other

Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Refused

Language: ___English ___Spanish ___French ___ Other ___Refused

RESPONSIBLE PARTY

Name:_____ D.O.B. _____ Social Security # _____-_____-_____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cellular Phone_____
Employer's Name: _____ Work Phone: _____
Employer's Address: _____ City: _____ State: _____ Zip Code:_____
Parent or Guardian e-mail address (patient portal): _____

* INSURANCE INFORMATION *

Name of Insurance:_____ **Policy #:** _____ **Group #:**_____
Name of Cardholder: _____ **Relationship to Patient:** _____
Social Security #: _____ **D/O/B/:** ____/____/____ **Insurance Tel. #:** _____
Address:_____ City: _____ State:_____ Zip Code:_____
Home Phone: _____ Cellular Phone:_____
Employer's Name: _____
Employer's Address: _____ City: _____ State:_____ Zip Code:_____

* MEDICAID/ CHIP INFORMATION *

Type of Insurance: _____ Regular/Traditional Medicaid ____ Amerigroup
_____ Aetna ____ Parkland
_____ Cook Children's ____ Other _____

Medicaid/Chip #: _____

Today's Date: _____

IMPORTANT: * Please fill out BOTH, if you have more than one Insurance Coverage

RAINBOW CHILDREN'S CLINIC

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 late to their scheduled appointment may need to reschedule or wait to be seen until the schedule allows.

PATIENT PAYMENTS DUE AT TIME OF SERVICE:
Copays and deductibles
Services and purchases made at time of service

PROFESSSIONAL SERVICES RENDERED:
If your child is seen for a scheduled preventive visit and another condition is treated at the same time, the provider will bill for each service performed.

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 fee for medical records and a fee for immunization records. 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. Please avoid the use of your cell phone while you are in the exam room.

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 agree to pay for any and all medical services I receive from this practice that my insurance company refuse to pay, for whatever reason. This office will file a claim on my behalf; however, if my insurance company refuses to pay (e.g., non-covered services that may include but are not limited to vaccines, developmental screenings, vision and hearing screenings, strep test, flu test and urine dips or insurance does not pay for preventive medicine visits), I will pay for same upon written/verbal notice of their refusal. I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical records. I have read and authorize the release of any medical information necessary to process any claims, either to myself or any parties who request this information.

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.

MISCELLANEOUS FEES:

Medical Records:	**Immunization Record:**	**Letters/Forms:**
$25.00 (for 1st 20 pages), $0.50 for every page after 20 pages CD - $25.00	$5.00 – paper copy ***you can print immunization records for free on the portal* $10.00 – hard copy	FMLA Forms - $30.00 Immigration Letters - $10.00 IRS Letters - $10.00 Six Flags Letters - $10.00

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

_____ _____
Parent/Guardian Signature **Date**

RAINBOW CHILDREN'S CLINIC

Nurse Practitioner/Physician Assistant Acknowledgement Form

Rainbow Children's Clinic employs NURSE PRACTITIONERS (NP) and PHYSICIAN ASSISTANTS (PA). They are licensed and nationally certified healthcare providers who have received advanced education and training in their specific fields. They provide a variety of services such as, but not limited to: evaluate, diagnose, and treat conditions, order and interpret diagnostic tests, write prescriptions and provide comprehensive patient education, in collaboration with physicians and other healthcare providers.

I have read the above, and hereby acknowledge that I may be seen by the NP or PA. I understand that I may request to see a specific provider, when available.

Patient Name _____ **Date of Birth** _____

Parent/Guardian Name _____

Parent/Guardian Signature _____ **Date** _____

Enfermera Practicante/Asistente Medico Formulario de Reconocimiento

Rainbow Children's Clinic emplea ENFERMERAS PRACTICANTES (NP) y ASISTENTES MEDICOS (PA). Son proveedores de atención medica con licencia y certificados a nivel nacional que han recibido educación avanzada y capacitación en sus campos específicos. Proporcionan una variedad de servicios tales como, entre otros: evaluar, diagnosticar y tratar condiciones, solicitar e interpretar pruebas de diagnóstico, escribir recetas y brindar una educación integral del paciente, en colaboración con médicos y otros proveedores de atención médica.

He leído lo anterior, y reconozco que la NP o la PA pueden verme. Entiendo que puedo solicitar ver a un proveedor especifico, cuando esté disponible.

Nombre de paciente _____ **Fecha de nacimiento** _____

Nombre del Padre/Tutor _____

Firma del Padre/Tutor _____ **Fecha** _____

RAINBOW CHILDREN'S CLINIC

Dr. Ruth Bernardez-Tan

MEDICAL HISTORY

Patient's Name: _____ **D.O.B:** _____

Birth History: Birth Weight: _____ **Birth Length:** _____

Gestational Age: _____ **Birth Place:** _____

Pregnancy Complications: _____

Delivery: **Vaginal** _____ **C-Section** _____ **Complications** _____

Developmental History: _____ **Normal**
_____ **Delayed**

Previous Hospitalizations: _____

Previous Surgeries: _____

Allergies: _____

Current Medications: _____

Family History: _____

Previous Doctor/Clinic: _____

PHARMACY INFORMATION:

Pharmacy name: _____

Pharmacy Phone number: _____

Address or Cross Streets: _____

Does your child have, or has he/she had any of the following?

Yes	No		Yes	No		Yes	No	
____	___	Anemia	___	___	Frequent/chronic cough	___	___	Weight loss
____	___	ADD/ADHD	___	___	Frequent headaches	___	___	Sickle Cell trait/disease
____	___	Asthma	___	___	Heart murmur	___	___	Stomach/intestinal problems
____	___	Blood disorder/Leukemia	___	___	Heart problems	___	___	Thyroid disease
____	___	Chest pains	___	___	High blood pressure	___	___	Tumors or growths
____	___	Convulsions/seizures	___	___	Kidney problems	___	___	Ulcers
____	___	Diabetes	___	___	Liver problems	___	___	Sexually transmitted Infections
____	___	Excessive bleeding	___	___	Lung disease	___	___	Other problems not mentioned
____	___	Fainting spells/dizziness	___	___	Psychiatric problems			

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform the clinic of any changes in my child's medical status.

_____ _____

Signature of Parent/Guardian **Date**

RAINBOW CHILDREN'S CLINIC

Mayfield
1915 E. Mayfield Rd., Ste. 115
Arlington, TX 76014
682-276-6700

Ballpark
1900 Ballpark Way, Ste. 106
Arlington, TX 76006
817-704-7339

PARENT DESIGNATION TO CONSENT FOR HEALTHCARE

Other contact information: People you authorize the clinic staff to:

1) Contact in case of an emergency.
2) Receive and release information regarding your child's medical care.
3) Bring your child for doctor's appointment and consent for medical treatment (Must bring photo ID).

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone: _____

Patient's Name: _____ **D.O.B:** _____

Guardian's Name: _____**Relationship to Patient:** _____

Signature: _____ **Date:** _____

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name

Child's Middle Name

Child's Date of Birth

*Children younger than 18 years old only.

Child's Gender: ☐ Male ☐ Female

Child's Address

Apartment #

Telephone

City

State

Zip Code

County

Mother's First Name

Mother's Maiden Name

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Upon completion, please fax or mail form to the DSHS ImmTrac2 Group or a registered Health-care provider.

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and affirm that consent has been granted. DO NOT fax to ImmTrac2. Retain this form in your client's record.

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations through the Texas Vaccines for Children (TVFC) Program must be kept in the health care provider's office for a minimum of five (5) years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. TVFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure eligibility status for the program. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines under the TVFC Program.

1. Child's Name: _____
   Last Name First Name MI
2. Child's Date of Birth: ____/____/____
   MM DD YYYY
3. Parent, Guardian, or Individual of Record: _____
   Last Name First Name MI
4. Primary Provider's Name: _____
   Last Name First Name MI
5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the TVFC Program, at each immunization encounter or visit, enter the date and mark the appropriate eligibility category. If Column A - F is marked, the child is eligible for the TVFC Program. If column G is marked the child is not eligible for federal VFC vaccine.

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

** Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC or an RHC and the state, local, or territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the TVFC Program because the provider or facility is not an FQHC or an RHC, or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-TVFC-eligible children.*

**** Children enrolled in the State of Texas Children's Health Insurance Program (CHIP). An agreement between the DSHS Immunization Unit and CHIP stipulates that vaccines for eligible CHIP enrollees are purchased through the federal contract.*

Texas Vaccines for Children (TVFC) Program

Patient Eligibility Screening Record
(Continued)

Date	Eligible for VFC Vaccine				State Eligible		Not Eligible
	A	B	C	D	E	F	G
	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	* Underinsured served by FQHC, RHC, or deputized provider	** Other underinsured	*** Enrolled in CHIP	Has health insurance that covers vaccines

Medicaid:

Medicaid Number:_____

Date of Eligibility:_____

CHIP:

CHIP Number:_____

Group Number:_____

Date of Eligibility:_____

Private Insurance:

Name of Insurer:_____

Insurance Name:_____

Insurer Contact Number:_____

Policy or Subscriber Number:_____

RAINBOW CHILDREN'S CLINIC

Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

Name of Releasing Facility: *(Previous Doctor)*	***Send Records to:*** *(New Doctor)*
Name:	Name: ***Rainbow Children's Clinic***
Address:	Address: ***1915 E. Mayfield Rd., STE. 115***
City, State, Zip:	City, State, Zip: ***Arlington, TX 76014***
Phone:	Phone: ***682.276.6700***
Fax:	Fax: ***682.276.6049***

***** MEDICAL RECORDS THAT EXCEED 25 PAGES MUST BE RECEIVED BY MAIL ONLY.**
PLEASE DO NOT FAX
***** DISC FILES MUST BE IN PDF FORMAT ONLY**

INFORMATION TO BE RELEASED

- ☐ IMMUNIZATION RECORD ONLY *** PLEASE FAX SHOT RECORD AS SOON AS POSSIBLE
- ☐ MEDICAL RECORDS – Date Range: _____ to _____ ☐ ALL RECORDS
- ☐ TEST RESULTS: TYPE OF TEST: _____ Date_____ ☐ ALL TESTS
- ☐ OTHER _____

This authorization will expire when I revoke this authorization in writing.

Patient Rights:

- I may refuse to sign this authorization and I have the right to revoke this authorization in writing at any time.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand released health record may contain information in reference to Hepatitis B or C testing, HIV testing and or other sensitive information, including mental health and substance abuse.
- I understand that if I wish to have copies made, then the facility may assess a fee for copying the records. I will be notified of the total amount due for copying and shipping the requested records. I agree that the facility will only send me the requested information once it has received payment in full for those costs. I may inspect or copy the protected health information to be disclosed as described in this document
- The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Federal Law, Health Insurance Portability Accountability Act (HIPAA) and will be reported as such.

_____ _____
Signature of Person Making the Request Date

Print Name _____ Relationship to Patient_____