Patient Registration Form

Patient name_____ D.O.B._____ M / F
Last First Middle m/d/yr

Mother/Guardian:_____ D.O.B.:_____

SSN: _____-_____-_____ CA Driver Lic #_____

Address: _____
Street Apt #

_____
City State Zip

Home Phone_____ Work Phone _____

Mobile Phone_____ Email _____

Mother Employer:_____

Employer Address: _____

Father/Guardian:_____ D.O.B.:_____

SSN: _____-_____-_____ CA Driver Lic #_____

Address (if different than mother): _____
Street Apt #

_____
City State Zip

Home Phone_____ Work Phone _____

Mobile Phone_____ Email _____

Father Employer:_____

Employer Address: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE . Your signature below indicates that you under- stand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

_____ _____
Signature of parent or legal guardian Date

Patient Medical Information

Patient name: _____ D.O.B._____
Age _____ Today's date: _____

PREGNANCY AND NEWBORN HISTORY:
How many total pregnancies have you had including recent _____
Delivery (circle): Full term Premature/Gestational age_____ Birth weight_____
Vaginal C-Section, reason: _____
Complications during delivery or soon after (fevers, breathing problems, low sugar, jaundice, NICU, etc…):
_____

During pregnancy with this child did you....	No	Yes, please explain
Take Medications or herbs?	____	_____
Have an illness?	____	_____
Smoke cigarettes?	____	_____
Drink alcohol?	____	_____
Use illegal drugs?	____	_____

CHILD'S HISTORY:
Hospitalizations (reason and date) _____
Surgeries (type and date) _____
Allergies (medicine, food, environment?) _____

DOES YOUR CHILD HAVE ANY OF THESE CONDITIONS:

	Yes	No		Yes	No		Yes	No
Vision problems	____	____	Wheezing	____	____	Easy bruising/bleeding	____	____
Hearing problems	____	____	Cough	____	____	Pain with urination	____	____
Speech problems	____	____	Vomiting	____	____	Behavior/emotional problems	____	____
Dental problems	____	____	Diarrhea	____	____	Snoring or sleep problems	____	____
Earaches/drainage	____	____	Abdominal pain	____	____	Fainting spells	____	____
Sore throat	____	____	Skin problems	____	____	Joint pain/swelling	____	____

FAMILY HISTORY: Please check the boxes where your child's blood relatives have any of these problems:

	Mother	Father	Sibling	Grandparent (mother/father side?)
Arthritis				
Asthma or lung disease				
Seasonal allergies				
Diabetes				
Heart disease				
High cholesterol				
High blood pressure/stroke				
Bleeding or clotting disorder				
Birth defects				
Cancer (type)				
Liver problems				
Intestinal disease				
Kidney problems				
Skin problems				
Migraines				
Seizures				
Mental health problems (ie. Anxiety, depression, ADHD, etc..)				
Immune system problems				
Thyroid problems (low, high)				

Parent or Responsible Party

Name: _____

Address: _____
Home phone:_____ cell ph_____ SSN: _____
D.O.B _____/_____/_____ M/F: _____

MARTIAL STATUS OF BIOLOGICAL PARENTS: _____
IF SEPARATED DO BOTH BIOLOGICAL PARENTS HAVE JOINT CUSTODY?: YES/NO
IF NO, WHO HAS LEGAL CUSTODY? _____ (PLEASE PROVIDE COPY OF COURT ORDER)

Other family members that are patients here: _____
Pharmacy of choice: _____ Phone _____
In case of Emergency, who should be notified? _____Ph: _____

Insurance Information (Please present insurance card at time of check-in) :

Primary insurance Name: _____
Ins.Address: _____
Name of Insured: _____
Insured's ID #: _____
Group # _____
Employer Name: _____
Employer Address: _____
Employer Phone: _____
Relation to insured: _____

Secondary Insurance Name:_____
Ins. Address _____
Name of Insured: _____
Insured's ID #: _____
Group # _____
Employer Name: _____
Employer Address: _____
Employer Phone: _____
Relation to insured: _____

I authorize release of medical information to referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of benefits to physician.

Responsible party signature_____ Date:_____

In order to establish optimal relation with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time that they are rendered unless you are in a prepaid plan in which we participate. For these patients, applicable co-payments and deductibles will be collected. We accept payment in form of Visa or Mastercard. In the event of hospitalizations our office may file with the appropriate insurance; however before such claims are filed, coverage will be pre -verified and you will be asked to pay any unmet deductible, non- covered services and co-payments. In the event that you must be turned over to collections, a collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Responsible party signature_____ Date:_____

Rainbow Children's Clinic Payment for Services

Dear Patient, Guardian or Guarantor:

There have been many changes in methods of payment for physician's services. We have found that patients are often confused by their insurance policies. The purpose of this letter is to provide information and help prevent misunderstandings. We strongly recommend you research your benefits prior to your office visit.

YOUR RESPOSIBILITY

Insurance coverage is not a guarantee of payment. You the patient, guardian or guarantors are ultimately responsible for payment of service rendered by this practice. There are several reasons why your insurance may not pay for your visit.

- You have not met your annual deductible. Many policies have a separate, higher deductible for in office/ outpatient surgical procedures.
- The services or procedures are not covered by your insurance. This varies greatly among insurance companies and plans. Examples include circumcision and wart treatments
- We are not contracted with your insurance carrier

We will inform you when we know a treatment or procedure will not be covered by your insurance but many times it is not possible for us to know with certainty. Often, insurance companies will make that determination until they have received the claim. Ultimately it is **YOUR RESPONSIBILITY** to know what provisions, restrictions and requirements are included/ excluded in your specific health insurance policy. If there is any uncertainty about your coverage, we will be happy to provide you with an estimate of our fees before treatment is given.

PAYMENT AT TIME OF SERVICE

Any co-payment, co-insurance or deductible must be paid at the time of service. Payment may be made by Visa or Mastercard. If both covered and non-covered services are performed at the same visit, you must pay your co-payment as well as the non-covered service. **A cancellation fee of $25 will be applied to any and all appointments not cancelled within a 24-hour notice to clinic.**

Payment in full is also required at the time of service in the following circumstances:
-You do not have insurance coverage or we are not contracted with your carrier.
-Any procedure or treatments we believe are not covered by insurance.
-You have not met your deductible. Note: If you have met your deductible, please bring statements or a letter from your insurance company indicating this.

By my signature below I acknowledge I have read and understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. This authorization is not limited by time.

Signature of Responsible Party_____ Date: _____

Relationship to Patient _____ Witness: _____

Rainbow Children's Clinic
Summary of Notice of Privacy Practice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that, effective April 14, 2003, we provide you a printed copy of our Notice of Privacy Practices. For your convenience we are providing this brief summary. We encourage you to read the full notice in its entirety, which is available upon request. We are required to ask you to sign a one time acknowledgement that you have received this summary.

Your Rights As a Patient

You have rights with respect to your protected health information. These are summarized below and described in detail in out full Notice of Privacy Practices.

Use of Protected Health Information

We are permitted to use your protected health information for treatment purposes, payment and to conduct our business and evaluate the quality and efficiency of our process. Also we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosure of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers the permissible.

Disclosure of Protected Health Information Requiring Your Authorization

For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosure of Protected Health Information Requiring Not Your Authorization

We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Restrictions to Use and Disclosure

You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such request. However, if we do agree, only the minimum amount of such information will be used to accomplish this goal.

Access to Protected Health Information

You may request access to or a copy of your medical records in writing. If we deny the request, we will tell you why. You may appeal this decision, in which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments to Medical records

You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

Accounting of Disclosures of Protected Health Information

You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatments, payment, or operations.

Complaints Related to Perceived Violations of Your Privacy Rights

You may register a complaint about any of our privacy practices with our Privacy Officer or with the Secretary of Health and Human Services.

Raoul B. Del Mar, M.D. FAAP
Board Certified Pediatrician
6508 Lonetree Blvd. Suite 103
Rocklin, CA 95765

Acknowledgement of Receipt of Summary Notice of Privacy Practices

Use and disclosure of protected Health Information is regulated by a federal law know as – The Health and Insurance Portability and Accountability Act of 1996 (HIPAA).

Under HIPAA, provider of healthcare are required to give patients their notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain written acknowledgement that this notice was received.

I hereby acknowledge that I have received a copy of this medical practice's ***Notice of Privacy Practices***
I further acknowledge my understanding and agreement to the standards set forth in the notice. I understand that this practice will not use my Private Health Information for purposes other than those specifically described in the notice. Additionally, I understand that my Private Health Information may be used at the discretion of my physician or by his/her staff representatives in order to facilitate my care with other physicians, laboratories, or other healthcare professionals as necessary to render appropriate diagnosis and/or treatment.

Name of Patient_____
Date of Birth _____

Name of Parent/Guardian (please print) _____

Signature_____Date_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.
(9-13)

AUTHORIZATION FOR USE AND DICLOSURE OF MEDICAL INFORMATION

This authorization allows healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize: _____

PREVIOUS: Physician/Healthcare Facility/Phone and Fax#

To release information regarding my medical history, illness or injury, consultations, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: Rainbow Children's Clinic or Raoul Del Mar M.D. PHONE (916) 771-5533

6508 Lonetree Blvd Ste 103, Rocklin, CA 95765 FAX (916) 771-5453

The medical information/records will be used for the following purpose: Continuation of Care

This authorization is:

[X] Unlimited (All records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Limited to following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse ____ (initial) HIV Diagnosis/Treatment ____ (initial)

Psychiatric/Mental Health ____ (initial) Genetic Information ____ (initial)

Tests for Antibodies to HIV ____ (initial)

DURATION: This authorization shall be effective immediately and remain in effect until _____

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

_____ _____

Signature of patient or legal/personal representative | Relationship if other then patient

_____ _____

Patient's Name (PRINT) | Date

N/A _____ _____

Patient's Social Security Number | Patient's Date of Birth

_____ _____

Witness Name | Witness Signature