# Medical Information

Name_____ D.O.B._____
Age _____ Date _____

**Birth History / Review of Systems** Check if you have ( or had ) any of the following:

During Pregnancy with this child did you

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Smoke cigarettes? | ___ | ___ | Have any illness | ____ | ____ |
| Packs/day_____ | | | Explain_____ | | |
| Drink Alcoholic bev | ___ | ___ | Have an STD | ____ | ____ |
| Drinks/day_____ | | | Explain_____ | | |
| Use illegal Drugs | ___ | ___ | Take Herbs or Meds | ____ | ____ |
| Kind_____ | | | Explain_____ | | |

How many Pregnancies have you had including recent_____
This baby C/section ___ ___ Delivery problems ____ ____
Problems with baby ___ ___ Explain_____
Explain_____ Birth weight_____ Ht _____

| Has your child had: | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Vision problems | ___ | ___ | sore throat | ___ | ___ | pain with urination | ___ | ___ |
| Hearing problems | ___ | ___ | wheezing | ___ | ___ | skin problems | ___ | ___ |
| Speech problems | ___ | ___ | cough | ___ | ___ | abdominal pain | ___ | ___ |
| Dental problems | ___ | ___ | vomiting | ___ | ___ | congestion | ___ | ___ |
| Earaches/drainage | ___ | ___ | diarrhea | ___ | ___ | constipation | ___ | ___ |
| Psychiatric problems | ___ | ___ | Behavior / Emotional problems | | | | ___ | ___ |

**Past Medical History**

Hospitalizations and dates _____

Surgeries and dates_____

Allergies medicine_____ food _____

**Family History**

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Arthritis | ___ | ___ | Hay Fever | ___ | ___ | Skin disease | ___ | ___ |
| Asthma | ___ | ___ | Lupus | ___ | ___ | Specify_____ | | |
| Cancer | ___ | ___ | Mental | | | Intestinal disease | ___ | ___ |
| Diabetes | ___ | ___ | problems | ___ | ___ | High blood pressure | ___ | ___ |
| Heart disease | ___ | ___ | Kidney | ___ | ___ | Liver disease | ___ | ___ |
| Blood disease | ___ | ___ | Seizures | ___ | ___ | Birth defects | ___ | ___ |

**Parent or Responsible Party**

Name: _____

Address: _____

Home Phone:_____ work ph_____ SSN: _____
D.O.B _____/_____/_____ sex: _____

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

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

Other Family members that are patients: _____
Pharmacy of Choice: _____ Phone _____
In Case of Emergency, who should be notified? _____Ph: _____

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 cash, check or credit card. 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 deductibles must be paid at the time of service. Payment may be made by cash, check, 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. **Returned checks will incur a $25.00 administrative fee. A cancellation fee of $25.00 will be applied to any and all appointments not canceled within a 24 hr notice to clinic.**

Payment in full is also required at the time of service in the following circumstance:

-You don not have insurance coverage or we are not contracted with your carrier

- Any procedures 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 to indicate 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 is 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. A copy of our full Notice is available, which we encourage you to read in its entirety. We are required to ask you to sign a one time acknowledgement that you have received this summary. A copy of the full notice is available upon request.

## 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 that 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 (print pls) _____
Signature_____
Date_____