Rainbow Pediatrics

Patient Information

Last Name: _____ First Name: _____ Sex: M F

Date of Birth: _____/_____/_____ Pharmacy: _____ School : _____

Address: _____ Email Address: _____

City: _____ State: _____ Zip Code: _____

Lives with: Mother ( ) Father ( ) Both ( ) Legal Guardian ( ) Other ( ) _____

Parent/Legal Guardian Information:

Mother's Name: _____

Date of Birth: (M) ____/____/____ **Telephone #:**_____/_____/_____ **Telephone#:**_____/_____/_____

Address: *(If different from above)* _____

City: _____ State: _____ Zip Code: _____

Responsible for bills: Yes or No

Father's Name: _____

Date of Birth: (F) ____/____/____ **Telephone #:**_____/_____/_____ **Telephone#:**_____/_____/_____

Address: *(If different from above)* _____

City: _____ State: _____ Zip Code: _____

Responsible for bills: Yes or No

Insurance Information:

Primary Insurance Name: _____ Policyholder Name: _____

Member #/SS#.:_____ Date of Birth: _____/_____/_____

Group Number: _____ Copay: $_____

Secondary Insurance Name: _____ Policyholder Name: _____

Member #/SS#.:_____ Date of Birth: _____/_____/_____

Group Number: _____ Copay: $_____

Relation to patient: Self ( ) Spouse ( ) Child ( ) Other ( ) _____

In Case of Emergency:

Name: _____ Relation to Patient: _____ Telephone: _____

Name: _____ Relation to Patient: _____ Telephone: _____

Signature: _____ **Date:**_____

Rainbow Pediatrics, LLC

Pankaj Sanwal, M.D.,F.A.A.P. & Vibha Sanwal, M.D.,F.A.A.P.

21141 Sterling Avenue, Unit #1, Georgetown, DE 19947
TEL: (302) 856- 6967 FAX: (302) 855- 0744

1212 Savannah RD, Lewes, DE 19958
TEL: (302) 645-2241 FAX: (302) 645-5079

Contact Consent for billing purposes

You agree, in order for us to service your account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives or our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

Consentimiento para contactarle sobre sus cuentas

Usted está de acuerdo que para darle servicio a su cuenta o para cobrar las cantidades que usted pueda deber, representantes de nuestra organización, proveedores auxiliares, asociados de negocios de HIPAA, vendedores y representantes o nuestra agencia de cobro/colecciones, pueden contactarle por teléfono en cualquier número de teléfono asociado a la cuenta, incluyendo los números de teléfonos móviles, lo cual podría resultar en cargos a usted. Representantes de nuestra organización, proveedores auxiliares, asociados de negocios de HIPAA, vendedores y representantes de nuestra agencia de cobro/colecciones, pueden ponerse en contacto con usted mediante el envío de mensajes de texto o mensajes de correo electrónico, utilizando cualquier dirección de correo electrónico que usted nos proporciona. Métodos de contacto pueden ser mensajes de voz pregrabados / mensajes artificiales de voz y uso de un dispositivo de marcación automática, según sea aplicable. Yo / Nosotros hemos leído esta descripción y estoy/estamos de acuerdo en que el Prestamista / Acreedor, sus proveedores auxiliares, asociados de negocios de HIPAA, vendedores y la agencia de cobro/colecciones puedan ponerse en contacto conmigo / nosotros como se describe anteriormente.

_____ _____

Patient Name (Nombre del paciente) DOB (Fecha de Nacimiento)

_____ _____

Parent/Guardian Signature (Firma de padre/tutor legal) Date (Fecha)

Rainbow Pediatrics, LLC

Pankaj Sanwal, M.D.,F.A.A.P. & Vibha Sanwal, M.D.,F.A.A.P.

21141 Sterling Avenue, Unit #1, Georgetown, DE 19947
TEL: (302) 856- 6967 FAX: (302) 855- 0744

1212 Savannah RD, Lewes, DE 19958
TEL: (302) 645-2241 FAX: (302) 645-5079

Portal Consent Form

Purpose of this Form

Rainbow Pediatrics offers secure viewing and communication through its EMR vendor's (eClinicalworks) secure servers as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. By signing, below, you confirm that you have read, understood, and agree to comply with our procedures and guidelines for using the Patient Portal. You also agree not to hold Rainbow Pediatrics or any of their staff liable for network infractions beyond their control.

How the Secure Patient Portal Works?

A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log into the portal side. Because the connection channel between your computer and the Web site uses *secure* sockets layer technology, you can read or view information on your computer, but it is still encrypted in transmission between the Web site and your computer.

Protecting Your Private Health Information and Risks

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to get access to it.

Only you can make sure these two factors are present. We need you to make sure we have your correct email address and are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.

If you pick up secure messages from a web site, you need to keep unauthorized individuals from learning your password. If you think someone has learned your password, you should probably go to the website and change it.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures Regarding the Patient Portal. I understand the risk associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein and including the policies and procedures, as well as any other instructions that my physician may impose to communicate with patients via online communications. All of my questions have been answered and I understand and concur with the information provided in the answers.

Confidential email, please print clearly:_____

Patient Name: _____ Date of Birth:_____

Signature:_____ Date:_____

Rainbow Pediatrics, LLC

Pankaj Sanwal, M.D., F.A.A.P. & Vibha Sanwal, M.D.,F.A.A.P.

21141 Sterling Avenue, Unit #1, Georgetown, DE 19947
TEL: (302) 856- 6967 FAX: (302) 855-0744

1212 Savannah RD, Lewes, DE 19958
TEL: (302) 645-2241 FAX: (302) 645-5079

Consent for medical photography

I consent for medical photographs to taken of my child (or person for whom I am legal guardian). I understand that the medical images will be used in his/her medical record, for purposes of diagnosis, treatment and follow up care. I understand that pictures will be taken of my child via mobile phone or tablet, through the EMR (Electronic Medical Record) and will only be attached to my child's medical record.

I have read and understand the above and I hereby authorize Rainbow Pediatrics to take medical images of my son/daughter for medical purposes and I agree for these photographs to be used in my child's medical chart for diagnosis, treatment and follow up care.

Consentimiento para fotografía médica

Yo doy mi consentimiento para que fotografías médicas sean tomadas de mi hijo(a) (o la persona por quien yo soy tutor legal). Entiendo que las imágenes médicas se utilizarán en su expediente médico, con fines de diagnóstico, tratamiento y atención de seguimiento. Entiendo que las imágenes se tomarán a través de un teléfono móvil o tableta, y a través de su Expediente Médico Electrónico y sólo se adjuntarán al expediente médico de mi hijo.

He leído y entendido lo anterior y yo autorizo a Rainbow Pediatrics tomar imágenes médicas de mi hijo(a) para fines médicos y estoy de acuerdo que las fotografías se utilizarán en el historial médico de mi hijo para el diagnóstico, tratamiento y atención de seguimiento.

_____ _____

Patient Name/ Nombre del paciente **Date of birth/Fecha de nacimiento**

_____ _____

Parent/ legal guardian Signature/ Firma de padres/tutor legal **Date/Fecha**

Rainbow Pediatrics, LLC Billing Policy

The following sets forth the general billing policy for **Rainbow Pediatrics, LLC. Please review the information, initial, then sign and date where indicated.**

_____I understand that it is my responsibility to provide Rainbow Pediatrics, LLC with current, accurate billing information at the time of check-in and to notify Rainbow Pediatrics, LLC of any changes with my information. I understand that I must provide **all insurance cards** at the time of check-in.

_____I understand that it is my responsibility to know my **co-pay amount /deductible** and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the practice also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

_____I understand that, I am responsible for maintaining active health insurance and lack of doing so may result in termination from the practice. **I understand that Rainbow Pediatrics has a right to refuse care if my account has a balance or if insurance is inactive at the time of visit.**

_____I understand that, if I am self-pay, that my self-pay payments MUST be paid upon check-in before services are rendered. I understand that this also applies if my insurance coverage is inactive. **I understand that Rainbow Pediatrics has the right to refuse care if my insurance is inactive or if I am self-pay and I am unable to pay at the time of visit.**

_____I understand that if I present insufficient funds check (NSF check) for payment on my account that I will be charged **$40.00** NSF fee. I further understand that to rectify my account, I will be required to pay either cash, money order, cashier's check or credit card.

_____I understand that I will be billed for any amounts due by me (co-payments, coinsurance amount, deductibles and auto accident claims) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balances due after insurance payments. I further understand that if I have not made payment or payment arrangements prior to the second statement being mailed, that the second statement will be a **"FINAL NOTICE"** and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any and all collection fee, interest, or legal expenses associated with the collection process. **I understand that my account will be made inactive and the patient will be discharged from the practice if no payment is received after 2 statements or no payment arrangement has been made.**

_____I understand that the practice may take verbal request to use my credit card for payment on my account should the account become delinquent, or to cover an NSF check.

_____I understand the practice will obtain the necessary prior authorization needed to rendered treatment. I further understand the prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by the insurance carrier.

_____ I understand that there is a $15 fee for CD medical records and that I am responsible for paying any balance owed before records are sent.

My signature below confirms that I have read these billing policies and my financial obligation as pertains to **Rainbow Pediatrics, LLC.**

_____ _____

Signature Date

- I hereby authorize the payment of medical benefits to **Rainbow Pediatrics, LLC** for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be insured to enforce the collection of any amount outstanding.
- I hereby authorize **Rainbow Pediatrics, LLC** to release any medical information necessary to complete and process my insurance claims.

_____ _____

Patient Name DOB

Rainbow Pediatrics, LLC

Pankaj Sanwal, M.D., F.A.A.P. & Vibha Sanwal, M.D., F.A.A.P.

21141 Sterling Avenue, Unit #1, Georgetown, DE 19947 TEL: (302) 856- 6967 FAX: (302) 855-0744

1212 Savannah RD, Lewes, DE 19958 TEL: (302) 645-2241 FAX: (302) 645-5079

We would like to welcome you to Rainbow Pediatrics! Please fill out all the attached paperwork and read the following office policies.

Patient Vaccination:

I understand that Rainbow Pediatrics does not accept patients who do not believe in vaccines or refuse vaccinations. I understand that Rainbow Pediatrics will terminate the established patients from the practice that no longer wish to be vaccinated. Unvaccinated children pose health risks not only to themselves but also to the other infants and children in the practice. Rainbow Pediatrics will be giving vaccinations strictly according to the Center for Disease Control and Prevention (CDC) and American Academy of Pediatrics (AAP) guidelines. We will no longer accommodate families who wish to follow alternate schedules.

Walk-in Patients:

We provide medical care for established patients who walk-in or call in the same day, depending on the doctor's schedule, but previously scheduled appointments will be seen first.

Referrals:

If you are enrolled in a managed care insurance plan (i.e., HMO); you must receive a referral from our office *before* seeing a specialist. NO retroactive referrals will be given.

Well checks/vaccinations:

Parent/legal guardian **must** be present for well check visits that include vaccinations. Only parents/legal guardians may sign for vaccines. Every patient is expected to get a yearly physical and getting it somewhere else like school or walk-in clinic is unacceptable and will lead to termination from the practice. The patient will be termed from the practice if not seen for well check exam within 2 years.

Missed Appointments:

Missed appointments represent a cost to us and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments. **After the third (3rd) no-show the patient will be discharged from the practice.**

Rainbow Pediatrics reserves the right to terminate the patient if medical advice given by doctor is not followed or the patient doesn't show up for follow up appointments.

Forms needed to be filled out:

If you need a form filled out you must give the office enough time to complete it. Regular physical forms require a 24-hour notice/sport physical forms and other forms require a 72-hour notice.

_____ _____

Parent/legal guardian signature Date

Patient Name: _____ Date of Birth: _____