Today's Date: _____

Rainbow Pediatric Center

Patient Information Sheet

Patient's Name:_____ DOB: _____

Patient's SSN: _____-_____-_____ Male Female Age:_____

School (if applicable): _____

Current Address:_____

City:_____ State:_____ Zip:_____

Home Phone No. (_____)_____ Cell Phone No. (_____)_____

Primary Guardian's Names: _____ Relation to Patient:_____

Parental Marital Status: Married Single Divorced Other_____

Mother's Name: _____	Father's Name: _____
DOB: _____ SSN: _____	DOB: _____ SSN: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Home Address: _____	Home Address: _____
(if different than above) _____	(if different than above) _____
Work No. (_____)_____	Work No. (_____)_____
Cell No. (_____)_____	Cell No. (_____)_____

Emergency Contact Information

(other than parents)

Name: _____ Phone No. (_____)_____

Relation to Patient:_____ Cell No. (_____)_____

Insurance Information

Primary Insurance: _____ (please provide copy of card)

Insurance Policy Holder's Name:_____ DOB_____

ID Number _____ Group Number _____

How did you hear about our practice? _____

Rainbow Pediatric Center

Dr. Prasanthi Reddy

CONSENT FOR TREATMENT OF A MINOR

I hereby authorize the treatment, administration of anesthesia, and surgical treatment(s) for my minor child:

_____

(child's name)

In the event of a medical situation occurring during my absence when the physician(s) or staff are unable to contact me; this authorization extends to both physician(s) and nursing personnel involved in the treatment of my child or child for which I am the legal guardian. I release the physician and any individual designated by the physician, as well as the health care facility in which such care is provided, from liability while performing indicated procedures for my minor child.

_____ _____

Signature of parent or legal guardian **Date**

_____ _____

Witness **Date**

FINANCIAL POLICY

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED.
We accept cash, personal checks, MasterCard and Visa. Returned checks are subject to a service charge of $20.00 or 5% of the face value of the check, whichever is greater and you will lose your privilege to write checks in our office.

CANCELLED/NO SHOW APPOINTMENTS - Patients who do not cancel appointments ahead of the scheduled time will be charged a $30.00 no show fee. After the third no show, the patient will be discharged from the practice.

BLUE CROSS/BLUE SHIELD PPC COVERAGE – CO-PAYMENT AND DEDUCTIBLE MUST BE PAID AT THE TIME OF SERVICE. Because we are under contract with these insurance companies, we will file your insurance claim.

WORKERS' COMPENSATION - We will call your employer to authorize your visit prior to your appointment. We will file with your company's insurance. In the event you fail to prosecute the claim for Workers' Compensation for this illness or condition or it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case, you agree to pay the usual and customary fees for services rendered to you in this case.

CHILDREN OF DIVORCED PARENTS - PAYMENT IS DUE AT THE TIME OF SERVICE no matter who is responsible by order of the divorce decree.

FINANCIAL AGREEMENT – We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover (i.e. yearly physicals).

COPYING OF MEDICAL RECORDS - There will be a charge of $1.00 per page for first 25 pages and $.25 thereafter for the copying of medical records.

We must emphasize that as your medical care provider our relationship and concern is with you and your health, not your insurance company. ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. On any balance on your account after 90 days, including those that insurance has not paid, collection action will be taken. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

If it becomes necessary to collect any sum due through an attorney, the the patient agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature: _____ Date: _____

Rainbow Pediatric Center

Dr. Prasanthi Reddy

CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to Rainbow Pediatric Center, P.A. and all health care providers furnishing care within the practice to use and disclose health information for the purposes of treatment, payment and health care operations.

I further authorize Rainbow Pediatric Center, P.A. to furnish information from my medical records as requested by other physicians or medical care facilities, hospitals or home health agencies for my continued care and treatment or for peer review activities.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe information may identify me.

I understand that I have a right to request Rainbow Pediatric Center, P.A. to restrict how they use and disclose my protected health information for the purposes of treatment, payment or health care operations. Rainbow Pediatric Center, P.A. is not required to grant my request, but if they do, the restriction will be binding on Rainbow Pediatric Center, P.A.

I acknowledge that I have received the Notice of Privacy Practices for Rainbow Pediatric Center, P.A., which provides more detailed information about how Rainbow Pediatric Center, P.A. may use or disclose by protected health information.

LIFETIME AUTHORIZATION FOR PAYMENT

I hereby authorize payment directly to Rainbow Pediatric Center, P.A. for surgical or medical benefits normally payable to me under the terms of my health insurance contract. I authorize use of this form on all my insurance submissions. I authorize my doctor to act as my agent in helping me obtain payment from my Insurance Companies.

FINANCIAL RESPONSIBILITY

Payment is due at the time of services are rendered. We accept cash, personal checks, Visa and MasterCard. I accept responsibility to pay for the medical and surgical care provided to me, or my dependents, by the providers of Rainbow Pediatric Center, P.A. This includes any account balance due after my health insurance carrier has made all payments or determinations under the terms of my insurance. Your visit may include other procedures that are not part of the consultation. Your insurance company may apply those procedures to your deductible and co-insurance.

_____ _____

Signature Date Relationship to Patient

_____ _____

Patient's Name Date of Birth

4788 Hodges Boulevard
Suite B-108
Jacksonville, FL 32224

(904) 223-9100
Fax: (904) 223-9282

Rainbow Pediatric Center
Prasanthi Reddy, MD

Date: _____

Re: Medical Release of my children's Medical Records

To whom it may concern:

I hereby authorize the release of my medical records, or copies of such, and request that they be transferred from your office to Rainbow Pediatric Center.

To: _____
(Name of previous Doctor/Clinic)

Address:_____

_____

Tel:_____ Fax: _____

Below are my children's names and Dates of birth:

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

I understand that this information may contain psychiatric, drug and alcohol treatment, HIV/AIDS testing and status, sexually transmitted disease diagnosis and other sensitive medical information of either my children, myself, or my child(ren)s' other parent. I agree to hold Rainbow Pediatric Center, PA and Dr. Reddy harmless from any and all costs, liability and damages of any nature resulting directly or indirectly from the release of my child(ren)s' medical records.

_____ _____
Parent's Printed Name Parent's Signature

_____ (____) _____
Address, City, State, Zip Code Phone Number