Registration for Newborns Less Than 1 Month Old

Name of Person Registering this Patient *

First Name Last Name

Email

example@example.com

Phone Number *

Area Code Phone Number

Child's Name *

First Name Last Name

Child's DOB *

Month Day Year

Which hospital was your child born in? *

Pregnancy

Did you have any of the following problems during pregnancy?

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Pre-Eclampasia
- ☐ Premature Onset of Labor
- ☐ Other

Other Medical Problems

Did you receive any medications during pregnancy other than Prenatal vitamins? *

- ○ No
- ○ Other

Birth

Delivery *

- ○ Vaginal
- ○ C-Section

Complications *

- ○ Yes
- ○ No

If yes, explain.

Was your baby Jaundiced before leaving the hospital? *

- ○ Yes
- ○ No

Did your baby have any other complications?

- ○ Yes
- ○ No

Explain

Baby's Weight *

Days Baby Stayed in Nursery *

If child was a boy, was he circumcised? *

- ○ Yes
- ○ No

Discharge Weight *

How is your baby being fed: *

- ☐ Breast
- ☐ Formula

How much? *

How often? *

Which formula? *

Approximately how many times a day is your baby having bowel movements? *

Ethnicity *

- ☐ Non Hispanic

☐ Hispanic
☐ Latin

Does the patient have siblings? *

○ Yes
○ No

Mother's Name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Mother's SSN *

Employer *

Mother's DOB *

Month Day Year

Occupation

Work Phone *

Area Code Phone Number

Email

example@example.com

Father's Name *

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Phone Number *

Area Code Phone Number

Father's SSN *

Father's DOB *

Day Year

Employer *

Occupation

Work Phone *

Area Code Phone Number

Email

example@example.com

Child Lives With: *

- ☐ Mother
- ☐ Father
- ☐ Guardian

Emergency Contact: Someone who does not live in home. *

First Name Last Name

Phone Number *

Area Code Phone Number

Relation *

What pharmacy do you use? *

E.G. Publix - Madison St

Primary Insurance Company *

Policy Number *

Insured Name *

First Name Last Name

Secondary Insurance Company

Policy Number

Insured Name

First Name Last Name

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFIT

I authorize Rainbow Kids Clinic to treat my child. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Rainbow Kids Clinic for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. Medical care of immunizations cannot be given unless my child is accompanied by one of the following:

Accompanied *

I understand that if my child's physician, or any person employed by or under the direction and control of my child's physician(s), is directly exposed to my child's body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C virus, that I am deemed by law to have consented to testing for infection with HIV or Hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my child's body fluids.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Rainbow Kids Clinic 111 Otis Smith Drive Clarksville, TN 37043 931-553-6666 Fax 931-553-6681
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to me requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name *

First Name Last Name

Child's Gender *

○ Male

○ Female

Child's Race *

Child's SSN *

List of medications the child is currently taking: *

Name and Dosage (If dose unknown, please list pharmacy where prescription was filled so we may call if needed) Please include all oral, inhaled, nasal, injectable, herbal, vitamins, and over-the-counter medications.

Relationship to Patient *

Child's DOB *

Month Day Year

Last Four Digits of Child's SSN *

RAINBOW KIDS CLINIC OFFICE POLICIES

APPOINTMENTS: Due to HIPPA requirements we are required to have each patient accompanied by a parent or legal guardian unless the parent has listed any other individual on initial paperwork. If your child is accompanied by a listed person from paperwork, he or she must present picture ID.

Scheduling: You can schedule appointments by calling our office or submitting a request on our website along with the date and time that works best for you. However, online scheduling is only for Well checks. For urgent appointments we ask that you please call our office directly.

Rescheduling and Cancellations: In order to reschedule or cancel an appointment, please do so at least 24 hours before appointment time for well exams/physicals, ADHD, and follow up appointments. We want to give all patients an opportunity to make an appointment if needed. If you are more than 10 minutes late for

an appointment it may have to be rescheduled (exceptions may be made for sick children on a case by case basis).

No Shows: If you fail to show for an appointment that has been scheduled, it is considered a NO SHOW. If you do not notify us within 2 hrs of an appointment that you need to reschedule, cancel, or are more than 10 minutes late, it is considered a NO SHOW. Our office does not tolerate NO SHOW'S. After 3 NO SHOWs you will receive a warning letter. After the 4th NO SHOW we will terminate you from our practice.

Well Checkups and Physical: All patients scheduled for a physical/well checkup should have a parent or legal guardian accompany the child so that the doctor or nurse practitioner can give your child the best possible care. We can only see two siblings at one given appointment time a day for well checkups/physicals.

VACCINATIONS: The providers at Rainbow Kids Clinic believe in the safety and efficacy of all routine vaccinations. We require full participation in obtaining RKC required vaccinations, see RKC Policy for Vaccine Refusal by Parents Informational Handout. By signing below you agree to discuss your questions or concerns with a provider today if you have any hesitations regarding vaccinations. Exceptions will be made on a case by case basis ONLY for existing families. A parent or legal guardian must be present to sign for vaccinations before they can be given.

PATIENTS IN WAITING ROOM AND EXAM ROOMS: Parents must watch their children in the waiting area. Please do not allow children to run or climb on the furniture. Children cannot be left alone in the waiting area or exam rooms. Children over the age of 13 can be seen in exam room without a parent IF they can answer history questions and relay information, but we ask that a parent be available in the lobby or by phone. Children must also be kept off the rolling stool in the exam rooms. Children are not to be left unattended on the exam tables. Due to HIPAA requirements, we cannot allow parent and patients to walk outside the exam rooms prior to the doctor or nurse practitioner entering the room. Please remain in the exam room with the door closed until the doctor or nurse practitioner has completed the examination of your child.

REQUESTS FOR PRESCRIPTION REFILLS OR FORMS: Requests for refills, forms for school, daycare or WIC can be submitted by telephone or on our website. Please allow 24-48 hours to complete.

MESSAGES FOR YOUR PCP: Messages can be submitted on our website or by calling our office directly. All telephone calls or messages of non-emergency will be answered by the end of the business day. If the matter is urgent PLEASE CALL OUR OFFICE IMMEDIATELY!

By signing these policy statements, I acknoledge that I have read all policies and practices of Rainbow Kids Clinic and agree to follow according to above policies.

Patient Name *

First Name Last Name

Relationship to Patient

Child's DOB

Month Day Year

Last Four Digits of Child's SSN

SOCIAL HISTORY

MOTHER

Age *

Heath Problems *

Smoker? *

Alcohol use *

Travel History *

Children from previous relationship? *

Are the parents of the patient married? *

- ◯ Yes
- ◯ No
- ◯ Other

SOCIAL HISTORY

FATHER

Age *

Heath Problems *

Smoker? *

Alcohol use *

Travel History *

Children from previous relationship? *

What type of heat is in the home? *

- ○ Electric
- ○ Gas
- ○ Wood
- ○ Other

Pets in the home? *

- ◯ Yes
- ◯ No

What kind of pets?

Pets kept inside or outside?

- ◯ Inside
- ◯ Outside

Name of School / Daycare child attends: *

Grade *

Teacher *

Who lives in household with your child? *

Explain others in household.

Does anyone in the household smoke: *

- ◯ Yes
- ◯ No

If yes, where?

FAMILY HISTORY

*

	Biological Mother	Biological Father	Sibling	Grandparent	Other
ADHD	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Autism / Asperger's	☐	☐	☐	☐	☐
Bipolar Disorders	☐	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	☐
Cancer (if yes, what type?)	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐
Crohn's / Ulcerative Colitis / IBS	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Hearing Loss	☐	☐	☐	☐	☐
Heart Attack / Stroke before age 55	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Irregular Heart Beats	☐	☐	☐	☐	☐
Kidney Reflux	☐	☐	☐	☐	☐
Kidney Stones	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐
Mental Retardation	☐	☐	☐	☐	☐

Migraine	☐	☐	☐	☐	☐
Neurofibromatosis	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
PTSD	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐
Seizure / Epilepsy	☐	☐	☐	☐	☐
Sickle Cell Anemia / Trait	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

Identification of Personal Representatives

State laws provide access to protected health information by biological parents regardless of marital status, unless there is a court order restricting parental access, or a parent has legally relinquished parental rights. To assure privacy and protection of a child's protected healthcare information please list the biological parents below:

Mother's Name *

First Name Last Name

Mother's DOB *

Month Day Year

Mother's SSN *

Mother's Phone Number *

Area Code Phone Number

Father's Name *

First Name Last Name

Father's DOB *

Month Day Year

Father's SSN *

Father's Phone Number *

Area Code Phone Number

Guardian's Name

First Name Last Name

Guardian's DOB

Month Day Year

Guardian's SSN

Guardian's Phone Number

Area Code Phone Number

- If your child has been adopted by you or spouse, please provide a copy of the official adoption decree.
- If your child is under joint custody, please provide a copy of the official Custody Order.
- If a child is under guardianship, please provide the court documents citing who is the child's legal guardian

OTHER PERSONAL REPRESENTATIVES

I am aware that my child may require medical treatment when I am not able to be present. In my absence, I hereby grant the individual(s) named below to access my child's protected health information and authorize any and all medical treatment(s) for my child. This individual may receive and act upon

information received from Rainbow Kids Clinic. This information may include clinical information about my child's care, as well as billing information related to my child's health insurance coverage and payment activity for services rendered by Rainbow Kids Clinic. Regardless of authorization, I acknowledge that I am fully responsible for payment of all charges related to my child's care.

- I understand that I may revoke this authorization at any time.
- I understand the protected health information released to my personal representative(s) may be further disclosed by the recipient. Rainbow Kids Clinic cannot guarantee the further safeguarding of the health information after disclosure.

Personal Representatives

Name of other Personal Representative

First Name Last Name

DOB

Month Day Year

Phone Number

Area Code Phone Number

This request and authorization applies to:

- ☐ All Medical Records
- ☐ Billing Records
- ☐ Authorize Medical Treatment including vaccinations
- ☐ Any behavioral/psychiatric treatment/information/medications
- ☐ Specific records/dates/information ONLY
- ☐ Other

Name of other Personal Representative #2

First Name Last Name

DOB

Month Day Year

Phone Number

Area Code Phone Number

This request and authorization applies to:

- ☐ All Medical Records
- ☐ Billing Records
- ☐ Authorize Medical Treatment including vaccinations
- ☐ Any behavioral/psychiatric treatment/information/medications
- ☐ Specific records/dates/information ONLY
- ☐ Other

I hereby grant my personal representative(s) to have access to my child's protected health information from Rainbow Kids Clinic.

Name

First Name Last Name

Last 4 of your SSN

I... (Full Name) *

First Name Last Name

...parent / guardian of the above named patient, hereby give my consent to Rainbow Kids Clinic to obtain my childes prescription history from outside pharmacies. I have been informed that the history so obtained may include history related to all medications prescribed to my child by any provider during the last two years.

Last 4 of your SSN *

AUTHORIZATION TO OBTAIN OF RELEASE PROTECTED HEALTH INFORMATION

I... (Full Name)

Last Name

First Name

hereby authorize Rainbow Kids Clinic to obtain:

- ☐ All Records
- ☐ Immunization Records
- ☐ Other

Of Protected Health Information of: (Child's Name)

First Name Last Name

Child's DOB

Month Day Year

Name of health care provide from whom you are getting the records below.

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

These records are to be sent to:
Rainbow Kids Clinic
111 Otis Smith Dr.
Clarksville, TN 37043
Fax: 931-553-6681

I understand that this information will not be disclosed to any other agency or indvidual without my written authorization, except as allowed by law. I also understand thay my protected health information, which is disclosed with this release, my be subject to re-disclosure by the recipient and no longer protected by law. Rainbow Kids Clinic is not responsible for any alterations made on its medical record copies, which have been release to any party.
I understand that I have a right to a copy of this authorization after I sign it and that Rainbow Kids Clinic will not condition any provision of treatment on my signing this authorization.

This authorization expires one year after the date I sign it. I understand that this authorization may also be revoked at any time with my written statement.

Name *

First Name Last Name

Last 4 of your SSN *

Language Spoken *

FOR OFFICE USE ONLY

Type of house lived in: *

- ○ Private
- ○ Apartment
- ○ Condo
- ○ Other

RKC Policy for Vaccine Refusal

The providers of Rainbow Kids Clinic affirm our strong belief that a trusting and confident relationship cannot develop between a care team, including providers and parents, who disagree on the basic standard of care. Information on required RKC vaccine requirements and policy is listed below.

1. RKC will not accept new patients (including siblings of existing patients) whose parents refuse all vaccines for any child.
2. We recommend the continually updated vaccination schedule suggested by CDC, AAP, and ACIP for children of all ages including adolescents. Noncompliance with an acceptable schedule will be grounds for discharge from the clinic. If parents wish to follow an alternate schedule, we will try to accommodate their request as long as parents agree to and comply with a schedule which will bring the child up to date by 18 months of age. This would include 1st dose of MMR, 1st dose of Varicella vaccine and 1st dose of Hepatitis A vaccine. We do not take any responsibility for the safety or efficacy of any such alternate schedule and we will ask the parent to take full responsibility by placing their signature on a form.
3.

Regarding immunizations for children of ages 11 and above also, we recommend all the vaccines recommended by CDC, AAP and ACIP. If parents decline either TDaP or the Meningococcal vaccine, such children will also be discharged from our practice.

4. For new and established patients in the in-between age group (18 months to 11 years), we expect the shots to be up to date. If a child is behind, we are willing to work with those families, but a plan needs to be in place for the child to be caught up within six months. All kindergarten shots must be completed by the child's sixth birthday.
5. If parents refuse vaccines for a new baby in the family, we will not accept such newborns as patients of this practice as per our policy above. If the parent's intention of not wanting vaccines for such a baby becomes apparent only during the first visit or later, we will provide care for such babies only until the baby is determined to be doing well and gaining weight. Then we will ask the family to find a different provider.
6. If parents and medical provider cannot agree on an acceptable vaccination schedule such patients will be discharged from the practice due to noncompliance with the advice given regarding immunizations. A discharge letter will be sent to these parents so that they can find another physician willing to take over care of their child.
7. Refusal by parents will be adequately documented by the provider. Vaccine refusal form will be completed and signed by one of the parents. Practice may submit additional charges to the insurance carrier reflecting additional time spent in counseling and may also provide codes documenting under-vaccination status and parental refusal of vaccination.

I have read and accept the RKC Policy for Vaccine Refusal

- ○ Yes
- ○ No

2023 Vaccine Changes in Law

On May 17th, 2023, the Governor signed an amendment into law (SB1111/HB1380 https://publications.tnsosfiles.com/acts/113/pub/pc0477.pdf), that states only parents or legal guardians of minors can consent for vaccination(s). This changes the previously given permissions for a delegated representative such as a family member, stepparents, or caregivers with power of attorney to provide consent for vaccination.

Children who are also in foster care or DCS custody will have to provide court ordered documents or other forms in paperwork. This will make it necessary for us to review all custodial forms on file and we may have to have further updated documentation.

To help parents/guardians that may not be able to bring the child/children in for appointments, we have an Advance Vaccination Form that may be signed. This will allow us to provide vaccines when patients our brought in by delegated representative. You can request this form from our office or download it from our website under the "Forms" tab. Due to this law, we will need the parent/guardian to drop this off prior to giving vaccines so we may verify the identity of legal parent/guardian and have proper documentation in our records. This will also need to be updated yearly or with each birthday.

We regret any extra hardships this will cause for our patient families and if you would like more information you can visit:
https://wapp.capitol.tn.gov/apps/BillInfo/default.aspx?BillNumber=SB1111&GA=113 or
http://www.capitol.tn.gov/Bills/113/Bill/SB1111.pdf

You may also reach out to our legislators to voice any concerns, hardships, or if you feel this bill will

impede your child's healthcare. https://capitol.tn.gov/legislators/

Thank you for choosing Rainbow Kids Clinic and we appreciate you allowing us to continue to take care of your child/children.

I have read and accept the 2023 Vaccine Changes in Law *

- ◯ Yes
- ◯ No

Advance Vaccine Consent

In accordance with Tennessee HB1380, my signature below indicates that I consent for Rainbow Kids Clinic and its staff to provide vaccinations for my children.

I attest under penalty of misrepresentation that I am the parent or legal guardian of the following child/children:

Name *

First Name Last Name

Date of Birth *

Month Day Year

Name

First Name Last Name

Date of Birth

Month Day Year

Name

First Name Last Name

Date of Birth

Day Year

Name

First Name Last Name

Date of Birth

Month Day Year

I consent for (check one) *

- ○ All vaccine recommended for my child by the AAP and ACIP.
- ○ All vaccines recommended for my child by the AAP and ACIP EXCEPT for: per our vaccine policy, only the influenza (starting at 6 months of age) and HPV (starting at age 11 but may be given as early as age 9) vaccine(s) may be declined unless medically necessary to do so. We highly recommend receiving these though.

- ☐ Influenza
- ☐ HPV

(We do not require or administir the COVID-19 vaccine at our clinic)

I understand that I can review the vaccine information sheets (VIS) for these vaccines by viewing this.

I understand that having my signature on file with Rainbow Kids Clinic in this way means that a nonparent/legal guardian who brings my child to vaccination appointments need not provide formal consent for vaccines. My written consent as a parent/guardian is adequate for vaccination.

This consent automatically expires one year from signature date.

Parent Name *

First Name Last Name

Date *

Month Day Year

RKC Staff Member

Last Name

First Name

Date

Month Day Year