Registration for New Patients More Than 1 Month Old

Must complete the below information to obtain records prior to appointment being scheduled

Welcome!
You are entering into an agreement. We are not a typical clinic that only sees our patients when they are sick. Rainbow Kids Clinic is a Patient Centered Medical Home (PCMH), a medical practice recognized by the National Committee for Quality Assurance (NCQA). This recognition indicates that we provide a higher quality of preventative and proactive care for our patients. With this model we utilize a team-based approach to coordinate the services all of our patients need and to provide care that puts the patient at the center. Due to HIPAA requirements, we are required to have each patient accompanied by a parent or legal guardian, unless the parent has listed any other individuals on the consent to disclose PHI form. If your child is accompanied by a listed person from this form, he or she must present a picture ID.
As a Patient Centered Medical Home, we are continually endeavoring to improve your patient experience. We feature cutting edge electronic health records which allow patients and staff to communicate with one another through our Patient Portal and Healow App providing the convenience of access to your healthcare team when you need them. By logging in to your Patient Portal or Healow account, you can view/or schedule appointments, request medication refills, send and receive messages to and from your care team, view results and view recommendations for upcoming care. Additionally, we are pleased to provide you with a new member of your healthcare team, the Quality Care Coordinator. Quality Care Coordinators provide outreach when you are due for preventive exams and screenings, review communications that we may receive from your insurance company and will ensure that you are seen by your Primary Care Provider following a trip to the Hospital or Emergency Room.
At Rainbow Kids Clinic, we are here for our patients in sickness and in health. We appreciate your faith in us and value your partnership. Thank you for your participation in improving how we provide your care.
Our Responsibility and Promise to our Patient
What does this mean for you?
As your medical home:
• We will develop a personal care plan with you to address any chronic conditions your child may have.
• We provide you with educational resources and material for your child's care plan.
• We ensure you are receiving all preventative services and care indicated by your demographic.
• We provide you with an after-hours clinical decision-maker available by phone when you call the office to reach our on call triage department.
• If needed, we provide you with a Quality Care Coordinator who calls you with pre-visit questions, hospital follow up, community resources, and education for your care needs.
• We will work with you to help you track and monitor your progress.
• We provide access to your child's health information with our Patient Portal app. Gain the peace of mind that comes from knowing you child's important health information is at your fingertips!
(For further information please ask a member of your care team)
• We will inform you of all healthcare results in a timely manner.
• We will create a patient centered plan with you for your child.
• We will be available to answer any questions or concerns that you may have in regards to your child's health.
• We are available to see any new addition to your family in the hospital, or sit down with you for a discussion prior to your new additions arrival.
Rainbow Kids Clinic is a group of Physicians, Nurse Practitioners, Physician Assistants, Nurses, Medical Assistants, Quality Care Coordinator and Administrative staff, but our team also includes you, and our mission is to achieve the best possible outcomes from this cooperative effort.
Your Responsibility
In the spirit of shared honesty, trust and respect, we ask you to:
• Bring your child in as required for their well exams. All patients scheduled for a physical/well checkup should have a parent or legal guardian accompany the child so that the care team can give your child the best possible care. **(Please be advised we can only see two siblings at one given appointment time per day for well checkups/physicals.)**
• As your child's Medical Home, seek us first for their routine and urgent care needs.
• Consult your child's doctor before seeing a specialist outside their Medical Home. Please provide us with the name and contact information for any specialists they see so that we may coordinate their care to ensure you receive the right services at the right time
• Arrive on time for their scheduled appointments, or give at least 2 hours' notice if you are unable to make

the appointment.
• Be prepared to update your personal information such as insurance card, ID, address, phone numbers and email at each appointment as necessary.
• Help us foster a family-friendly environment by remaining respectful to other patients and staff, speaking at a volume appropriate for indoors, and refraining from obscene language.
• Comply with the healthcare plan you have made with your child's provider.
• Be responsible for your actions if you refuse care or do not follow doctor's orders.
• Give true and complete information about your child's health status, medication history, contact information and any other caregiver's information.
• Treat your physician and all care team members with respect and consideration.
• Honor all agreements made with the clinic and update us within 24 hours of any changes or concerns that you have.
• Honor your co-pays at the time of service and pay previous balances.
RAINBOW KIDS CLINIC REQUIRES THAT ALL PATIENTS BE VACCINATED. A copy of our vaccine policy is available upon request. We reserve the right to limit the privileges of, or discharge patients who do not uphold these responsibilities. By signing, you are agreeing to abide by these terms.
COVID-19 Information

Rainbow Kids Clinic takes the health and safety of our patients and staff seriously. In response to the recent Coronavirus outbreak, we wanted to address certain percautions, recommendations, and information to aid in minimizing chances of contracting not just the COVID-19, but any similar virus(s) and/or bacterial infections.
Prevention is the best way to protect you and your family from possibly illness. By removing the possiblity of coming in contact with any illness, you remove the possibility of getting sick. Best practices of prevention are:
• Washing your hands for at least 20 seconds and thoroughly to remove any dirt/bacteria/virus that are on the skin. If unable to wash hands then an alcohol based sanitizer (60-90%) is a good alternative.
• Cover your mouth and nose with a tissue when sneezing or coughing. Throw tissue into the trash can and wash your hands afterwards
• Avoid touching eyes, mouth, or nose with unwashed hands
• Keep child home if sick and limit access of visitors
• Avoid others that are sick
• Avoid traveling to high risk areas. You can check for up to date information on the CDC website
• Disinfect/sanitize areas that are touched frequently (door knobs, keyboards, cell phones, etc.)
Although the COVID-19 is scary, the chances of testing positive with it is very low. The chances of contracting influenza is so much higher because you need to be in contact with someone who has the virus to get the virus. The Tennessee Department of Health is prepared for new viruses/outbreaks. Be aware that there are numerous protocols for multiple locations and situations to include schools, reaching small knit communities, hospitals, long term care facilities, etc. At this time there is no vaccine for COVID-19 and testing is limited. We are not able to test for this here as of yet and there are certain guidelines that would have to be met to even qualify to be tested. We are looking into ways of testing in the future as options become available. Rainbow Kids Clinic takes every patient's symptoms and risks into consideration. We will be deligent with keeping up to date as new information arrives and hope that some of this information will ease your mind. For more information you can visit the CDC website, https://www.cdc.gov/coronavirus/index.html, and they update frequently. The Department of Health launched a Tennessee Coronavirus Public Information Line to ask questions. The number is 877-857-2945 and is available daily from 10 a.m to 10 p.m central time. As always you may contact us with any questions or concerns.

Sincerely,
Rainbow Kids Clinc

Child's Name *

First Name Last Name

Child's DOB *

Day Year

Child's SSN *

Child's Gender *

- ○ Female
- ○ Male
- ○ Other

Race *

Ex: Caucasian, African American, Mixed Race

Language Spoken *

Ex: English, Spanish

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

Phone Number *

Area Code Phone Number

Mother's SSN *

Mother's DOB *

Month Day Year

Employer *

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

Phone Number *

Area Code Phone Number

Father's SSN *

Father's DOB *

Month Day Year

Employer *

Occupation *

Work Phone

Area Code Phone Number

Email

example@example.com

Emergency Contact: Someone WHO DOES NOT LIVE IN THE HOME. *

First Name Last Name

Does the emergency contact live in the same house as the child?

- [ ] Yes
- [ ] No

We're sorry, please choose an emergency contact of someone who does not live in the same home are the child.

Phone Number *

Area Code | Phone Number

Relation *

What pharmacy do you use? *

Example: Walgreens

Pharmacy Phone Number *

Area Code | Phone Number

Pharmacy Address *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Is your insurance through TennCare? *

- [ ] Yes
- [ ] No

TennCare Type *

- [ ] Bluecare
- [ ] UHC Community Plan
- [ ] Tncare Select

○ Amerigroup

Primary Insurance Company *

Policy Number *

Insured Name *

First Name Last Name

Secondary Insurance Company

Policy Number

Insured Name

First Name Last Name

FINANCIAL POLICY

Good health care for newborns, infants, children, and adolescents begins with the well child visit (checkup) and other services that help keep children healthy. These are preventive services. Our doctors and staff provide these services based on a plan called Bright Futures. The American Academy of Pediatrics (AAP) made this plan to help doctors and families know what preventive services children should receive from birth to 21 years of age, such as screening tests, and advise about staying healthy and safe. This plan can be altered to suit each child as needed. We also follow the AAP vaccine schedule for newborns, infants, children, and adolescents.

Because preventive services are important to keeping children healthy, the Patient Protection and Affordable Care Act (health care reform law) includes a rule that all preventive care screenings and services included in the Bright Futures plan and vaccine schedule must be covered by most health plans. This is not always true, though, as some older plans, called grandfathered plans, do not have to pay in full for preventive services.

Health Plan Terms to Know

Co-payment: A fixed amount that you pay for certain health services before the health plan pays

Coinsurance: The portion of the charge that is not paid by the health plan (usually a fixed percent of each amount paid by the plan)

Deductible: An amount that must be paid before the health plan pays for covered services.

There may also be times when a child needs a service that is not considered preventive on the same day as a well-child visit. If a child is not well or a problem is found or needs to be addressed during the checkup, the physician may need to provide an additional office visit service (Called a sick visit) to care for the child. This is a different service and is billed to your health plan in addition to the preventive services provided on that day. If you have a co-payment for office visits or coinsurance or deductible amounts that you must pay before your health plan pays for these services, our office will charge you these amounts.

We value your time and want to make the most of each appointment for the child. This is why we will address any problem that needs a doctor's care during well-child visits so that only one trip is needed. Some services that may be provided and billed in addition to preventive services include:

- The doctor's work to address more than a minor problem, which will be billed as an office visit (e.g., If the doctor gives a prescription, orders tests, referrals, or changes care for a known problem)
- Medical treatments (e.g., breathing treatments)
- Any surgery (e.g., removing splinters or something the child put in his or her nose or ear) tests performed in the office that are not included in the Bright Futures plan.

Our office does not want you to be surprised by a bill but must always bill your health plan based on the actual services provided. Please feel free to ask questions about services that may not be paid in full by your health plan on the day of your visit. It is our pleasure to help

Date *

Month Day Year

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:

Parent/Guardian *

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.

Past Medical History

Who has been your child's doctor until now? *

Has your child had allergic reactions to any medications, foods, insect bites? *

- ◯ Yes
- ◯ No

Which ones?

Has your child had reactions to immunizations: *

- ◯ Yes
- ◯ No

Which ones?

Has your child been hospitalized for anything other than birth? *

- ◯ Yes
- ◯ No

What?

Has your child had any surgeries? *

- ○ Yes
- ○ No

Which?

Has your child had any serious injuries? *

- ○ Yes
- ○ No

What kind / when:

Does your child see any medical specialists? *

- ○ Yes
- ○ No

What kind / who:

Has your child had frequent ear infections? *

- ○ Yes
- ○ No

Has your child had any eye problems? *

- ○ Yes

○ No

Has your child had any problems with their teeth? *

○ Yes
○ No

Has he/she had any problems with asthma, used inhalers or had nebulizer treatments? *

○ Yes
○ No

Has your child had pneumonia? *

○ Yes
○ No

How many times?

Does he/she have a heart murmur or any heart problems? *

○ Yes
○ No

Does he/she have any problems with urination? *

○ Yes
○ No

Does he/she have any problems diarrhea or constipation? *

○ Yes
○ No

Have there been any seizures or other problems with the nervous system? *

○ Yes
○ No

Does he/she have any problems eczema, hives, or other skin problems? *

○ Yes
○ No

Has your child ever been anemic? *

○ Yes
○ No

Has your child ever had high lead levels in blood? *

- ○ Yes
- ○ No

Does your child have any developmental concerns? *

- ○ Yes
- ○ No

Does your child have any discipline / behavior problems? *

- ○ Yes
- ○ No
- ○ Other

Other Concerns:

Do you have a record of immunizations: *

- ○ Yes
- ○ No

If yes, please bring a copy of immunization record to the appointment and be ready to give to receptionist or upload below. For faster service and scheduling, please provide vaccination records for patient(s).

List medications taken by child at present: *

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.

SOCIAL HISTORY

Child Lives With: *

- ☐ Mother
- ☐ Father
- ☐ Guardian
- ☐ Brother
- ☐ Sister
- ☐ Aunt
- ☐ Uncle
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other

What are the names of the persons or person living in the residence with the child? *

Explain others in household.

Does anyone in the household smoke: *

- ○ Yes
- ○ No

If yes, where?

I.G. inside home, car

Type of house lived in: *

- ○ Private
- ○ Apartment
- ○ Condo
- ○ N/A

- ○ Other

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 *

SOCIAL HISTORY

MOTHER

Mother's Age *

Health Problems *

Smoker? *

Alcohol use *

Travel History *

Children from previous relationship? *

Are the parents of the patient married? *

- ◯ Yes
- ◯ No
- ◯ Other

SOCIAL HISTORY

FATHER

Father's Age *

Heath Problems *

Smoker? *

Alcohol use *

Travel History *

Children from previous relationship? *

Family History

Check only applicable options:

	Biological Mother	Biological Father	Sibling	Grandparent	Other	N/A
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	☐	☐	☐	☐	☐	☐

Other Family History

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name *

First Name Last Name

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 *

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 *

Last Name

First 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.

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
- ☐ Decline
- ☐ 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

May we leave you or your designated individual(s) a message regarding appointments? *

- ○ Yes
- ○ No
- ○ Other

May we leave you or your designated individual(s) a message regarding test/lab results? *

- ○ Yes
- ○ No
- ○ Other

May we leave you or your designated individual(s) a message regarding Billing-Related Questions? *

- ○ Yes
- ○ No
- ○ 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 *

Consent for Checking External Prescription History

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... (Parent/Guardian) *

First Name Last 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

What is the purpose of the transfer of health information? *

Name of facility or practice *

Name of the doctor in charge of the child's care *

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

Former Provider Phone Number *

Area Code Phone Number

Former Provider Fax Number *

Area Code Phone Number

These records are to be sent to:
Rainbow Kids Clinic
111 Otis Smith Dr.
Clarksville, TN 37043
Phone: 931-553-6666
Primary 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.

Your Name (Parent/Guardian) *

First Name Last Name

Last 4 of your SSN *

Your email *

example@example.com

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 *

Month Day Year

Name

First Name Last Name

Date

Month Day Year

Name

First Name Last Name

Date

Month Day Year

Name

First Name Last Name

Date

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

First Name Last Name

Date

Month Day Year