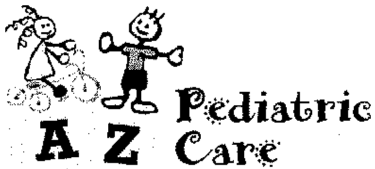


PATIENT ENROLLMENT INFORMATION

NAME (Last, First, Middle Initial)	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE

ADDRESS	CITY, STATE, ZIP

PRIMARY PHONE	ALTERNATE PHONE	PRIMARY LANGUAGE

GUARANTOR INFORMATION (PARENT AND/OR GUARDIAN THE PATIENT LIVES WITH)

NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE

ADDRESS (if different from patient)	CITY, STATE, ZIP

PRIMARY PHONE	ALTERNATE PHONE	EMAIL ADDRESS

EMPLOYER	WORK PHONE NUMBER	RELATIONSHIP TO PATIENT ☐ PARENT ☐ GUARDIAN

OTHER PARENT INFORMATION

NAME (Last, First, Middle Initial)	SSN#	BIRTHDATE	GENDER ☐ MALE ☐ FEMALE

ADDRESS (if different from patient)	CITY, STATE, ZIP

PRIMARY PHONE	ALTERNATE PHONE	EMAIL ADDRESS

EMPLOYER	WORK PHONE NUMBER	RELATIONSHIP TO PATIENT ☐ PARENT ☐ GUARDIAN

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

NAME OF OWNER OF POLICY	RELATIONSHIP OF OWNER OF POLICY TO PATIENT

OWNER OF POLICY DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	OWNER OF POLICY EMPLOYER

COPAY AMOUNT	DEDUCTIBLE AMOUNT	

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

NAME OF OWNER OF POLICY	RELATIONSHIP OF OWNER OF POLICY TO PATIENT

OWNER OF POLICY DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	OWNER OF POLICY EMPLOYER

COPAY AMOUNT	DEDUCTIBLE AMOUNT	

AUTHORIZED INDIVIDUALS TO ACCOMPANY CHILD FOR MEDICAL CARE – Parents, please keep in mind, emergencies do come up and unless a person is listed on your child's chart, per HIPAA guidelines, they will not be able to have your child treated without documentation from you that they have authorization to have your child seen without you being present. Please list anyone who may ever need to bring your child in, in the event that you can not and/or be authorized to receive medical information for this child.

NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE
NAME (Last, First, Middle Initial)	RELATIONSHIP	Date of Birth	PRIMARY PHONE

PHARMACY INFORMATION

NAME OF PHARMACY

ADDRESS

OTHER INFORMATION

PRIMARY LANGUAGE OF HOUSEHOLD

☐ English

☐ Spanish

☐ Other ______________________

HOW WERE YOU REFERRED TO ARIZONA PEDIATRIC CARE

☐ Friend

☐ Physician, Name ______________________

☐ Yellow Pages

☐ Newspaper, Name ______________________

☐ Other ______________________

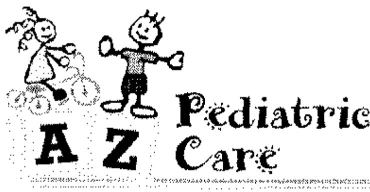
I hereby agree that this information is correct and I understand that I must provide in writing any changes to the above information:

____
Patient Name (Please print)

____
Signature of Parent or Guardian

____
Printed Name of Parent or Guardian

____
Date



Medical History

Date: ____________

Pt Name: ________________________________

Name of person completing this form ________________

How many people live with patient ? Adults ______ Children ________

Birth History: Birth Weight ______ Length______

During Pregnancy did the patient's mother:

Have any medical problems or complications ? Yes No

If yes, please explain: ________________________

Smoke tobacco ? Yes No

Drink alcohol? Yes No

Used any drugs or medications ? Yes No

If yes, please explain: ________________________

Have any problems with labor or delivery ? Yes No

If yes, please explain: ________________________

Was the delivery: Vaginal Cesarean

Patient Past Medical History

Overall health is: Good Fair Poor

Allergies to any medication ? Yes No

Name of Medication allergic to ___________________

Currently taking medication ? Yes No

Name of Medications currently taking _______________ _____________

_______________ _____________

Has the patient ever had any problems with any of the following? If yes please explain

Eyes/Vision	yes	No	______________________
Ears/Nose/Throat	Yes	No	______________________
Headaches	Yes	No	______________________
Joints/Bones	Yes	No	______________________
Seizures	Yes	No	______________________
Repeated infections	yes	No	______________________
Heart/Lungs	Yes	No	______________________
Stomach/Liver	Yes	No	______________________
Intestines/Colon	Yes	No	______________________
Kidneys/Urine	Yes	No	______________________
Indigestion/Nutrition	Yes	No	______________________
Anemia/Bleeding	Yes	No	______________________

Please list surgeries, hospitalizations, serious illness or accidents with dates:

_________________ Date ______ _______________ Date ______

_________________ Date ______ _______________ Date ______

Patient Eligibility Screening Record
Vaccines for Children Program

This record must be kept in the healthcare provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the VFC program. The record may be completed by the parent, guardian, individual or record, or by the healthcare provider.

This same record may be used for all subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of responses is not required, but it is necessary to retain this record on file for a minimum of three years.

(Please print or type)

Today's Date: ______________________________

Child: ______________________________
Last Name First Name M.I.

Date of Birth: ________ / ________ / ________
Month/mes Day/dia Year/año

Parent/Guardian/
Individual of Record: ______________________________

Provider: AZ PEDIATRIC CARE

This child qualifies for vaccination through the VFC program because he/she (check only one box):

(0) [ ] is enrolled in KidsCare: or

(1) [ ] is enrolled in AHCCCS; or

(2) [ ] does not have health insurance; or

(3) [ ] is American Indian or Alaskan Native; or

(4) [ ] has health insurance that does not pay for vaccines

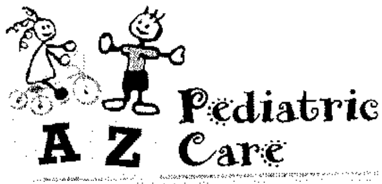
[ ] Check here if this child has health insurance that pays for vaccines.
These children do not qualify for VFC

Please be advised, if your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make Vaccines For Children Program retroactive and you are only eligible for Vaccines For Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

Thank You

Signature: ______________________________ Date: ______________________

Scan: Medinotes\Patient View\Multimedia\Authorizations: (Type in: VFC)



FINANCIAL POLICY

Thank you for choosing **Arizona Pediatric Care** for your child's health care. We are committed to providing quality medical care for your children. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior beginning treatment.

Insurance
Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to those plans with which we have a contractual agreement. As a courtesy, we will file claims to those plans with which we do not have a contractual agreement as unassigned and the insurance company will send the payment directly to you, therefore full payment is expected at the time of service.

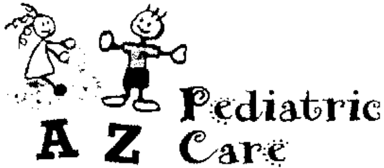
All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. Payment for services rendered is due by the 1st day of the month after the charge has printed on your statement.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible and co-payment amount as well as approved labs, radiology facilities, and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change. Any cost incurred by this office because of incorrect information you provided to us will be passed on to you.

If you have insurance coverage with a plan with which **Arizona Pediatric Care** does not participate charges for your child's care and treatment are due at the time of service, unless prior financial arrangements have been set up by our Office Manager.

No Insurance
If you have no insurance coverage **Arizona Pediatric Care** has implemented a Self Pay Fee Schedule for those services that are 'Medically Necessary'.

Deductibles/Copays/Payments
Our insurance contracts require us to collect deductible amounts and copays at the time of service. These amounts will be collected prior to service being rendered. For your convenience we accept VISA and MasterCard in addition to personnel checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge equal to the bank fees assessed to **Arizona Pediatric Care**.



Appointments
Our goal is to provide the best possible care and physician availability to each of our patients. Our policy is to request you to call and cancel appointments 24 hours prior to scheduled appointment. Please call us, as early as possible, when you know you will need to reschedule and/or cancel an appointment.

Minor Patients
For all services rendered to minor patients, the parent and/or guardian responsible for patient is responsible for payment.

Information
I hereby agree that the enrollment information is correct and I also agree that any changes to the enrollment information will be communicated to **Arizona Pediatric Care** as required to fulfill the medical and financial obligation for services rendered.

Authorization
I hereby request and consent that my medical records and non written records be sent to my referring physicians, those physicians or ancillary facilities that I am referred to by the **Arizona Pediatric Care** and to my insurance company or its agents that may be authorizing treatment. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the above.

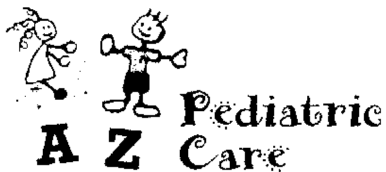
I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any from the insurance carrier to **Arizona Pediatric Care** if paying cash; I am responsible to pay at the time of service.

____
Patient Name (Please print)

____
Signature of Parent or Guardian

____
Printed Name of Parent or Guardian

____
Date



Acknowledgement of Notice of Privacy Practices and Patient Rights and Responsibilities

I have been presented with a copy of the Notice of Privacy Practices for the office of **AZ Pediatric Care** detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Notice of Privacy Practices.

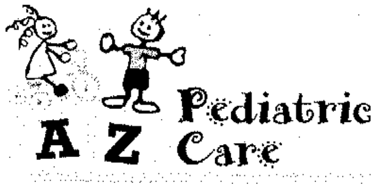
I have been presented with a copy of the Patient Rights and Responsibilities for the office of **AZ Pediatric Care.** I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Patient Rights and Responsibilities.

____
Printed Patient Name

____
Signature of Parent or Guardian

____
Printed Name of Parent or Guardian

____
Date



AUTHORIZATION TO RELEASE MEDICAL RECORDS

I herby authorize the release of photocopies of my medical records in the possession and control of the below named individual/facility, employees and/ or agents for the purpose hereof. Medical records shall include all confidential HIV related information (A.R.S. Section 35-6511); communicable disease related information (A.R.S. Section 36-651); confidential alcohol and drug abuse related information (42CRF Section 2.1 et al); and confidential mental health diagnosis-treatment information unless otherwise directed by me. Description of information to be released (i.e. date of service, test results, immunization records, etc).

________________________________ whose date of birth is ____________

Name of Patient **Birth Date**

FROM:

AZ Pediatric Care
9305 W Thomas Rd Suite 410
Phoenix, AZ 85037
Phone: (623)322-8478 / Fax: (623)322-8479

TO:

____

____

____

Please transfer and/or disclose ALL the following information:

- ○ All medical records, files, charts, reports and other associated health information.
- ○ The following specific Protected Health Information (PHI) (Check ALL that apply)
  - o Medical Records & Charts
  - o Immunization Records
  - o X-Rays or Diagnostic Results/Lab Results
  - o Other (Please Specify)____________________________

TO BE RELEASED FOR:

____

Printed Patient Name **Date of Birth**

____

Printed Name of Person Completing Form **Relationship to Patient**

____

Signature of Person Completing Form **Today's Date**