ARBOR MEDICAL PARTNERS

North Scottsdale Pediatrics | Papago Buttes Pediatrics
Scottsdale Children's Group | Southwest Pediatrics
Arbor Medical Partners Pediatrics – Gilbert

PATIENT INFORMATION

PATIENT NAME : _____ DOB: _____

PREFERRED NAME: _____ SEX: _____ AGE: _____

ADDRESS: _____

CELL # FOR APPOINTMENT CONFIRMATIONS: _____

PREFERRED LANGUAGE: _____ RACE/ETHNICITY: _____

SIBLINGS AT PRACTICE: _____

PARENTS INFORMATION

PARENT NAME: _____ RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____ EMAIL: _____

_____ SS #: _____

_____ EMPLOYER: _____

PARENT NAME: _____ RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____ EMAIL: _____

_____ SS #: _____

_____ EMPLOYER: _____

STEP MOM: _____ STEP DAD: _____

DATE OF BIRTH: _____ DATE OF BIRTH: _____

PHONE #: _____ PHONE #: _____

****This form does not give consent for step parents to bring children into the office. Please ask the front office for a "Consent to Treat" form to keep on file.****

INSURANCE INFORMATION DOCTOR'S NAME: _____

PRIMARY INSURANCE CARRIER: _____

PRIMARY CARD HOLDER: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP NUMBER: _____

SECONDARY INSURANCE CARRIER: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP NUMBER: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby certify that the information provided here is true and correct. I authorize Arbor Medical Partners to release information to my insurance company for the processing of medical claims. I assign insurance benefits to Arbor Medical Partners for all medical services performed. I understand that insurance benefits are determined by the contract I hold with my insurance company, and that I am responsible for all fees not paid by insurance as stated in my policy. I also hereby certify that the person signing the form will be listed as the Responsible Party (Guarantor) of the Child (ren) accounts. This is who all statements will be sent to.

_____

Signature of Guarantor/Responsible Party Date

NORTH SCOTTSDALE PEDIATRICS
A Division of Arbor Medical Partners
NEW PATIENT HISTORY QUESTIONNAIRE

Patient name

Date of Birth

Form completed by Date

HOUSEHOLD

Please list all those living in child's home.

Name	Relationship to child	Birthdate	Health Problems

Are there siblings who do not live in the household not listed? If so, please list their names and where they live:_____

_____

What is child's living situation if NOT with both biological parents?

___Joint custody ____Single custody

___Lives with adoptive parents

___Lives with foster family

If one or both parents do not live in home, how often does the child see parent(s) not in home?

_____

BIRTH HISTORY

_____ Don't know birth history

Birth Weight_____

Was baby born at term? YES____ or _____ weeks

Vaginal _____ OR C-section _____? If C- section, why? _____

Was an NICU stay required? No _____ OR Yes ____ If yes, why? _____

Feeding: Formula _____ Breast feeding _____ Both Formula and Breast Feeding_____

During pregnancy, did mother use: (please checkmark)

	YES	NO
Tobacco		
Alcohol		
Drugs or Medications	List meds/drugs:	
Prenatal Vitamins		

Please list any problems during the newborn period: _____

_____

_____

_____

GENERAL AND PAST MEDICAL HISTORY

PROBLEM LIST: Does your child have any medical conditions, mental conditions or serious illnesses? _____Yes _____No

If yes, please list and explain:_____

_____

SURGERY/HOSPITALIZATIONS: Has your child had any surgery or been hospitalized? _____Yes _____No If yes, what date(s) and explain: _____

_____

ALLERGIES: Is your child allergic to any medicine or drugs or foods? _____Yes _____No If yes, please list and explain:

_____

MEDICAL TEAM: Please list all other doctors/specialists who are involved in child's care _____

_____

General and Past Medical History (continued)
MEDICATIONS: Please list all medications child is taking:

_____

_____

Does your child have or has your child ever had:

	Yes	No
Chickenpox		
Frequent ear infections		
Nasal allergies		
Asthma		
Heart problems		
Heart murmur		
Anemia/bleeding problem		
Blood transfusion		
Frequent headaches		
Problems with vision or eyes		
Thyroid or other endocrine problems		
For girls who have started periods: Any problems with periods? Age of first period:		

	Yes	No
Problems with hearing		
Diabetes		
High blood pressure		
Frequent Urinary tract infections		
ADHD/anxiety/depression		
Developmental delay/learning disability		
Seizures		
Congenital syndrome		
Cancer		
Alcohol or Drug use		
Tobacco use		

BIOLOGICAL FAMILY HISTORY

FAMILY HISTORY OF:	YES	NO	DON'T KNOW	LIST RELATIONSHIP TO PATIENT OF FAMILY MEMBER(S) AFFECTED
Heart Disease/Heart attack or sudden death before age 50				
Diabetes				
Seizures				
Kidney Disease				
Liver Disease				
Mental illness/Depression				
Developmental Disability				
Congenital Syndromes				
Asthma				
Alcohol/Drug Abuse/Tobacco				
Immune Problems				
Cancer				
Additional family history: Describe:				

IMMUNIZATION HISTORY

**PLEASE ATTACH OR PROVIDE A COPY OF ALL IMMUNIZATIONS THAT YOUR CHILD HAS RECEIVED
THIS IS IMPORTANT TO ASSURE THAT YOUR CHILD IS UP TO DATE ON IMMUNIZATIONS AS VACCINE RECOMMENDATIONS AND SCHEDULES MAY CHANGE

_____ My child is up to date on immunizations Signed by parent/patient if 18 y.o or above _____

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MEDICAL AUTHORIZATION/ CONSENT TO TREAT

Date: _____
(valid for 1 year from date signed)

Consent from Parents or Guardians for Authorized Persons:

As the parent or guardian of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and/or care.

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

_____**Initials** I am granting full consent, meaning the below listed person(s) will be allowed to agree to treatments/vaccines, and know all health history pertaining to my child.

_____**Initials** I am granting partial consent, meaning the below listed person(s) is only allowed to bring my child in, and can agree to treatments/vaccines but is not allowed to access any medical information/health history pertaining to my child.

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

Consent to Leave Voicemail

_____ **Initials** I am granting consent to Arbor Medical Partners to leave phone messages regarding my child's medical health to the number(s) provided on the registration form.

_____

Parent/Guardian Signature Date

_____

Witness Signature Date

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Notice of Privacy Practices, HIE (Health Information Exchange) Acknowledgments

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices and HIE (Health Information Exchange)* containing a more complete description of the uses and disclosures of my PHI. 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 to obtain a current copy of the *Notice of Privacy Practices and/or HIE*.

Patient Name _____

Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

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FINANCIAL POLICY 2020

Thank you for choosing Arbor Medical Partners, for the care of your child. This Financial Policy is an important part of your child's care. Due to increased insurance company demands, we ask you to read and agree to the following Arbor Medical Partners provisions:

Private Pay Patients: If you have no insurance coverage, full payment is expected at the time of service.

Insurance: As a courtesy, Arbor Medical Partners will file your claim to your insurance company; however, at the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover), and money orders. Payments are also accepted through our patient portal. We advise you to contact your insurance company in advance to verify coverage for specific benefits such as well checks, immunizations, behavioral visits, and lab services.

** **We make every attempt to keep our non-participating insurance plans list up to date however due to continuous changing insurance plans and networks they utilize we HIGHLY recommend that you check with your specific insurance plan to verify that our providers are showing as participating as we cannot guarantee coverage or be held responsible for any balances incurred if we later find out that we are not contracted with your insurance plan.**
Any Patient responsibility will be billed to the guarantor on file.

Fee Schedules: Our prices are dictated by our insurance contracts. It is a violation of our contractual agreements with your insurance plans to discount or waive charges for coverage, etc.

Payment Options: By signing the Credit Card Authorization Form, you understand that as soon as your EOB (Explanation of Benefits) is received by our office from your insurance plan, an email will be sent with a notice that your credit card will be charged for the balance due on your account, per your insurance contract. In the event you opt not to sign the Credit Card Authorization Form and your balance is not paid within 14 days, you will incur a $25.00 service fee for each statement that we generate that shows a balance on your account.

Statements: Statements are generated to your portal account. If you do not have a portal account, your statement will be mailed to the address that we have on file for you. For your convenience and for

ease of processing, we would prefer that you utilize our credit card processing service, where online payments can be made through our new and expanded portal, or our website.

Refunds: Any patient accounts showing credit balances will be thoroughly researched to analyze if credit is accurate and the billing department will determine if the credit is owed to the patient or the insurance company. The credit balance report is reviewed as frequently as possible and as refund checks are requested. Once determined who credit is owed to, please allow 6 weeks for credit or refund check to be issued.

Outside Collections: If your balance has not been paid to Arbor Medical Partners within 120 days, your account will be turned over to our outside collection agency. Thereafter, within 30 days, if your balance has not been paid, dismissal from Arbor Medical Partners will occur.

Laboratory Fees: You will receive a separate laboratory fee for their services. Any lab services that are not covered by your insurance will be your responsibility.

Address and insurance changes: Please let us know if your address, phone numbers, insurance, etc., change, so that your information is always current and accurate in your child's records. This can also be updated through our Patient Portal.

Authorization for medical treatment of a minor: Patients under the age of 18 (minors) must be accompanied by a parent/legal guardian unless prior arrangements have been made. If the accompanying adult is not the parent/guardian, we will require a "Consent to Treat Form" be filled out. The person bringing in the child for medical treatment will be held responsible for payment at the time services are performed.

Divorce/Custody: We cannot and will not become involved with parental billing disputes in divorce and/or custody cases. Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at time of service. Arbor Medical Partners **DOES** require documentation from the court for all legal matters that relate to your child's care; i.e., custody, medical decisions, medical record access, etc.

Cancellations/No Shows: If you cancel your appointment with less than a 24-hour notice or do not show for the appointment, a $50 fee will be charged to your account.

Coordination Of Benefits: Often times insurance companies will require proof of other insurance or the lack thereof. In this instance, it is the responsibility of the patient to make sure the insurance company receives this in a timely manner so that claims for Arbor Medical Partners are paid promptly and not delayed due to failure to comply with COB requests. Responsible party will be given 30 days from notice from insurance that COB needs to be updated. Failure to comply will result in charges from Arbor Medical Partners becoming patients responsibility and or being discharged from the division of Arbor Medical Partners.

AHCCCS Recipients - Please note that failure to disclose your AHCCCS eligibility will result in your financial responsibility for services rendered at this office.

I have read and understand Arbor Medical Partners Policy and agree by its terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by Arbor Medical Partners. I understand that my insurance is an arrangement between myself and my insurance company, and that it is my responsibility to understand my benefits.

Patient Name & Date of Birth: _____

Parent/Guardian (Please Print): _____

Your Signature: _____ Date: _____

Vaccines for Children (VFC) Program
Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name :_____
   Last Name First Name MI

2. Child's Date of Birth: __ __/__ __/__ __ __ __

3. Parent/Guardian/Individual of Record:_____
   Last Name First Name MI

4. Primary Provider's Name:_____
   Last Name First Name MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in KidsCare

Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.

** *Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

***Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*

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 the Vaccines for Children Program retroactive and you are only eligible for the 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.

Please sign below indicating that you understand and agree with the above statement.

Signature:_____ **Date:**_____