SOUTHWESTERN PEDIATRICS

Last Name: ____________________ First Name: ____________________ Middle: ______________
Date of Birth: __________ Gender M F Primary Phone#: ___________ Pharmacy: __________

Primary language spoken in home: __________ Race: ________ Ethnicity: __________________

Address: ____________________________City: ______________State: _____Zip:____________

Mailing Address: ____________________City:_______________ State:____Zip:____________

____

Mothers Name: _______________________ Date of Birth: _____________ Lives with child: ____

Address: ____________________________ City: ______________ State: ________ Zip: _______

Phone#: ________________ Email: ____

Fathers Name: _______________________ Date of Birth: _____________ Lives with child: ____

Address: ____________________________ City: ______________ State: ________ Zip: _______

Phone#: ________________ Email: ____

Emergency Contact________________________ Phone#: ______________________________

INSURANCE INFORMATION

Insurance Company: ________________________________ Effective Date: _________________

Member ID: ______________________________ Group: ___________________________________

Policy Holder: ____________________________ Policy Holder's Date of Birth: _______________

Social Security #: _________________________

Do you have secondary Insurance? Yes No

Insurance Company: ________________________________ Effective Date: _________________

Member ID: ______________________________ Group: ___________________________________

Policy Holder: ____________________________ Policy Holder's Date of Birth: _______________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also give my permission for Southwestern Pediatrics to download and maintain my electronic prescription history for my medical treatment.

Signature: _________________________________ Date: _______________________________

SOUTHWESTERN PEDIATRICS

BIRTH & DEVELOPMENT

Birth wt:___ Full term/Premature @ ___ wks, Vaginal or C-Section, Condition at Birth: _______ Prenatal Care: Yes / No

Any Problems with: (please circle all that apply) Growth / Development / Speech / Behavior / School

Any allergies to Medications? Reaction: ____________________

Current medications taken on a regular basis & dose: ____________________

SOCIAL HISTORY

Parents marital status: Married / Separated / Divorced / Single Parent

If divorced, who has legal custody? ____________________

Who lives at home with the child? ____________________

Smokers in Home? Yes / No Who? ________________ Pets in Home? Yes / NO Kind of Pets? ______________

MEDICAL HISTORY

Has this child ever been hospitalized?	Age at incident & YR	Hospital Name/ Location	Reason for Hospitalization
	________	________	________
	________	________	________
	________	________	________

Has this child ever had any surgeries? On what & at what age? ____________________

FAMILY HISTORY (circle if any family member suffers from the following, and who: Example Diabetes- Maternal Gma)

Allergies	Diabetes	Lung Disease	Anemia
Anemia	Eczema	Learning Disabilities	Arthritis
Heart Attack	Mental Illness	Asthma	High Blood Pressure
Seizures	Birth Defects	High Cholesterol	Strokes
Bleeding Problems	Intestinal Disease	Thyroid Disease	Blood Disorders
Kidney Disease	Cancer	Liver Disease	Other ____________
Other ____________			

ILLNESS (Circle if your child has suffered from any of the following)

Allergies	Serious Burns	Lung Problems
Anemia	Chicken Pox	Poisoning
Bedwetting	Fractures	Skin problems
Bladder Infection	Frequent Ear Infections	Other ____________
Bowel Problems	Heart Problems	Other ____________

Person completing this form / Relationship: ____________________

Patient's sibling name(s) & age(s): ____________________

____

Patient Name: ____________________ **Date of Birth:** ____________________

Southwestern Pediatrics

Medical Records Release

Patient Name ______________________________ *Date of Birth* ________________

Phone number ______________________________ *Work/Msg#* ________________________

Address ____

Parent/Guardian Name & Relationship ______________________________________

I authorize the release of photocopies of the following medical records and/or x-ray films/reports to the possession or control of Southwestern Pediatrics, its employees and/or agents of the purpose here of "Medical record" and "X-ray films" shall include ALL confidential "HIV related" information as defined in A.R.S. section 36-661, confidential "Alcohol or Drug Abuse" related information as defined in 42-CFR section 21 ET SEQ, confidential communicable disease related information as defined in A.R.S. section 36-3661 and confidential mental diagnosis and treatment information.

MEDICAL RECORDS TO INCLUDE:

ACCUTE ILLNESS SUMMARY
IMMUNIZATION RECORDS
GRAPHIC GROWTH CHART
WELL VISIT EVALUATION SHEET/FORMS
HOSPITAL SISCHARGE SUMMARIES (if applicable)

This consent will expire 120 days after the signed date below. I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization at any time, providing that notify Southwestern Pediatrics in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

I hereby authorize:

Dr. / Facility ________________________ *Phone:* ________________________________

Fax: ________________ *Address:* ____

City: ____________________ *State:* ______________ *Zip code:* ____________________

To send /release photocopies of medical records concerning the above named patient to:

Southwestern Pediatrics
21300 N. JohnWayne Pkwy #112
Maricopa, AZ 85139
Ph: 520-568-9500 Fax: 520-568-9533

*Printed Name:*________________ *Signature:*________________ *Date:* ________________

Southwestern Pediatrics

21300 N. JohnWayne Pkwy #112
Maricopa, AZ 85139
Phone: (520) 568-9500 Fax: (520) 568-9533

Authorization for Release of medical Information

Patient's Name ________________________________ *Date of Birth* ______________

Address ____

City/State/Zip code ____

Patient's Phone # ______________________

Parent/Guardian Name: ____________________________________

I hereby authorize Southwestern Pediatrics to release photocopies of Medical Records concerning the above named patient to:

____

____

____

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession of control of Southwestern Pediatrics its employees, and/or agents. If further information is required we will be happy to provide to you the records at a nominal charge of $10 base fee and 25 cents for each page. When we are required to produce the chart for a second time, a $10 retrieval fee is required in addition to the above requirements. If you have personal records that you wish us to put in your child's chart, please make sure to retain a copy for your records. This consent will expire 120 days after the signed date below. I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization at any time, providing that I notify Southwestern Pediatrics in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my child's rights to confidentiality. I understand that photocopy of this authorization is considered acceptable in lieu of the original.

I understand that Southwestern Pediatrics DOES NOT release copies of records received form other Health Care Providers.

Parent/Legal Guardian ________________________________ *Date* ____________

Relationship to patient ____

Southwestern Pediatrics

ADVANCED WRITTEN CONSENT FOR FUTURE VISITS

Patient Name: ______________________________

Date of Birth: ______________________________

Printed Name of Parent/Guardian giving consent and relationship to child:

____

Name of Person(s) receiving consent and relationship to the child:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

I hereby state I am the natural parent, legal guardian, or have legal custody of the above named minor and that I am authorized to consent to medical services on the minor's behalf. I hereby authorize Southwestern Pediatrics

All necessary or routine medical services

I hereby acknowledge that I understand and have had fully described to me the nature and risk/benefits of and alternatives to the above described proposed medical service(s) and have had all my questions regarding these service(s) answered to my satisfaction.

Parent/Guardian Signature: ______________________________ *Date:* ____________

Witness Signature: ______________________________

<u>SOUTHWESTERN PEDIATRICS</u>

INSURANCE / FINANCIAL POLICY PATIENT AGREEMENT

As a courtesy to our patients, we will file insurance claims for those insurances with which we participate. The agreement of the insurance carrier to pay for medical care is a contract between you and your insurance company. Any amount not covered by your insurance company is your financial responsibility. This includes co-payment, coinsurance and deductibles. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. It is your responsibility to notify our office when either your insurance plan or benefits change. All insurance contracts require us to collect deductibles, coinsurance and co-pay amounts at the time of service.

*** IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS***

PAYMENT

Payment will be requested at the time of service for all services which are non-covered or determined to be patient's responsibility, including co-payments, co-insurance and deductibles. (This is the policy of your insurance company)

We will kindly reschedule your appointment if you are unable to provide payment of co-pays, co-insurance, and deductibles.

Payment for past due balances for previous services rendered is also expected when you are seen in this office. We will be happy to set up a payment plan for you.
Delinquent accounts over 60 days will be sent to collections for processing. At which point all collection fees, contingent or not, shall be added to the patient's responsibility. In the event legal action is required, the patient shall be responsible attorney's fees and cost. Please remember we will be happy to set up a payment plan for you.

APPOINTMENT POLICY

Southwestern Pediatrics strives to provide the best possible care and provide availability to each of our patients. Our policy is to charge $30.00 for each missed appointment unless it is cancelled at least 24 hours in advance. Please help us to respect and better serve each patient in our office practice by making every effort to keep each oy your scheduled appointments and by calling as early as possible when you must cancel or postpone an appointment.

I hereby authorize Southwestern Pediatrics to release information required by my insurance company for payment of my medical bills or to review activities related to my healthcare provider's participation in my health plan. I assign Southwestern Pediatrics any and all benefits to which is entitled for medical services rendered.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND I AGREE TO ABIDE BY ITS TERMS.

PRINTED NAME: ________________________________ ***DATE:*** ______________________________
SIGNATURE: __________________________________ ***WITNESS:*** ____________________________

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:**__________________

Privacy Practices Acknowledgement

I have received the NOTICE OF PRIVACY PRACTICES and I have been provided the opportunity to review it.

Patient Name: ______________________________ *Date:* ______________

Parent/Guardian Printed Name: ______________________________

Parent/Guardian Signature: ______________________________ *Date:* ______________

Active AHCCCS Members Only

If you are a member of any AHCCCS plan, you must notify us of any and all insurance coverage you may carry. *We realize that insurance coverage can change frequently. This policy is intended to insure that we provide the most accurate billing information to your insurance plan(s).*

I certify that as of the date of my signature below ***I do NOT have insurance coverage of any kind*** *other than AHCCCS.*

Patient Name ______________________________ *Date of Birth* ______________

______________________________ ______________

Signature of AHCCCS Plan Member (Guardian) *Date*