Southwestern Pediatrics & Family Care

Last Name: _____ First Name: _____ Date of Birth: _____

Gender: Male / Female Social Security #: _____

Race: _____ Ethnicity: _____ Pharmacy: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Please provide us with your email address: _____

Mothers Name: _____ Date of Birth: _____ Lives w/Child: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Work #: _____

Fathers Name: _____ Date of Birth: _____ Lives w/Child: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Work #: _____

Emergency Contact_____ Phone#: _____

INSURANCE INFORMATION

Insurance Company: _____ Effective Date: _____

Member ID: _____ Group: _____

Policy Holder: _____ Policy Holder's Date of Birth: _____

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 & Family Care to download and maintain my electronic prescription history for my medical treatment.

Signature: _____ Date: _____

Southwestern Pediatrics & Family Care

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 the home with the child? _____
Smokers in the Home? Yes / No Who? _____ Pets in Home? Yes / No Kind of Pets? _____

MEDICAL HISTORY

Has this child ever been hospitalized? Yes / No

Age at incident & YR	Hospital Name / Location	Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has this child ever had any surgeries? On what and at what age? _____

FAMILY HISTORY (circle if any family member suffers from the following, and who:

Allergies	Diabetes	Lung Diseuse	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 _____	

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

Allergies	Serious Burns	Lung Problems	Anemia	Chicken Pox
Poisoning	Bedwetting	Fractures	Skin Problem	Bladder Infections
Frequent Ear Infections	Bowel Problems	Heart Problems	Other _____	

Person completing this form / Relationship: _____

Patient's sibling name(s) and age(s):

_____

_____

Patient Name: _____ Date of Birth: _____

Southwestern Pediatrics & Family Care

Medical Records Release

Patient Name _____ Date of Birth _____

Phone Number _____ Work Number _____

Address _____

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 & Family Care, 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 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 DISCHARGE 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 I notify Southwestern Pediatrics & Family Care in writing to that effect. I understand that any release which was made prior to 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:* _____

Please send/release photocopies of medical records to:

SOUTHWESTERN PEDIATRICS & FAMILY CARE
21300 N. John Wayne Pkwy #112
Maricopa, AZ 85139
Ph: 520-568-9500 Fax: 520-568-9533

Signature: _____ **Date:** _____

Revised 05/20/22

Southwestern Pediatrics & Family Care

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 & Family Care 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,*** *and/or for established patients that have* ***three "no-show"*** *appointments, that patient and any person who is either a guarantor for, or guarantee of, the account in question may be* ***discharged*** *from the practice and asked to seek healthcare with another physician. Patients seeking to establish care with us who fail to cancel or reschedule their initial appointment at least 24 hours prior to the scheduled appointment are also considered to be "no-shows". The second instance of failing to keep their initial appointment as scheduled will result in denial of entry to the practice.*

I hereby authorize Southwestern Pediatrics & Family Care 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 & Family Care 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:*** _____

Revised 05/20/22

Southwestern Pediatrics & Family Care

21300 N. John Wayne 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 & Family Care to release photocopies of my 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 & Family Care 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 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 & Family Care 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 photocopy of this authorization is considered acceptable in lieu of the original.

I understand that Southwestern Pediatrics & Family Care DOES NOT release copies of records received from other than Health Care Providers.

Signature: _____ Date: _____

Revised 05/20/22

Southwestern Pediatrics & Family Care
Privacy Practices Acknowledgement

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

Patient Name: _____ Date: _____

Signature: _____ Date: _____

Active AHCCCS Members Only

If you are a member of any AHCCCS plan, you must notify us of all insurance coverage you may carry. We realize that insurance coverage can change frequently. This policy is intended to ensure 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

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-E is marked, the child is eligible for the VFC program. If column 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	**Enrolled in Kids Care	***Other underinsured	Has health insurance that covers vaccines

*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.

**Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are eligible for VFC vaccines but will need to be billed to AHCCCS as KidsCare.

***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.

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:**_____

updated 10/05/2018