



**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: \_\_\_\_\_ RELATIIONSHIP 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.

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Signature of Guarantor/Responsible Party

Date



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**Arbor Medical Practices**

**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 (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* 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*.

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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**18+ years CONSENT TO SHARE HEALTH INFORMATION WITH PARENTS**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's Phone Number \_\_\_\_\_

I understand that by law, 18 year-olds are adults. As adults, they have the right to keep health records confidential (regardless of who pays for their insurance or whether they live at home).

Providers at Arbor Medical Partners believe parents should be partners in their children's care at every age. However, it is up to the patient to whom he/she gives permission to share privileged information. Therefore, we ask all our patients over the age of 18 to consent as follows (*PLEASE CHOOSE ONE*):

I DO NOT give permission to the healthcare providers at Arbor Medical Partners to Speak with my parent(s)/legal guardian(s) at any time regarding all healthcare conditions and financial information

OR

I give permission to the healthcare providers at Arbor Medical Partners to Speak with my parent(s)/legal guardian(s) at any time regarding all healthcare conditions and financial information

Consent given to:       Mother \_\_\_\_\_       Father \_\_\_\_\_

Step-Mother \_\_\_\_\_       Step-Father \_\_\_\_\_       Other \_\_\_\_\_

I understand that I may change my mind at a future time and rescind this authorization.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



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## ARBOR MEDICAL PARTNERS

### FINANCIAL POLICY 2019

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. If you have any **"Out of Network Benefits"** with a plan we are not contracted with, we will bill your insurance company as a courtesy. 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, 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.

**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 60 days, if your balance has not been paid, dismissal from Arbor Medical Partners will occur. Any fees incurred from the collection agency may be assessed to your account.

**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.

**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: \_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_