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.

____

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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MEDICAL AUTHORIZATION/ CONSENT TO TREAT

Date: ________________
(valid for 1 calendar year)

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 permissions, 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 permissions, meaning the below listed person(s) is only allowed to bring my child in, and will have access to all health history, but not allowed to agree to treatments without my direct consent.

_____**Initials** I am granting limited permissions, meaning the below listed person(s) is allowed to bring my child in to the office, but is not allowed access to any medical information or treatment of my child. I will be informed of the visit results, and I will be notified prior to any treatment for my child.

Please list person(s) here	Relationship
________________________	________________
________________________	________________
________________________	________________

Consent to Leave Voicemail

__ **Initials** I am granting permission 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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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: ____

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:**______________