Today's Date: ____________________

<table>
<tr><td colspan="4">Patient's Legal Name
FIRST, MIDDLE, LAST</td><td colspan="2">DOB
mm/dd/yyyy</td></tr>
<tr><td colspan="2">Address</td><td>Apt #</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td>Phone #</td><td colspan="5">Phone # for appointment reminder calls</td></tr>
<tr><td colspan="4">Mother or Legal Guardian Name</td><td colspan="2">Mother/LG DOB</td></tr>
<tr><td colspan="2">Single Married Divorced Widowed</td><td colspan="4">Phone #</td></tr>
<tr><td colspan="2">Address</td><td>Apt/Sp #</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td colspan="6">E-Mail Address</td></tr>
<tr><td colspan="2">Employer Name</td><td colspan="4">Employer Phone #</td></tr>
<tr><td colspan="4">Father or Legal Guardian Name</td><td colspan="2">Father's DOB</td></tr>
<tr><td colspan="2">Single Married Divorced Widowed</td><td colspan="4">Phone #</td></tr>
<tr><td colspan="2">Address</td><td>Apt/Sp #</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td colspan="6">E-Mail Address</td></tr>
<tr><td colspan="2">Employer Name</td><td colspan="4">Employer Phone #</td></tr>
</table>

I acknowledge that I have received and/or read a copy of Pediatric Cardiac Care of Arizona Notice of Privacy Practice.

Signature ______________________________ **Date** ____________________

Payment Policy: We will scan your insurance card at your first visit, however, **in order to ensure your insurance is billed accurately, please fill out the information below in full.** While we are happy to file a claim with your insurance company as a courtesy to you, we will not know beforehand what they will pay. It is always a good idea to familiarize yourself with the specifics of your insurance so you are knowledgeable about the services that are covered. **Thank you!**

PRIMARY INSURANCE AHCCCS and Tricare are ALWAYS secondary to any other insurance coverage you may have		
Name of Insurance Co	ID/Policy #	Group/Plan #
Name of Primary Policy Holder	Policy Holders SS#	Policy Holder DOB
Policy Holder Employer		
SECONDARY INSURANCE		
Name of Insurance Co	ID/Policy #	Group/Plan #
Name of Primary Policy Holder	Policy Holders SS#	Policy Holder DOB

INSURANCE AUTHORIZATION I authorize Pediatric Cardiac Care of Arizona to release any medical or other information to the insurance carrier, which may be necessary to process the claims. I authorize my insurance carrier to pay the provider of service. In the event that payment is made to the policyholder, I agree to submit payment to Pediatric Cardiac Care Of Arizona immediately.	
Childs Name (Please Print)	Childs DOB
Parent/Legal Guardian Name (Please Print)	
Relationship to Patient	DOB
Parent/Legal Guardian Signature	Today's Date

April 2016

Pediatric Cardiac Care of Arizona
FINANCIAL POLICY

Welcome to Pediatric Cardiac Care of Arizona and thank you for choosing our practice for your child's cardiac care. We are committed to providing quality medical care for your child. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior beginning treatment.

Forms of Payment

Pediatric Cardiac Care of Arizona accepts cash, checks, debit cards that can be run as a credit card, Visa, Discovery, MasterCard and American Express. Any payment returned from our financial institute will be assessed a $30 fee which must be paid by cash or credit card. No future checks will be accepted.

Insurance

Your insurance policy is a contract between you and your insurance plan.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible, coinsurance, and copay amounts prior to your appointment.

Our insurance contracts require us to **collect deductible, coinsurance, and copays at the time of service** for office visits. The amount collected for deductibles and coinsurance will be based on the allowed amount by your insurance company. Your insurance company may require copays/coinsurance for "testing" visits (i.e. echo, ekg, heart rate monitors and treadmill tests)—in addition to or in lieu of an office visit.

Without your complete insurance information prior to date of service, you will be responsible to pay in full. We participate with most insurance plans; however there are a few we do not participate with. Please check with our administrative staff for up to date information on those plans we are "in network" with.

We will file claims to those plans with which we have a contractual agreement as long as we have valid insurance information **AND** insurance card(s). Please contact your insurance company if you do not agree with their decision. We do not bill third party insurance carrier i.e., auto insurance, school insurance etc.

All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. Any cost incurred by this office because of incorrect information you provided to us will be passed on to you. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage.

Payment for Account Balance

Payment for outstanding balances is due immediately upon receipt of the bill. There will be a late fee of $10 on all past due accounts. If you need to setup a payment plan, please contact our billing department prior to any upcoming appointments. Any outstanding balances (without a payment plan) will be due at the time of the appointment if the balance has not been **received** prior to the appointment.

Appointments

If you are unable to keep a scheduled appointment or if your child is ill, we request that you call at least 24 hours in advance to cancel. If it is after hours, you may leave a message with our answering service.

I have read and agree to abide by the above policy.

Child's Full Legal Name – PLEASE PRINT	Child's Date of Birth
Custodial Parent Name – PLEASE PRINT	**Relationship to patient**
Custodial Parent Name – Signature	**Date**

PEDIATRIC CARDIAC CARE PARENTING POLICY

TODAY'S DATE: ____________________________

We require a custodial parent or guardian be present for each visit for children under 18

We require a valid photo identification card of the custodial parents(s), foster parent, or any adult in which you have submitted a notarized statement indicating they may consent to any and all treatment for that child.

A **valid photo ID** card includes any state issued ID card, a valid state driver's license, military ID card, or a valid passport.

If a custodial parent is not able to be present, we must have a notarized power of attorney or notarized letter on file giving permission for another adult to be present and consent for the care of the minor child.

The parent or authorized adult bringing in the minor child is responsible for any monies owed for copays, deductibles, and coinsurance or denied claims **at the time of the visit**. We will be happy to let you know an **estimated** amount due for the visit at the time you schedule the appointment. Be advised that the amount given is only an estimate. There may be additional fees charged that we are unaware of or insurance does not cover, etc. We are equipped to take these payments over the phone prior to the visit as an option.

It is not the responsibility of the physician and/or staff to communicate visit information to each custodial parent separately.

The providers and office staff of Pediatric Cardiac Care of Arizona will not be put in the middle of domestic issues or disagreements. If we feel this is becoming an issue and compromising the care of the minor child and/or if at any time a family OR non-family member becomes abusive with the staff, we have the right to discharge the family from the care of the practice.

Only in situations where there is a **confirmed, documented Court Order** will one of the parent's be denied access to the minor child's health records or visits at the office. Pediatric Cardiac Care of Arizona **must** have a copy of this Court Order on file in the minor child's electronic chart.

Stepparents, fiancés, girlfriends, boyfriends, or non-legal partners are not considered parents authorized to consent for care without a valid notarized letter signed by both custodial parents.

I have read and agree to abide by the above policy.

Child's Full Legal Name – PLEASE PRINT	**Child's Date of Birth**

Custodial Parent Name- Print	**Custodial Parent Name – Signature**