Today's Date:____________

Patient's Legal Name			DOB		
FIRST, MIDDLE, LAST			mm/dd/yyyy		
Address	Apt #	City		State	Zip Code
Cell Phone #	Secondary Phone #				
Mother or Legal Guardian Name			Mother/LG DOB		
Single Married Divorced Widowed			Cell Phone #		
Address ☐ Same as above	Apt #	City		State	Zip Code
E-Mail Address					
Father or Legal Guardian Name			Father/LG DOB		
Single Married Divorced Widowed			Cell Phone #		
Address ☐ Same as above	Apt #	City		State	Zip Code
E-Mail Address					

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

Signature ______________________________ Date _______________________

I acknowledge that I have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE).

Signature ______________________________ Date________________________

Payment Policy: Please fill out in full even though we scan your card. This gives us permission to bil your insurance. Thank you!

December 2018

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 Holder DOB
Policy Holder Employer		
SECONDARY INSURANCE		
Name of Insurance Co	ID/Policy#	Group/Plan #
Name of Primary Policy Holder		Policy Holder DOB
Policy Holder Employer		

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

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.

We require **deductibles, coinsurance, and copays at the time of service** for office visits.

Without your complete insurance information prior to date of service, you will be responsible to pay in full.

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

If you need to setup a payment plan for an account balance, our front office staff or billing office can assist you. We reserve the right to send balances to an outside collection agency if left unpaid.

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 on our voicemail.

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**

PARENTING AND NO SHOW POLICY

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

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

We require a valid photo identification card of the custodial parents(s), foster parent, or any adult in which you have submitted a signed letter 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.

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.**

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.

No Show Policy

Please call our office as soon as possible if you know you will not make an appointment. We have a voice mailbox that you can also leave messages before and after hours. This gives us time to schedule emergency patients or other individuals on our waiting list.

- Any established patient who fails to show for an appointment without 24 hours' notice will be charged $35. For each scheduled testing time held (i.e. echo) the same fee will apply.
- If there are three no show/cancellations without a prior notice, we reserve the right to dismiss the patient from our practice. We will notify your PCP and provide information for another cardiology practice.

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	Custodial Parent Name - Signature

Patient Information

Name: ________________________________ **Todays Date:** _________________

Date of Birth: ________________________ **Primary Care MD/NP:** ____________________

Reason for evaluation today: ____

____

List of Current Medications: ________________________ ________________________

________________________ ________________________

Pharmacy________________________ **Cross Streets/Phone:** _________________________________

Allergies to Medications: □**Yes** □ **No** (If Yes, please list.) _________________________________
Immunizations up to date? □ **Yes** □ **No** □ **No Vaccinations by choice**

Patients under 1 year old:
Problems During Pregnancy □ **Yes** □ **No** If yes, please explain:_________________________________

How many weeks or months was the pregnancy? ________ **Normal Delivery or C-section** (please circle)

Birth Weight: ________ pounds/kilograms (Please circle)

Diet: Breast milk/Formula (Please circle) **If bottle fed, how many ounces per feeding?** _________________

How often does the baby eat? ________ **How long does it take for each feeding?** _________

Any Difficulty Feeding?: □ **Yes** □ **No** Explain : _________________________ **Solid foods**: □ **Yes** □ **No**

Past Medical History: **(Please use back of sheet if necessary)**
Prior hospitalizations? □ Yes □ No Explain: ____

Prior Surgeries? □ Yes □ No Explain: ____

Chronic Medical Conditions: ____

Social History:
Patient lives with? (Check all that apply)
□ Mother □ Father □ Sister(s) □ Brother(s) □ Grandparents □ Other ________________
Smokers in household?
□ Mother □ Father □ Sister(s) □ Brother(s) □ Grandparents □ Other ________________

Grade: ____________________________ **School:** ______________________________________

Family History:
□ No family history of any of the below
□ Murmurs ______________________________ □ Congenital Heart Defects: _________________________
□ Heart attack before age 50, Who? ___________ □ High Blood Pressure □ High Cholesterol
□ Rheumatic Fever □ Heart rhythm problems □ Long QT Syndrome □ History of fainting
□ Sudden Death □ Diabetes □ Asthma

Other concerning family history not listed above: ____

REVIEW OF SYSTEMS (INFANT)

(Please check if your child has a history of any of the following)

General: □ None □ poor weight gain □ irritability □ fatigue (tiredness) □ paleness □ frequent fevers	**Allergy/Immunology: □ None** □ seasonal or chronic runny nose □ watery eyes □ nasal congestion □ sneezing □ frequent infections	**Endocrine: □ None** □ Abnormal growth □ Thyroid issues □ Excessive weight gain
Respiratory: □ None □ wheezing □ coughing □ shortness of breath □ noisy or fast breathing	**Skin: □ None** □ eczema □ rashes □ jaundice (yellow skin) □ dryness □ hemangiomas/birthmarks □ blue or purple nail beds or lips	**Neurologic: □ None** □ Irritability □ excessive sleeping □ seizures □ weakness □ apnea (stops breathing)
Gastrointestinal: □ None □ coughing/choking/gagging w/eating □ frequent vomiting □ feeding problems □ constipation □ frequent diarrhea/loose stools □ blood in stool	**Ears/Nose/Throat: □ None** □ ear infections □ weak cry □ hearing loss □ nasal drainage/congestion	**Hematologic: □ None** □ anemia □ easy bruising/bleeding □ swollen lymph nodes/glands
Cardiovascular: □ None □ heart murmur □ sweating with feedings □ blue spells □ swelling in hands/feet/face □ abnormally fast heart beats □ syncope (passing out)	**Eyes: □ None** □ lazy eye □ eye redness/drainage □ jaundice (yellow eyes)	**Genitourinary: □ None** □ foul smelling urine □ blood in urine □ frequent infections
Please use this space to list other important symptoms not listed above:		