PEDIATRIC CARDIAC CARE of Arizona

Today's Date:_____

Patient's Legal Name FIRST, MIDDLE, LAST			DOB 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

Today's Date: _____ **Who is with patient today (Mom, Dad, etc)?** _____

Patient Name: _____ **Date of Birth:** _____

Primary Care Doctor/Provider: _____

Please list other specialists the patient sees: _____

Reason for Cardiology evaluation: _____

List of Current Medications: _____

_____

Pharmacy_____**CrossStreet/Phone**_____

Allergies to Medications: □**Yes** □ **No** (If Yes, please list.) _____

Immunizations up to date? □ **Yes** □ **No** □ **No Vaccinations by choice** □ **Other** _____

BIRTH HISTORY: **(Please use back of sheet if necessary)**

Problems During Pregnancy □ **Yes** □ **No** If yes, please explain:_____

Prolonged hospitalization at birth? □**Yes** □ **No** (If Yes, describe)_____

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? (please list even if smoking outside)

□ Mother □ Father □ Sister(s) □ Brother(s) □ Grandparents □ Other _____

Primary Language spoken at home: _____

FAMILY HISTORY: □ **No family history of any of the below**

□ Heart Murmurs □ Heart Problems in Children (CHD) □ Death before age 50 □ Cardiac Issues before age 65

□ High Blood Pressure □ High Cholesterol □ Rheumatic Fever □ Heart rhythm problems □ Long QT Syndrome

□ History of fainting □ Sudden Death □ Pacemaker/Defibrillator □ Diabetes □ Asthma □ Other_____

Details about any answers above: _____

_____

REVIEW OF SYSTEMS (2-4 years)

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

General: □ None □ poor weight gain □ recent weight loss □ frequent fevers □ fatigue (tiredness) □ Appetite change	**Allergy/Immunology: □ None** □ seasonal or chronic runny nose □ watery eyes □ nasal congestion □ sneezing □ frequent infections	**Endocrine: □ None** □ heat or cold intolerance □ excessive urination □ excessive sweating □ diabetes □ excessive thirst/ hunger
Respiratory: □ None □ Asthma symptoms □ coughing □ Wheezing □ Shortness of breath □ Frequent infections/ pneumonia	**Skin: □ None** □ eczema □ rashes □ itching □ dryness □ nailbed changes	**Neurologic: □ None** □ speech problems □ headaches /migraines □ seizures □ weakness □ hyperactivity
Gastrointestinal: □ None □ coughing/choking/gagging w/eating □ frequent vomiting □ constipation □ frequent diarrhea/loose stools □ reflux (heartburn) □ blood in stool	**Ears/Nose/Throat: □ None** □ ear infections □ gums bleeding □ sleep apnea (stopping breathing) □ hearing loss □ sinus trouble/frequent infections	**Musculoskeletal: □ None** □ muscle pain □ limp □ recent trauma/fractures □ joint pain or stiffness □ joint/muscle swelling
Cardiovascular: □ None □ heart murmur □ chest pain □ fainting □ high blood pressure □ swelling in hands/feet/ face □ palpitations (fluttering in heart/fast beats) □ syncope (passing out) □ high cholesterol	**Eyes: □ None** □ glasses/contact lenses/ vision changes □ eye pain □ eye redness □ None	**Genitourinary: □ None** □ pain or burning with urination □ frequent urination □ decreased urination
Hematologic/Lymphatic: □ None □ anemia □ enlarged lymph nodes □ easy bruising/bleeding □ history of cancer/lymphoma/leukemia	**Psychiatric: □ None** □ trouble sleeping □ depression □ nervousness	

Please add any concerning symptoms not listed above:

_____