



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 <input type="checkbox"/> 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 <input type="checkbox"/> 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 bill your insurance. 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 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 MD/DO//NP: _____

Please list other specialists your child 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 _____

Birth Weight: _____ pounds/kilograms (Please circle)

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 _____

Grade: _____ School: _____

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 (Aged 5-9)

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

General: <input type="checkbox"/> None <input type="checkbox"/> Activity change <input type="checkbox"/> Irritability <input type="checkbox"/> trouble sleeping <input type="checkbox"/> fatigue (tiredness) <input type="checkbox"/> paleness	Allergy/Immunology: <input type="checkbox"/> None <input type="checkbox"/> seasonal or chronic runny nose <input type="checkbox"/> watery eyes <input type="checkbox"/> nasal congestion <input type="checkbox"/> sneezing <input type="checkbox"/> frequent infections	Endocrine: <input type="checkbox"/> None <input type="checkbox"/> heat or cold intolerance <input type="checkbox"/> short stature <input type="checkbox"/> excessive sweating <input type="checkbox"/> diabetes <input type="checkbox"/> excessive thirst/ hunger
Respiratory: <input type="checkbox"/> None <input type="checkbox"/> wheezing / coughing <input type="checkbox"/> chest pain <input type="checkbox"/> asthma symptoms <input type="checkbox"/> shortness of breath with exercise <input type="checkbox"/> frequent infections /pneumonia	Skin: <input type="checkbox"/> None <input type="checkbox"/> eczema <input type="checkbox"/> rashes <input type="checkbox"/> itching <input type="checkbox"/> dryness	Neurologic: <input type="checkbox"/> None <input type="checkbox"/> speech problems <input type="checkbox"/> headaches /migraines <input type="checkbox"/> seizures <input type="checkbox"/> weakness <input type="checkbox"/> school problems
Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> abdominal distension / bloating <input type="checkbox"/> frequent vomiting <input type="checkbox"/> constipation <input type="checkbox"/> frequent diarrhea/loose stools <input type="checkbox"/> frequent heartburn/stomach aches <input type="checkbox"/> eating problems	Ears/Nose/Throat: <input type="checkbox"/> None <input type="checkbox"/> ear infections <input type="checkbox"/> gums bleeding <input type="checkbox"/> tooth pain/ frequent cavities <input type="checkbox"/> hearing loss <input type="checkbox"/> sinus trouble/frequent infections <input type="checkbox"/> sleep apnea (stop breathing)	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> scoliosis <input type="checkbox"/> limp <input type="checkbox"/> recent trauma/fractures <input type="checkbox"/> joint pain or stiffness <input type="checkbox"/> joint/muscle swelling
Cardiovascular: <input type="checkbox"/> None <input type="checkbox"/> heart murmur <input type="checkbox"/> chest pain <input type="checkbox"/> pale spells <input type="checkbox"/> high blood pressure <input type="checkbox"/> excessive sweating/ cool extremities <input type="checkbox"/> palpitations (fluttering in heart/fast beats) <input type="checkbox"/> syncope (fainting) <input type="checkbox"/> high cholesterol	Eyes: <input type="checkbox"/> None <input type="checkbox"/> glasses/contact lenses/ vision changes <input type="checkbox"/> eye pain <input type="checkbox"/> eye redness	Genitourinary: <input type="checkbox"/> None <input type="checkbox"/> pain or burning with urination <input type="checkbox"/> Early menstruation
Hematologic/Lymphatic: <input type="checkbox"/> None <input type="checkbox"/> anemia <input type="checkbox"/> enlarged lymph nodes <input type="checkbox"/> easy bruising/bleeding <input type="checkbox"/> history of cancer/lymphoma/leukemia	Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> sleep disturbance <input type="checkbox"/> temper outbursts	Other important symptoms not listed above: