PEDIATRIC CARDIAC CARE of Arizona

Fetal Visit Registration Form

Today's Date: _____

Patient's **Legal** Name FIRST, MIDDLE, LAST				DOB mm/dd/yyyy
Address	Apt #	City	State	Zip Code
Phone #	Phone # for appointment reminder calls			
E-Mail Address				
Employer Name	Employer Phone #			
Name of Emergency Contact				
Phone Number	Relationship to Patient			

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_____

PEDIATRIC CARDIAC CARE of Arizona

In order to bill your insurance(s) company you must supply your insurance card(s) or a print out from your insurance company that contains all pertinent billing information.

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	By checking this box I acknowledge that I fully understand my insurance benefits and my financial responsibility for copays, coinsurance & deductibles	
SECONDARY INSURANCE		
Name of Insurance Co	ID/Policy #	Group/Plan #
Name of Primary Policy Holder	Policy Holders SS#	Policy Holder DOB
Policy Holders Employer	By checking this box I acknowledge that I fully understand my insurance benefits and my financial responsibility for copays, coinsurance & deductibles	

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.

Patient Name (Please Print)	Patient DOB
Patient Signature	Today's Date

Pediatric Cardiac Care of Arizona
FINANCIAL POLICY

Welcome to Pediatric Cardiac Care of Arizona and thank you for choosing 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.

Please provide a copy of your ID and insurance card at the first appointment. A **valid photo ID** card includes any state issued ID card, a valid state driver's license, military ID card, or a valid passport.

Forms of Payment

Pediatric Cardiac Care of Arizona accepts cash, checks, debit cards that can be run as a credit card, Discovery, Visa, 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.

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 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.

Print Name _____

Signature _____ **Date** _____

Fetal Cardiology Evaluation/Follow Up

Patient Name _____ DOB: _____

Primary OB: _____ Referring Dr: _____

Last menstrual period _____ Due Date: _____

Delivery Hospital: _____

Reason for fetal echo today:

_____

Does this baby have any anomalies detected? _____

Do you have any medical conditions? Please explain

_____

Do you have any of the following?

Connective Tissue Disorder	Y	N
Diabetes	Y	N
Congenital heart disease	Y	N

Are you taking medication during this pregnancy? _____ If yes, please list: _____

_____

How many other pregnancies have you had? _____

Were there any complications? If yes, please explain

_____

Is there any family history of any of the following?

Congenital Heart Disease	Y	N
Long QT	Y	N
Birth Defects or syndromes (if yes please explain below)	Y	N

_____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Signature _____ Date _____