Date:_____

22 E. Mitchell Dr. • Phoenix, AZ 85012
Phone: 602-277-5731 • Fax: 602-277-5995

Patient Information Form

Thank you for choosing Arizona Pediatrics for your child's medical care.
Please take a few minutes to fill out the front and back of this information form completely.

PATIENT INFORMATION

Patients Name:_____ Date of Birth_____

Social Security Number:_____ Gender: Male_____ Female_____ Age_____

Patient lives with: Mother_____ Father_____ Both _____Other_____

Address:_____
(apt#) (City) (State) (Zip Code)

Home Phone:_____ Other Phone:_____

PARENT'S INFORMATION

Mother's Name:_____ **Father's Name:**_____

Social Security Number:_____ Date of Birth:_____ Social Security Number:_____ Date of Birth:_____

Address:_____ Address:_____

_____ _____

Employer Name_____ Employer Name_____

Address:_____ Address:_____

_____ _____

Phone:_____ Phone:_____

EMERGENCY CONTACT

Name_____ Phone:_(_____)_____

Address_____ Relationship:_____

INSURANCE INFORMATION

Primary Insurance Name:_____ Secondary Insurance Name:_____

Address:_____ Address:_____

Phone:_____ Phone:_____

Policy Holder:_____ Policy Holder:_____

Policy Holder Date of Birth:_____

Relationship to patient:_____

Policy #:_____

Group #:_____

Policy Holder Date of Birth:_____

Relationship to patient:_____

Policy #:_____

Group #:_____

AGREEMENT TO PAY FOR TREATMENT AND RELEASE OF INFORMATION

I hereby authorize direct payment to be made to Arizona Pediatrics. I understand that Arizona Pediatrics will file an insurance claim on my behalf as a courtesy, nevertheless. I am financially responsible for any charge or service not covered by my insurance company. By signing below I certify that all data provided is accurate including insurance information.

_____ _____

Signature of Parent/Legal Guardian Date

I authorize the release of medical information necessary to process insurance claims

_____ _____

Signature of Parent/Legal Guardian Date

WE ARE REQUIRED BY LAW TO HAVE A COPY OF YOUR INSURANCE CARD

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CONTINUING CONSENT TO MEDICAL TREATMENT

Patient Name:_____ Date of Birth:_____

I, _____ am the natural parent or Legal Guardian with
(parent name)

legal custody of _____. I authorize the individuals listed below to
(patient name)

consent to medical treatment for my minor child when I personally cannot be present. This includes consent for medical examination, laboratory tests, and treatment necessary.

I permit any licensed physician from Arizona Pediatrics to render care for my child.

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

Emergency contact number for parent/guardian:_____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Date

Practice Limited to infants, children, and adolescents

ARIZONA pediatrics

Consent To Treatment

Date_____

Patient Name_____

Date of Birth_____

By signing below, I give Arizona Pediatrics permission to treat my child.

☐ I understand that my child **does not** have insurance coverage and I will be financially responsible for all charges incurred for today's visit. I also understand that if my child's account is sent to a collection agency then all collection fees and/or legal fees will also be my responsibility.

☐ I understand that although my child **does** have insurance coverage, I am financially responsible for any charges or service not covered by my insurance company. I also understand that if my child's account is sent to a collection agency then all collection fees and/or legal fees will also be my responsibility.

Note: Certain laboratory tests can be performed in our office if necessary. There are additional charges for the specific tests which must be paid after the same day office visit. However, certain laboratory tests may need to be performed at an established laboratory site. In that case you will receive a separate bill from the established laboratory and you will be responsible for those charges.

_____ _____

(parent/guardian signature) (date)

Patient Eligibility Screening Record
Vaccines for Children Program

This record must be kept in the healthcare provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the VFC program. The record may be completed by the parent, guardian, individual of record, or by the healthcare provider. This same record may be used for all subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of responses is not required, but it is necessary to retain this record on file for a minimum of three years.

Please print or type:

Date: _____

Child: _____
Last Name First Name M.I.

Date of Birth: _____

Parent/Guardian/ Individual of Record: _____

Provider: _____

This child qualifies for vaccination through the VFC program because he or she (check only one box):

(0) [ ] is enrolled in KidsCare; or

(1) [ ] is enrolled in AHCCCS; or

(2) [ ] does not have health insurance; or

(3) [ ] is American Indian or Alaskan Native **(no matter what the insurance situation is)**; or

(4) [ ] has health insurance that does not pay for vaccines.

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(5) [ ] **Check here if this child has health insurance that pays for vaccines. This child does not qualify for VFC.**

Please be advised: If your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We cannot make the Vaccines for Children Program retroactive and you are only eligible for the Vaccines for Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company.

Thank You.

Signature: _____ **Date:** _____

ARIZONA pediatrics

Wendy Rocha Saucedo, MD
Paul Antseliovich, MD
Patrick Arambula, MD

22 E. Mitchell Dr. • Phoenix, AZ 85012
Phone: 602-277-5731 • Fax: 602-277-5995

Authorization to Release Records

Patient Name_____ Date of Birth_____

To_____
(physician's name/practice name)

_____
Address

_____
City State Zip Code

I hereby authorize the above named medical facility/Doctor to send/fax/release photocopies of medical records concerning the named patient to:

_____
(Name of company or person(s) to receive records)

_____
Address

_____
City State Zip Code

I authorize the release of medical records. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ) , AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

Medical Records (Check One)

( ) All medical records
( ) The following described records ONLY (specify types and dates) _____

_____

_____ _____
(Signature of Parent/Legally Authorized Representative) Date

_____ _____
Signature of Arizona Pediatrics Representative Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how your child's health information may be used and disclosed and how you can get access to this information. **Please review it carefully and sign below**

Arizona Pediatrics understands that medical health information about your child is private and personal. We are committed to protecting it. Protected health information, about your child, is obtained as a record of your child's visits for healthcare services with Arizona Pediatrics. Specifically, "Protected health information" is information about your child, including demographic information (name, address, phone, etc) that may identify your child and relates to their past, present, or future physical or mental health condition and related health care services.

Arizona Pediatrics is required by law to:

- keep medical information about your child private,
- give you this notice describing our legal duties and privacy practices for medical information about your child
- follow the terms of the notice that is currently in effect

HOW WE MAY USE AND DISCLOSE YOUR CHILD'S PROTECTED HEALTH INFORMATION

Following are examples of use and disclosures of your child's protected health care information that our office is permitted to make. You have the opportunity to agree or object to use or disclosure of all or part of your child's protected health information.

Examples:

For Treatment- We may use and disclose your child's protected health information for purposes of treatment. An example is sending medical information about your child to a specialist as part of a referral or to a pharmacy that would fill your prescription.

We may also call your child by name in the waiting room when your physician is ready to see you. We may use or disclose your child's protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information about treatment alternatives regarding your child's care. We may contact you to provide information about health related benefits and services offered by our office.

For Payment- We may use and disclose your child's protected health information to obtain payment for our health care services. An example, is giving information about your child to your health insurance plan.

For Healthcare Operations- We may use and disclose your child's protected health information in order to support the business activities of our practice. This includes business quality assessment and improvements, medical review, education, and insurance related activities.

To Family Members or others involved in your healthcare- We may use and disclose your child's protected health information to a member of your family, a relative, close friend or any other person **you identify** that is directly involved in your child's health care. Only the protected health information that is relevant to your child's health care will be disclosed.

As required by Law- We may use and disclose your child's protected health information to the extent that the use and disclosure is required by law. For example, we must report child abuse and/or neglect. In addition, we use and disclose your child's protected health information if we believe that your child has been a victim of abuse, neglect, or domestic violence to the government entity or agency authorized to receive such information.

For Public Health- We may use and disclose your child's protected health information for public health purposes. This includes reporting communicable diseases to a public health authority that is permitted by law to collect or receive this information. We may disclose your child's protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Public Safety- We may disclose your child's protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or public. We may also disclose protected health information if necessary for law enforcement authorities to identify or apprehend an individual.

To Law Enforcement- We may disclose your child's protected health information for law enforcement purposes.

To the Food and Drug Administration- We may disclose your child's protected health information to the FDA to report adverse events and product defects or problems to enable product recalls and replacements.

For Health Oversight Activities- We may disclose your child's protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections.

To Coroners, Medical Examiners, Funeral Directors and Organ and Tissue Donation- We may disclose your child's protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.