



**PAPAGO BUTTES
PEDIATRICS**

A Division of Arbor Medical Partners

Phone: (480) 778-1732 Fax: (480) 778-1709

Email: records@papagopedcs.com

Phone: (480) 778-1732 Fax: (480) 778-1709

www.arbormedicalpartners.com

CONSENT FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

RELEASE MEDICAL INFORMATION TO: **Please note, all medical records come by disk, if you require another form please inform the office ASAP**

(Name of practice/physician/parent) (Address)

(Phone Number) (Fax Number)

Reason for request: (Please check one)

Changing providers _____, Reason _____ Moving _____ Parent/Patient Copy _____
Insurance change _____ Legal _____ Other _____, Reason _____

Information to be released:

- _____ All health information (\$25 per chart / \$45 if coming from storage)
- _____ All health information related to the following condition: _____
- _____ All health information for the following dates: From: ___/___/___ To: ___/___/___
- _____ Billing records for the following dates: From: ___/___/___ To: ___/___/___
- _____ Other information (please be specific): _____

RELEASE MEDICAL INFORMATION FROM:

**Papago Buttes Pediatric Center, P.C.
8573 E San Alberto, Suite E-100
Scottsdale, AZ 85258**

By signing this consent form, I authorize Papago Buttes Pediatric Center, P.C. to release protected health information regarding my child/children (listed above) in the form specifically noted. I authorize this information to be released to the party specifically listed above. I understand you will only be able to release protected health information generated by your office.

Patient/Authorized Adult Signature Date

Printed Name Relationship (if signing on behalf of the patient)



PAPAGO BUTTES
PEDIATRICS

A Division of Arbor Medical Partners

SERGIO SOTELO, MD, FAAP
SCOTT A. CANNON, MD, FAAP
RICHARD H. REZNICK, MD, FAAP
KELSEY E. CHELEMIEWSKI, MD, FAAP
BRITTANY WILSON, PA-C

WELCOME TO OUR OFFICE

NEW PATIENT HEALTH INFORMATION

(Please complete this form prior to your visit with our doctors.)

DATE: _____

1. Patient's Name: _____
2. Hospital / Place of Birth: _____
3. Mother's year of birth: _____ Father's year of birth _____
4. Age and Sex of Patient's Siblings: _____
5. Do you smoke? Mother (Y) (N) Father (Y) (N)
6. Family history of illness *(please indicate which family member(s))*:
 - Asthma / Hayfever / Allergy:
 - Diabetes:
 - Epilepsy (Seizures) and/or Neurologic Disorder:
 - High Blood Pressure:
 - Coronary Artery Disease *(55 years and under)*/Strokes:
 - Elevated Cholesterol:
 - Thyroid Disease:
 - Kidney Disease:
 - Blood Disorders:
 - Stomach or Intestinal Disease:
 - Others: _____
7. Duration of pregnancy: Full term _____ Premature _____
8. Type of delivery: Vaginal _____ Caesarian Section _____
9. Birth weight: _____ Birth length: _____
10. Child's blood type *(if known)*: A _____ B _____ AB _____ O _____; Rh: pos _____ / neg _____
11. Apgar Score *(if known)*: _____
12. Problems in the newborn period *(jaundice, respiratory distress, sepsis)*: _____
13. Did you breast (B) or formula (F) feed this child? B _____ F _____
- 13a. If you breast fed – how long did you breast-feed this child? _____

14. Has this child had any surgeries and/or hospitalizations? Y ___ N ___
(if so, what type surgery and/or hospitalization and when):

14a. Does this child have any chronic (recurrent) illnesses? Y ___ N ___
(if so, what type of illness):

15. Does this child have any known food and/or drug allergies? Y ___ N ___
(if yes, to what - describe reaction)

16. Does this child regularly take any medications? Y ___ N ___
(if so, please list medication and dosage)

17. Please include any other health information about your child that you think will be helpful to us in providing proper care.

THANK YOU FOR COMPLETING THIS INFORMATION



ARBOR MEDICAL PARTNERS
North Scottsdale Pediatrics Papago Buffet Pediatrics
Scottsdale Children's Group Southwest Pediatrics
Arbor Medical Partners Pediatrics - Gilbert

PATIENT INFORMATION

PATIENT NAME : _____ DOB: _____

PREFERRED NAME: _____ SEX: _____ AGE: _____

ADDRESS: _____

CELL # FOR APPOINTMENT CONFIRMATIONS: _____

PREFERRED LANGUAGE: _____ RACE/ETHNICITY: _____

SIBLINGS AT PRACTICE: _____

PARENTS INFORMATION

PARENT NAME: _____ RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____ EMAIL: _____

SS #: _____

EMPLOYER: _____

PARENT NAME: _____ RELATIONSHIP TO CHILD: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____ EMAIL: _____

SS #: _____

EMPLOYER: _____

STEP MOM: _____ STEP DAD: _____

DATE OF BIRTH: _____ DATE OF BIRTH: _____

PHONE #: _____ PHONE #: _____

****This form does not give consent for step parents to bring children into the office. Please ask the front office for a "Consent to Treat" form to keep on file.****

INSURANCE INFORMATION

DOCTOR'S NAME: _____

PRIMARY INSURANCE CARRIER: _____

PRIMARY CARD HOLDER: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP NUMBER: _____

SECONDARY INSURANCE CARRIER: _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURED ID#: _____ POLICY GROUP NUMBER: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby certify that the information provided here is true and correct. I authorize Arbor Medical Partners to release information to my insurance company for the processing of medical claims. I assign insurance benefits to Arbor Medical Partners for all medical services performed. I understand that insurance benefits are determined by the contract I hold with my insurance company, and that I am responsible for all fees not paid by insurance as stated in my policy. I also hereby certify that the person signing the form will be listed as the Responsible Party (Guarantor) of the Child (ren) accounts. This is who all statements will be sent to.

Signature of Guarantor/Responsible Party

Date



ARBOR MEDICAL PARTNERS
 North Scottsdale Pediatrics Papago Hill Pediatrics
 Scottsdale Children's Group Southwest Pediatrics
 Arbor Medical Partners Pediatric - Gilbert

MEDICAL AUTHORIZATION/ CONSENT TO TREAT

Date: _____
 (valid for 1 year from date signed)

Consent from Parents or Guardians for Authorized Persons:

As the parent or guardian of _____ I am granting permission for the below listed person(s) to bring my child in for treatment and/or care.

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

____ Initials I am granting full consent, meaning the below listed person(s) will be allowed to agree to treatments/vaccines, and know all health history pertaining to my child.

____ Initials I am granting partial consent, meaning the below listed person(s) is only allowed to bring my child in, and can agree to treatments/vaccines but is not allowed to access any medical information/health history pertaining to my child.

Please list person(s) here	Relationship
_____	_____
_____	_____
_____	_____

Consent to Leave Voicemail

____ Initials I am granting consent to Arbor Medical Partners to leave phone messages regarding my child's medical health to the number(s) provided on the registration form.

 Parent/Guardian Signature Date

 Witness Signature Date



ARBOR MEDICAL PARTNERS

North Scottsdale Pediatrics Papago Bulles Pediatrics
Scottsdale Children's Group Southwest Pediatrics
Arbor Medical Partners Pediatrics - Gilbert

**Notice of Privacy Practices,
HIE (Health Information Exchange)
Acknowledgments**

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- < Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- < Obtain payment from third-party payers
- < Conduct normal healthcare operations such as quality assessments and physician certifications

I received, read and understand your *Notice of Privacy Practices and HIE (Health Information Exchange)* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices and/or HIE*.

Patient Name _____

Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:
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ARBOR MEDICAL PARTNERS
North Scottsdale Pediatrics Papago Butte Pediatrics
Scottsdale Children's Group Southwest Pediatrics
Arbor Medical Partners Pediatrics - Gilbert

ARBOR MEDICAL PARTNERS

FINANCIAL POLICY 2020

Thank you for choosing Arbor Medical Partners, for the care of your child. This Financial Policy is an important part of your child's care. Due to increased insurance company demands, we ask you to read and agree to the following Arbor Medical Partners provisions:

Private Pay Patients: If you have no insurance coverage, full payment is expected at the time of service.

Insurance: As a courtesy, Arbor Medical Partners will file your claim to your insurance company; however, at the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience, we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover), and money orders. Payments are also accepted through our patient portal. We advise you to contact your insurance company in advance to verify coverage for specific benefits such as well checks, immunizations, behavioral visits, and lab services.

**** We make every attempt to keep our non-participating insurance plans list up to date however due to continuous changing insurance plans and networks they utilize we HIGHLY recommend that you check with your specific insurance plan to verify that our providers are showing as participating as we cannot guarantee coverage or be held responsible for any balances incurred if we later find out that we are not contracted with your insurance plan.**

Any Patient responsibility will be billed to the guarantor on file.

Fee Schedules: Our prices are dictated by our insurance contracts. It is a violation of our contractual agreements with your insurance plans to discount or waive charges for coverage, etc.

Payment Options: By signing the Credit Card Authorization Form, you understand that as soon as your EOB (Explanation of Benefits) is received by our office from your insurance plan, an email will be sent with a notice that your credit card will be charged for the balance due on your account, per your insurance contract. In the event you opt not to sign the Credit Card Authorization Form and your balance is not paid within 14 days, you will incur a \$25.00 service fee for each statement that we generate that shows a balance on your account.

Statements: Statements are generated to your portal account. If you do not have a portal account, your statement will be mailed to the address that we have on file for you. For your convenience and for

ease of processing, we would prefer that you utilize our credit card processing service, w/ payments can be made through our new and expanded portal, or our website.

Refunds: Any patient accounts showing credit balances will be thoroughly researched to analyze if credit is accurate and the billing department will determine if the credit is owed to the patient or the insurance company. The credit balance report is reviewed as frequently as possible and as refund checks are requested. Once determined who credit is owed to, please allow 6 weeks for credit or refund check to be issued.

Outside Collections: If your balance has not been paid to Arbor Medical Partners within 120 days, your account will be turned over to our outside collection agency. Thereafter, within 30 days, if your balance has not been paid, dismissal from Arbor Medical Partners will occur.

Laboratory Fees: You will receive a separate laboratory fee for their services. Any lab services that are not covered by your insurance will be your responsibility.

Address and insurance changes: Please let us know if your address, phone numbers, insurance, etc., change, so that your information is always current and accurate in your child's records. This can also be updated through our Patient Portal.

Authorization for medical treatment of a minor: Patients under the age of 18 (minors) must be accompanied by a parent/legal guardian unless prior arrangements have been made. If the accompanying adult is not the parent/guardian, we will require a "Consent to Treat Form" be filled out. The person bringing in the child for medical treatment will be held responsible for payment at the time services are performed.

Divorce/Custody: We cannot and will not become involved with parental billing disputes in divorce and/or custody cases. Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at time of service. Arbor Medical Partners **DOES** require documentation from the court for all legal matters that relate to your child's care; i.e., custody, medical decisions, medical record access, etc.

Cancellations/No Shows: If you cancel your appointment with less than a 24-hour notice or do not show for the appointment, a \$50 fee will be charged to your account.

Coordination Of Benefits: Often times insurance companies will require proof of other insurance or the lack thereof. In this instance, it is the responsibility of the patient to make sure the insurance company receives this in a timely manner so that claims for Arbor Medical Partners are paid promptly and not delayed due to failure to comply with COB requests. Responsible party will be given 30 days from notice from insurance that COB needs to be updated. Failure to comply will result in charges from Arbor Medical Partners becoming patients responsibility and or being discharged from the division of Arbor Medical Partners.

AHCCCS Recipients - Please note that failure to disclose your AHCCCS eligibility will result in your financial responsibility for services rendered at this office.

I have read and understand Arbor Medical Partners Policy and agree by its terms. I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by Arbor Medical Partners. I understand that my insurance is an arrangement between myself and my insurance company, and that it is my responsibility to understand my benefits.

Patient Name & Date of Birth: _____

Parent/Guardian (Please Print): _____

Your Signature: _____ Date: _____

Vaccines for Children (VFC) Program Patient Eligibility Screening Record

A record of all children 18 years of age or younger who receive immunizations must be kept in the health care provider's office for 6 years. The record may be completed by the parent, guardian, individual of record, or by the health care provider. VFC eligibility screening and documentation of eligibility status must take place with each immunization visit to ensure the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine. Providers using a similar form (paper-based or electronic) must capture all reporting elements included in this form.

1. Child's Name : _____
Last Name
First Name
MI

2. Child's Date of Birth: ____/____/____

3. Parent/Guardian/Individual of Record: _____
Last Name
First Name
MI

4. Primary Provider's Name: _____
Last Name
First Name
MI

5. To determine if a child (0 through 18 years of age) is eligible to receive federal vaccine through the VFC and state programs, at each immunization encounter/visit enter the date and mark the appropriate eligibility category. *If Column A-D is marked, the child is eligible for the VFC program. If column E, F or G is marked the child is not eligible for federal VFC vaccine.*

	Eligible for VFC Vaccine				Not eligible for VFC Vaccine		
	A	B	C	D	E	F	G
Date	Medicaid Enrolled	No Health Insurance	American Indian or Alaskan Native	*Underinsured served by FQHC, RHC or deputized provider	Has health insurance that covers vaccines	**Other underinsured	***Enrolled in KidsCare

**Underinsured includes children with health insurance that does not include vaccines or only covers specific vaccine types. Children are only eligible for vaccines that are not covered by insurance. In addition, to receive VFC vaccine, underinsured children must be vaccinated through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or under an approved deputized provider. The deputized provider must have a written agreement with an FQHC/RHC and the state/local/territorial immunization program in order to vaccinate underinsured children.*

*** Other underinsured are children that are underinsured but are not eligible to receive federal vaccine through the VFC program because the provider or facility is not a FQHC/RHC or a deputized provider. However, these children may be served if vaccines are provided by the state program to cover these non-VFC eligible children.*

****Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are considered insured and are not eligible for vaccines through the VFC program. Each state provides specific guidance on how CHIP vaccine is purchased and administered through participating providers.*

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.

Please sign below indicating that you understand and agree with the above statement.

Signature: _____ Date: _____