Angel Pediatrics

2023 Patient Information

**PLEASE LIST ALL CHILDREN ATTENDING UNDER 19 YEARS OF AGE**

| First Name | Last Name | DOB | Gender |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Email address for patient portal: _____**

**Biological Mother/Guardian 1:**

Name: _____ DOB: _____ Phone: _____

Home Address: _____
(Street, City, State, and Zip Code)

Employer Name: _____ Address: _____

**Biological Father/Guardian 2:**

Name: _____ DOB: _____ Phone: _____

Home Address: _____
(Street, City, State, and Zip Code)

Employer name: _____ Address: _____

**Child's Parents:** _____ Married _____ Divorced _____ Never Married _____Other

Any Special Custody Arrangements? _____

Name: _____ DOB: _____ Phone: _____
**(Step parent or other guardian)**

**Emergency Contact Other Than Parents:**

Name: _____ DOB: _____ Phone: _____

**Insurance Information: (Please list ID number, group number, and name/DOB of policy holder.)**

*Please have your insurance card and photo ID ready at check-in at each visit.*

Primary Insurance: _____

Seconday Insurance: _____

**Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I hereby authorize Angel Pediatrics to furnish information to insurance carriers concerning my child's illness and treatments and I hereby assign to Angel Pediatrics all payments for medical services rendered to myself of my dependents. I understand that I am responsible for any amount not covered by insurance. In the event of default, I promise to pay collection cost and reasonable attorney fees as my by required to effect collection of this account. I further acknowledge that I have received the HIPAA Notice of Privacy Practices.**

*It is your responsibility to complete paperwork annually and read all policies. Thank you for your cooperation.*

_____ _____

**Signature and Relationship to Patient** **Date**

Angel Pediatrics

# Financial Policies 2023

1. **Insurance: As a courtesy, Angel Pediatrics will file your claim; however, at the time of service you will be responsible for all fees that are not covered by insurance, including co-pays, co-insurance, deductibles and non-covered services. In addition, all previous balances must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Whoever brings the child to the appointment is responsible for payments of previous balances and copayments. As a courtesy, we will take payments of balances and co-pays over the phone prior to the visit if someone else is bringing your child to an appointment. If you are not insured by a plan we contract with, payment in full is expected at each visit. Please be aware that some, and perhaps all, of the services you receive may not be covered or not considered reasonable or necessary by your insurance company. It is your responsibility to know what is covered under your policy. The balance will automatically be billed to you. If your insurance coverage changes, please notify us before your next visit so that we may make the appropriate changes to the records. **Understanding your insurance benefits is your responsibility.**

2. **Self-Pay Patients: If you have no insurance coverage, full payment is expected at the time of service. Please contact our office to learn about our self-pay rates.**

3. **Primary Care Physician Selection:** Please be aware that your insurance company may require you to select a Primary Care Physician (PCP). Please select a PCP prior to your child's visit.

4. **Newborns:** All newborns must be added to the insurance as soon as possible. Please contact your insurance company directly to make this addition. **If your newborn/child is not added before the appointment, your visit will be considered self- pay until your insurance has added the child to the policy.**

5. **Claims submission:** We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. **Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.**

6. **Returned checks:** We will charge you a $30 service charge for any returned checks.

7. **Divorced/Separated Families:** We cannot and will not get involved with parental billing disputes in divorce or split custody cases. Our policy is to hold the parent who brings in the child for medical treatment responsible at the time of service. Angel Pediatrics requires documentation from the court for all legal matters that relate to your child's care (e.g. custody, medical decision making, medical record access, etc.).

8. **Non-payment:** If you receive a 3rd statement and your account is 90 days past due, you will be referred to an outside collection agency. You will be responsible for ALL collection fees and any attorney fees as a result of your past due balance. If a payment plan is requested and authorized by our office, arrangements must be made **PRIOR** to being sent to an outside collection agency.

Angel Pediatrics is committed to providing the best treatment to our patients. Our prices are representative of the customary charges for our area. Please notify us of any questions or concerns.

**I have read and understand the financial policy and agree to abide its guidelines:**

_____ _____

**Signature of patient or responsible party** **Date**

_____

**Print Name**

Angel Pediatrics

# Office Policies 2023

At Angel Pediatrics, we strive for excellent patient care in a nurturing setting.
We want to maintain an environment that is clean, safe, and enjoyable to our patients.

1. **Appointments**: Please be on time for your appointment. Our providers will try to honor the schedule but there may be unforeseen delays. If timing is crucial to your schedule and we are delayed, please notify the front office staff to be rescheduled. If you arrive late for your child's appointment, you may be asked to reschedule. **SICK VISITS ARE SAME-DAY. We do not pre-book sick, injury, or acute pain appointments. Please call the morning of the day you wish to be seen. Sick appointments are first come, first serve. If you make an appointment and cannot attend, please call to cancel so we may free this space for another patient.**

2. **Cancellations**: We ask that you call us as soon as possible if you need to cancel an appointment. We would appreciate a cancellation at least twenty-four hours prior to the appointment, as this would enable us to use that appointment slot for another patient. **If you fail to call within two hours of your appointment, we will charge a $35 fee.** After three "No Shows," you may be discharged from Angel Pediatrics and asked to seek healthcare elsewhere.

3. **Walk-ins**: Our office visits are by **appointment only** and the phone lines open at 8 AM. If you walk in and want your child to be seen, we will do our best to accommodate your child as our schedule permits.

4. **Supervision**: No child may be left unsupervised by an adult in the office. We are not responsible for any injuries sustained while in our office.

5. **Personal belongings**: Please do not leave any personal property in the office. We will not be responsible for lost or stolen personal belongings.

6. **Electronic Devices:** Please turn off all electronic devices during your visit with the provider. Your undivided attention is required during your child's visit.

7. **Referrals**: Advanced notice is necessary for all routine referrals. Allow seven business days for your referral to be processed. It is your responsibility to know if a selected specialist participates in your plan. We must approve all referrals before they are issued.

8. **Forms**: Please bring any sports or other forms to your child's wellness exam. Any additional school, camp, or sports forms requested after your child's annual wellness exam will be completed within seven business days.

9. **Vaccinations:** During a wellness exam, you and your child's provider will discuss which vaccinations are due at the time. The parent or guardian will be asked for verbal consent to have the vaccinations administered. Once the provider leaves the room, he or she will give orders to the medical assistant to draw up the vaccinations. If the parent or guardian changes their mind about the child receiving the consented vaccinations once the medical assistant is in the room with the shots, the parent or guardian **will be responsible for the costs of the vaccinations**, as the shots cannot be used for other patients.

10. I**ntentional damage** to decorations, furniture, and/or office equipment is unacceptable. Parents will be financially responsible for any repair fees which will be determined by the office management.

11. **Good communication** is always crucial between patient families and providers. We will make a courtesy reminder call the day before any future scheduled appointments. However, do not depend on our calls or texts as a reminder. You are responsible for keeping your child's appointments when scheduled.

**I have read and understand the office policies and agree to abide its guidelines:**

_____ _____

**Signature of patient or responsible party** **Date**

_____

**Print Name**

Angel Pediatrics

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/We have read this disclosure and agree that the lender/creditor may contact me/us as described above.

_____ _____

**Signature of patient or responsible party** **Date**

_____

**Print Name**

Angel Pediatrics

# CONSENT FOR MEDICAL TREATMENT

**I hereby give consent for medical treatment of my children who are minors:**
**(Please list all children)**

_____ _____

_____ _____

_____ _____

I grant my permission for treatment at Angel Pediatrics, PLLC, by licensed physician, licensed nurse practitioner, licensed physician assistant, and/or designees, including such personal as the physician my deem necessary. I am aware that the practice of medicine is a not an exact science and that no guarantee can be made concerning the results of treatment.

**Any person not listed (aside from mother and father or guardians) will not be able to participate in the children's care at Angel Pediatrics.**

**I grant my permission for the following individuals to contact Angel Pediatrics regarding the above children and accompany them to medical appointments:**

_____ _____

_____ _____

*Please remind these individuals to have their photo ID and, if necessary, a method of payment available each time they accompany your child to an appointment.*

This consent will be in effect from this date until the above minors are 18 years of age unless cancelled by me in writing.

_____ _____

**Print Name** **Signature**

_____ _____

**Relationship to Patient** **Date**

Angel Pediatrics, PLLC
41930 N Venture Drive, Suite 160
Anthem AZ 85086
623-551-0442

AUTHORIZATION FOR THE RELEASE, USE, OR DISCLOSURE OF HEALTH INFORMATION

I request release of my child's medical records, including vaccinations and growth charts

FROM:
Office Name: _____
Doctors Name _____
Address: _____
_____

Phone: _____
Fax: _____

TO:
Angel Pediatrics
41930 N. Venture Drive, Suite 160
Anthem, AZ 85086

Phone: 623-551-0442
Fax: 623-551-0830

I authorize Angel Pediatrics to use or disclose protected health information relating to the health records and information, medical history, mental and/or physical condition, and services rendered to:

CHILDREN:

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

Indicate specific records here:

_____ Entire Chart

_____ Health information for the date(s): _____

_____ Imm. Records

_____ Other

I understand this may include information relating to AIDS, HIV Infection, Psychiatric Care and or treatment for alcohol and or drug treatment.

I understand this authorization may be revoked in writing at any time, according to the instructions in the Angel Pediatrics Notice of Privacy Practices and Procedures, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire sixty (60) days from the date of this authorization. I further understand that I have a right to receive a copy of this authorization.

_____ _____
Parent / Legal Guardian Signature Date

**PLEASE ONLY FAX OR MAIL. NO CDS.**

Angel Pediatrics

## BIRTH HISTORY

**CHILDS NAME:** _____ DOB: _____

Birth Weight_____ Length_____ Place of birth _____

Preterm or Full Term_____ Vaginal or C-Section Delivery_____

List any complications during pregnancy or delivery: _____

Length of baby's hospital stay after birth: _____

Did he/she have any problems? (E.g. Jaundice, respiratory distress, infection)

_____

## PAST MEDICAL HISTORY

Has the child ever had any problems with the following? If YES, please explain:

| | |
|---|---|
| ADHD | Yes_____ No |
| Asthma/RAD | Yes_____ No |
| Allergies (Food/Environmental) | Yes_____ No |
| Anemia/Blood Disorders | Yes_____ No |
| Bones/Joints | Yes_____ No |
| Diabetes | Yes_____ No |
| Ears (Multiple infections) Hearing | Yes_____ No |
| Eyes/Vision | Yes_____ No |
| Gastrointestinal (GE reflux/ Constipation/diarrhea | Yes _____ No |
| Heart | Yes_____ No |
| Repeated infections | Yes_____ No |
| Seizures/Headaches | Yes_____ No |
| Skin (Eczema) | Yes_____ No |
| Urine/Kidneys | Yes_____ No |
| Other | Yes _____ No |

Allergies to medicine Yes_____ No

Please list any hospitalizations, operations, serious illnesses or injuries with dates:

_____ Date: _____

_____ Date: _____

Please list any developmental problems or delays and when they occurred:

_____ Age: _____

_____ Age: _____

Immunizations up to date? Yes ___ No ___

Please list medications child is currently taking and reason:

| Medication | Reason |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Angel Pediatrics

## FAMILY HISTORY

**Below you will find diseases and disorders that may be hereditary. Indicate by checking the disease/disorder; list any immediate family members or relatives who have had the disease/disorder and specify the condition if possible:**

__**Allergies/Asthma/Respiratory** _____

__**Brain or Nervous System Disorder** _____

__**Headaches/Migraines** _____

__**Blood Disorder** _____

__**Bone/Joint Disorder** _____

__**Cancer** _____

__**Elevated Cholesterol** _____

__**Endocrine Disorders** _____

__**Gastrointestinal Disorder** _____

__**Genetic Disorder** _____

__**Heart Disease** _____

__**High Blood Pressure** _____

__**Immunologic Disorder** _____

__**Mental Illness** _____

__**Kidney Disease** _____

__**Rheumatologic or Autoimmune Disorder** _____

__**Tuberculosis** _____

__**Seizures** _____

**This will go in all the children's charts. If this information differs between your children, please indicate next to the disease/disorder or list below.**

_____

# Affordable Healthcare Act

# Mandatory EMR Compliance

## RACE

White

Black or African American

Hispanic

American Indian or Alaska Native

Asian

Native Hawaiian or other Pacific Islander

Other Race

Refused to Report

## ETHNICITY

Hispanic or Latin

NOT Hispanic or Latin

Refused to Report

## LANGUAGE

English

Spanish

Other Language

Refused to Report

**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-E is marked, the child is eligible for the VFC program. If column 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 | **Enrolled in Kids Care | ***Other underinsured | Has health insurance that covers vaccines |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

*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.

**Children enrolled in separate state Children's Health Insurance Program (CHIP). These children are eligible for VFC vaccines but will need to be billed to AHCCCS as KidsCare.

***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.

**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:_____**