# Pediatrics Demographic Record

**Last Name:**_____ **First Name:**_____ MI:___ Sex: M____F____

Address:_____ DOB:_____

City_____ State_____ Zip_____ Phone:_____

**Parent Guardian:**_____ DOB:_____

Address:_____ Phone:_____

City_____ State_____ Zip_____ Cell:_____

Employer/Occupation:_____ Work:_____

Email:_____

**Parent Guardian:**_____ DOB:_____

Address:_____ Phone:_____

City_____ State_____ Zip_____ Cell:_____

Employer/Occupation:_____ Work:_____

Email:_____

**Emergency/Alternate Contact 1:**(preferred outside of home)_____

Relationship:_____ Phone:_____

**Emergency/Alternate Contact 2:**(preferred outside of home)_____

Relationship:_____ Phone:_____

## Primary Insurance (required information all fields):

Plan Name:_____ Policy Holder's Name:_____

Policy Holder's SSN:_____ Policy Holder's DOB:_____

Policy/ID#:_____ Group:_____ Effective Date:_____

## Secondary Insurance (required information all fields):

Plan Name:_____ Policy Holder's Name:_____

Policy Holder's SSN:_____ Policy Holder's DOB:_____

Policy/ID#:_____ Group:_____ Effective Date:_____

**Do you want to sign up for MY CHART-Online access to your Medical Records? Y____N____**

**Tucson Central Pediatrics**
**Member of Arizona Community Physicians, P.C.**
**Minor Child Release Form**

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which someone may need to care for your child. In order to provide the best medical care possible we would like you to provide us with the following information.

Please list the names of anyone who has your permission to be involved with your child's medical care. This permission will include appointments, medical decision making, authorizing treatment, authorization to release test results, etc.

☐ Myself by: _____ Home Phone _____ Answering Machine _____ Work _____ Other

☐ Spouse _____ Phone # _____

☐ Child _____ Phone # _____

☐ Parent _____ Phone # _____

☐ Other _____ Phone # _____

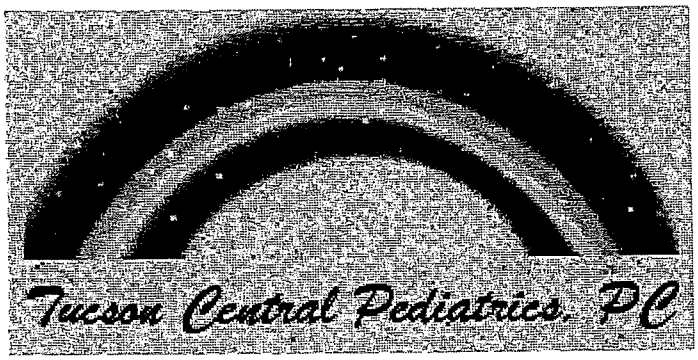
_____ Yes/No I give permission for my child to be seen without the presence of an adult. (Child is of age to drive themselves to their own appointment).

_____ Patients Name

_____ Account #

_____ Signature of Parent/Legal Guardian

_____ Date




# LATE ARRIVAL AND MISSED APPOINTMENT AGREEMENT

As a patient of Tucson Central Pediatrics, I agree to comply with the office policies set forth:

In order to remain fair to all patients, Tucson Central Pediatrics reserve the right to reschedule your appointment if you arrive later than your scheduled appointment time.

When an appointment is canceled without giving prior notice, it is subject to a $25 fee.

When an appointment has been missed, it is considered a NO SHOW and is subject to a $25 fee.

When patients do not arrive or cancel their appointments in a timely manner, it takes away from the available time we have to schedule other patients. We very much want to continue serving you, so we urge you to make every effort to keep your future appointments.

**SIGNATURE** **DATE**

# TUCSON CENTRAL PEDIATRICS

MEMBER OF ARIZONA COMMUNITY PHYSICANS

## Financial Policy

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

Patient's name: _____ Date of Birth: _____

INSURANCE: **At the time of service you are responsible for the co-pay, deductible and co-insurance amounts and any amounts not covered by the insurance company.** A claim will be submitted directly to the insurance company if all necessary information is provided, which includes a copy of the patient's insurance card and subscriber's information. If coverage is denied for any reason, you are responsible for the entire balance. It is your responsibility to contact the insurance company in the event of non-payment. Insurance benefits are a matter between you and the insurance company. You are ultimately responsible for the payment on your child's account. If the doctors are not contracted with your insurance company you are expected to pay for the child's visit at the time of service.

NO INSURANCE: If you do not have insurance or unable to provide insurance information, you are expected to pay for your child's visit at the time of service. There is a 40% discount.

PAYMENT FORMS: Cash, checks, Visa, Master Card, and Discover are accepted for payment. If the bank returns a check, there will be a $25.00 return check fee and you will not be able to use this form of payment.

DELINQUENT ACCOUNTS: If an account becomes delinquent, you will be responsible not only for charges incurred but also any costs involved in collecting the balance. Balances over (60) days will be assessed a 1% per month finance charge. Balances sent to bad debt or a collection agency will be assessed a one time 30% finance charge.

If you have any questions regarding the financial policy, please ask prior to the appointment.

I have read and understand the financial policy and have been given the opportunity to ask questions about this policy. I understand my responsibility for payment of my child's account with Tucson Central Pediatrics and Arizona Community Physicians. I have provided to the best of my ability the information requested accurately and completely. **I understand I might be turned away for non-compliance of the financial policy.**

_____ _____

Responsible Party Signature Date

_____ _____

Responsible Party (Print) Relationship

ARIZONA COMMUNITY PHYSICIANS

PRINT PATIENT NAME | PT DOB | MRN

Dear Patient:

You are scheduled today for your Annual Preventative Medicine visit, commonly referred to as an Annual Physical.

Please know that your insurance may limit the reimbursement for this service to once every 365 days. If you have received this service from another provider within the past 365 days you may be charged for this visit.

The Annual Preventative Medicine visit includes the following:

- An age appropriate history and exam that is not part of disease management.
- Counseling, guidance and risk factor reduction.
- Ordering of routine tests such as screening colonoscopy, screening labs and radiology services to identify potential problems.

The Annual Preventative Medicine visit does not include the services below. If you require these additional services today, please be aware your insurance has a separate billing category for which your provider may charge your insurance. Alternatively, please let your provider know if you do not want these services.

- Evaluation and Management of new or ongoing problems requiring further workup or discussion. This may include a more extensive problem focused physical exam, ordering of diagnostic tests for known problems, prescription drug management, coordinating care with another specialist, or simply providing further counseling related to a chronic diagnosis.

If you have any questions regarding this information, please see the front desk staff.

I have received and read this information.

PATIENT SIGNATURE | DATE

# Arizona Community Physicians P.C.
# Authorization to Disclose Medical Information

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____

Daytime Telephone_____ Birth Date_____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____

Street Address _____

City/State/Zip _____

Phone # _____ Fax# _____

To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization Tucson Central Pediatrics

Street Address 1628 N Alvernon Way

City/State/Zip Tucson, AZ 85712

Phone # 520-325-8000 Fax# 520-325-8016

PURPOSE FOR THIS REQUEST (Please check a box)

☐ Moving ☐Treatment or consultation ☐Dissatisfaction ☐ Change of Insurance Plans ☐ At patients request

☐Other (specify) _____

| TYPE OF INFORMATION TO BE RELEASED (No information will be released unless a box is checked) | |
|---|---|
| General Release<br>☐Medical Records/Excluding Protected Records<br>(This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated) | DATES OF TREATMENT<br>From_____ To_____ |
| ☐ Other Records (specify) _____ | From_____ To_____ |
| Information Protected by State/Federal Law<br>☐ All of my records including:<br>AIDS/HIV and Other Communicable Disease Information,<br>Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment | From_____ To_____ |

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Personal Representative Who May request Disclosure

I understand that Arizona Community Physicians may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for Request. I can inspect or receive a copy of the protected health information to be used or disclosed. **I authorize Arizona Community Physicians to use and disclose the protected health information specified above**

_____ _____ _____

**Signature of Patient OR Legal Representative** **Date** **Please Print Name of signing party**

**Patient Requesting Medical Record Copies**

The standard charge for copying medical records is $6.50 for a disc and $0.07 per page for paper. However there maybe additional charges for shipping and handling.

FORM # 100
Updated: 08/04/2017