Angel Pediatrics

2021 Patient Information

Todays Date: _____

Children

First Name	Last Name	DOB	Gender

EMAIL ADDRESS FOR PATIENT PORTAL:_____

Biological Mother/Gardian 1

Name: _____ DOB: _____ Phone: _____

Address Street, City, State and Zip

_____

Biological Father/Guardian 2

Name: _____ DOB: _____ Phone: _____

Address Street, City, State and Zip

_____

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

Any Special Custody Arrangements? _____

If Applicable: Step Parent Name, DOB and Phone Number

_____

_____

Emergency Contact Other Than Parents
Name, Relationship to Patient and Phone Number

_____

INSURANCE INFORMATION

Primary Insurance: _____
ID Number, Group Number and Policy Holders Name: _____
Seconday Insurance: _____
ID Number, Group Number and Policy Holders Name: _____

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.

_____ _____

Signature and Relationship of Parent Date

Angel Pediatrics

Financial Policies 2021

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 can 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 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.

9. 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 Agreement 2021

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. Please read the following office policies and sign at the bottom, acknowledging your understanding.

1. **Appointments**: Please be on time for your appointment. The 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.

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 incurred 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**: Advance 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 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** done to the 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 the patient family and the provider. We usually make a courtesy reminder call the day before any future scheduled appointments. Do not depend on our call or text as a reminder. You are responsible for keeping your child's appointments when scheduled.

_____ _____

Signature Date

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.

_____ _____

Parent/Guardian Signature/ Date

41930 N Venture Drive, Suite 160 Anthem, AZ 85086 Phone: 623-551-0442 Fax: 623-551-0830

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.

I am giving permission for the following adults to bring my children for their treatment:

_____ _____

_____ _____

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