

PATIENT INFORMATION FORM

Please Complete This Entire Form (list all children the information applies to)



PLEASE PROVIDE A COPY OF ANY DOCUMENTS RELATED TO CUSTODIAL RIGHTS FOR THE PATIENT'S RECORD

PATIENT LAST NAME: GENDER: ☐ M ☐ F ☐ Other		PATIENT FIRST NAME:		MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: ☐ M ☐ F ☐ Other		PATIENT FIRST NAME:		MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
PATIENT LAST NAME: GENDER: ☐ M ☐ F ☐ Other		PATIENT FIRST NAME:		MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
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PATIENT LAST NAME: GENDER: ☐ M ☐ F ☐ Other		PATIENT FIRST NAME:		MIDDLE INITIAL:	PATIENT DATE OF BIRTH:
MAILING ADDRESS:		CITY:		STATE:	ZIP:
PHYSICAL ADDRESS (if different):		CITY:		STATE:	ZIP:
PRIMARY PHONE: ()	CELL PHONE: ☐ Check if same as Primary ()	WORK PHONE: ()		EXTENSION:	
E-MAIL ADDRESS:				ENABLE FOR PATIENT PORTAL: ☐ Yes ☐ No ☐ Not Applicable	
PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other Language (Please specify):		ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined to Specify			
RACE: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Hawaiian Native/ Pacific Islander ☐ White ☐ Declined to Specify ☐ Other (Details) _____					

GUARANTOR INFORMATION

(Individual responsible for bills and payment – If you are an 18+ year old patient, this would be YOUR name)

GUARANTOR LAST NAME:		GUARANTOR FIRST NAME:		MIDDLE INITIAL:	RELATIONSHIP TO PATIENT (Check all that apply): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Self ☐ Other (Specify):	
STREET ADDRESS: ☐ Check if same as patient			CITY:		STATE:	ZIP
PRIMARY PHONE: ()	CELL PHONE: ☐ Check if same as Primary ()	WORK PHONE: ()		EXTENSION:		
E-MAIL ADDRESS: ☐ None		SOCIAL SECURITY #:		DATE OF BIRTH (mm/dd/yyyy):		
GENDER: ☐ Male ☐ Female ☐ Other		EMPLOYER NAME:		EMPLOYER PHONE #: ()		
OCCUPATION:		Receive Statements via: ☐ Mail ☐ Email		MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ☐ Yes ☐ No		

OTHER PARENT

PARENT LAST NAME:		PARENT FIRST NAME:		MIDDLE INITIAL:	RELATIONSHIP TO PATIENT (Check all that apply): ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Self ☐ Other (Specify):	
STREET ADDRESS: ☐ Check if same as patient			CITY:		STATE:	ZIP:
PRIMARY PHONE: ()	CELL PHONE: ☐ Check if same as Primary ()		DATE OF BIRTH (mm/dd/yyyy):			
OCCUPATION:		E-MAIL ADDRESS:		MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: ☐ Yes ☐ No		

***ADDITIONAL CONTACT (OPTIONAL) *DOES NOT GIVE MEDICAL AUTHORITY, NEED PROXY FOR ANY NON- BIOLOGICAL PARENT**

CONTACT LAST NAME:		CONTACT FIRST NAME:		RELATIONSHIP TO CHILD <i>(Check all that apply)</i> : ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Legal Guardian ☐ Other <i>(Please specify)</i> :	
STREET ADDRESS: ☐ <i>Check if same as patient</i>			CITY:		STATE: ZIP:
PRIMARY PHONE: ()		CELL PHONE: ☐ <i>Check if same as Primary</i> ()		DATE OF BIRTH <i>(mm/dd/yyyy)</i> :	
OCCUPATION:			E-MAIL ADDRESS:		

INSURANCE INFORMATION*(Please present all current insurance cards to the Front Desk)*

I HAVE INSURANCE: ☐ Yes ☐ Yes, but pending, not active, or you're not contracted ☐ No <i>(Self Pay)</i>			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION TO PT:	SUBSCRIBER:	RELATION TO PT:
Policy ID:	Group ID:	Policy ID:	Group ID:
GENDER: ☐ Male ☐ Female ☐ Other		GENDER: ☐ Male ☐ Female ☐ Other	
DATE OF BIRTH:	SOCIAL SECURITY #:	DATE OF BIRTH:	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION*(I hereby request to receive confidential communications from Camelback Pediatrics, PC in the following manner)*

PHONE MESSAGES – Please leave messages as follows (Check All That Apply) Primary Phone: ☐ Mom ☐ Dad ☐ Both ☐ Self (for 18+ year old patients) ☐ BRIEF MESSAGE ☐ DETAILED MESSAGE Cell Phone: ☐ Mom ☐ Dad ☐ Both ☐ Self (for 18+ year old patients) ☐ BRIEF MESSAGE ☐ DETAILED MESSAGE	APPOINTMENT CONFIRMATIONS/RECALLS CONTACT: (Check one) ☐ Mom ☐ Dad ☐ Self (for 18+ year old patients) VIA THE FOLLOWING METHOD: (Check one) ☐ Text message ☐ Home/Cell Phone – automated call ☐ Email address
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Telephone. Email Contacts

I hereby consent and agree that: (1) anyone acting on behalf of Camelback Pediatrics, PC (herein known as "CP") may contact me as necessary regarding my account (including for collections purposes or related to insurance coverage); (2) any and all of CP's contacts with me may be made via text message or with an automated dialing and announcing or similar device, and via email; (3) CP may contact me at any telephone number I provide to them, whether a residential, business number, or cellular number; (4) I have an established business relationship with CP and that CP may contact me at the telephone number or email address I provide to them, in any of the ways described above. I understand that, if I accept now, I may change at any time by notifying CP staff. ☐ Accept ☐ Decline **Initials:** _____

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize Camelback Pediatrics, PC to examine and treat my child when necessary. I also authorize the release of my protected health information, acquired in the course of examination to carry out treatment, payment and health care operations of my child. I hereby authorize payment directly from my insurance company to the physicians of Camelback Pediatrics, PC for medical treatment(s) provided to my child. I understand that payment in full of my responsible portion is required at the time of visit. If Camelback Pediatrics, PC is not a provider on my insurance, full payment is due on the date of service. If Camelback Pediatrics, PC is a provider on my insurance, then any deductibles, copays, or percentages are due at the time of service. Additionally, should it be necessary to assign my account for collections, it is hereby agreed that I shall pay additional fees up to 35% of the balance due, collection agency charges, attorney's fees, and any other costs.

By signing below, I am acknowledging that I have read and understand the above statements.

Parent, Legal Guardian, or Patient (18 or older) Printed Name

Parent, Legal Guardian, or Patient (18 or older) Signature

Date Signed



Welcome to Camelback Pediatrics!

We are thrilled to have you choose us for your child's medical care. Our mission is to provide your family with convenient, accessible, and high-quality healthcare. For more detailed information about our services and helpful resources for your child's health and development, please visit our website at www.camelbackpediatrics.com.

Below are some important details and our Financial Agreement. Please review carefully, initial each section to acknowledge the policies, and sign on the last page.

Appointments:

We request that all patients arrive 15 minutes early for their scheduled appointments to allow our team time to complete necessary administrative tasks. Please bring a photo ID, insurance card, and a form of payment. If you need any paperwork for your appointment, the forms are available on our website under the "Forms" section. You will receive an automated confirmation via call, text, or email 1-2 days before your appointment.

Late Arrivals:

Arriving more than 15 minutes late may result in your appointment being rescheduled.

Cancellations and No-Shows:

We kindly ask for 24-hour notice if you need to cancel or reschedule your appointment. Failing to do so will result in a \$50 Late Cancellation fee for well or sick visits, and \$100 for mental health appointments. A "No-Show" will incur the same fees. Multiple missed appointments may result in dismissal from our practice.

Service Animals:

Only service animals are allowed in the clinic.

Patient Portal:

Our patient portal allows you to access shot records, pay bills, and request routine visits. You can access it via our website.

Well Visit with Additional Health Concerns:

If additional health concerns are addressed during a well visit, your insurance may require a separate charge for the extra services, which may result in copays or other costs.

Medical Records:

To request medical records, visit our website's "Forms" page and complete the Medical Records Release form. Records will be processed within 3 business days. Fees may apply.

Divorce/Separation/Custody:

Camelback Pediatrics does not engage in custodial or financial disputes between parents. Both parents can access their child's medical records unless a court order says otherwise.



FINANCIAL AGREEMENT:

_____ All payments, including copays, deductibles, and coinsurance, are due at the time of service. The individual bringing the child is responsible for payment. We accept cash, check, Visa, MasterCard, Discover, and Amex. Please review our Credit Card on File policy.

Insurance:

_____ While we strive to verify insurance benefits, it is your responsibility to know your coverage and manage authorizations. Please provide your insurance card at each visit. If your insurance does not pay within 30 days, you may be responsible for the full balance.

Returned Checks:

_____ A \$40 fee will be charged for returned checks, and future payments will need to be made via cash or credit card.

HIPAA Notice:

You have been offered the HIPAA Notice of Privacy Practices, which explains your privacy rights and how your information may be used.

☐ Yes ☐ No ☐ Offered but Declined Initials: _____

I have read and agree to the terms and conditions outlined above.

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____

Pediatric Medical History

Child's Full Name: _____ Nickname: _____

Date of birth: ____/____/____ Gender: ☐ M ☐ F Race/Ethnicity: _____

Height: _____ Weight: _____ Date of last physical examination: _____

Name, address, and/or phone of PREVIOUS primary physician: _____

Name, address, and/or phone of medical specialists: _____

THESE QUESTIONS APPLY TO JUST THIS PATIENT

Is your child being treated by a physician at this time? ☐ YES ☐ NO

Reason: _____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ☐ YES ☐ NO

List name, dose, frequency & date started: _____

Has your child ever had a reaction or allergy to an antibiotic or other medication? ☐ YES ☐ NO

If yes, list: _____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? ☐ YES ☐ NO

If yes, list: _____

PAST MEDICAL HISTORY

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line.

- | | |
|--|--|
| Significant problems or specialty care | ☐ YES ☐ NO |
| Any serious injuries or accidents | ☐ YES ☐ NO |
| Any surgeries | ☐ YES ☐ NO |
| Any hospitalizations | ☐ YES ☐ NO |
| Delayed or missing immunizations | ☐ YES ☐ NO |
| Attends daycare | ☐ YES ☐ NO |
| Allergies: Outdoor, indoor, or animal | ☐ YES ☐ NO |
| Allergies: food | ☐ YES ☐ NO |
| Eye conditions or corrective lenses | ☐ YES ☐ NO |
| Recurrent ear infections | ☐ YES ☐ NO |
| Other problems with ears or hearing | ☐ YES ☐ NO |
| Allergic rhinitis or other allergy | ☐ YES ☐ NO |
| Recurrent sinusitis | ☐ YES ☐ NO |
| Recurrent sore throat/tonsillitis | ☐ YES ☐ NO |
| Recurrent croup | ☐ YES ☐ NO |
| Recurrent bronchitis/pneumonia | ☐ YES ☐ NO |

Asthma, reactive airway disease, bronchiolitis	☐ YES ☐ NO
Heart problem or heart murmur	☐ YES ☐ NO
Newborn/infant feeding issues	☐ YES ☐ NO
Abdominal pain, GERD, or colitis	☐ YES ☐ NO
Constipation requiring doctor visits	☐ YES ☐ NO
Bladder or kidney infection or other urologic problem	☐ YES ☐ NO
Bed-wetting (after 5 years old)	☐ YES ☐ NO
Gynecological problems/menstrual problems	☐ YES ☐ NO
Male genital problems	☐ YES ☐ NO
Sexually active	☐ YES ☐ NO
Recurrent skin rash or eczema	☐ YES ☐ NO
Other chronic skin problems (acne, warts, etc.)	☐ YES ☐ NO
Orthopedic problems	☐ YES ☐ NO
Concussion	☐ YES ☐ NO
Recurrent headaches	☐ YES ☐ NO
Seizures, developmental delays, or other neurological disorder	☐ YES ☐ NO
Autistic spectrum disorder	☐ YES ☐ NO
ADD/ADHD	☐ YES ☐ NO
Psychiatric, behavioral, emotional concerns	☐ YES ☐ NO
Use of alcohol or drugs	☐ YES ☐ NO
Thyroid or other endocrine problems	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO
Anemia, bleeding problem, or blood transfusion	☐ YES ☐ NO
Significant family history (celiac, cholesterol, autoimmune, lazy eye, etc.)	☐ YES ☐ NO
Significant social history	☐ YES ☐ NO
Other infectious illnesses	☐ YES ☐ NO
Chickenpox	☐ YES ☐ NO

Other significant past medical history not listed above _____

Explain your "Yes" answers: _____

Signature of Parent/Guardian

Date

Patient and Sibling(s) Name (please print): _____

SOCIAL HISTORY

ONLY ONE PER FAMILY -- ANSWER QUESTIONS FOR ALL CHILDREN IN THE FAMILY.

Biological parents live together

☐ YES ☐ NO

Issues with custody of your children

☐ YES ☐ NO

Siblings

☐ YES ☐ NO

Pets

☐ YES ☐ NO

Smokers in the home

☐ YES ☐ NO

Swimming pool at home

☐ YES ☐ NO

Swimming pool with fence

☐ YES ☐ NO

Guns in the home

☐ YES ☐ NO

Guns are locked and kept separate from ammunition

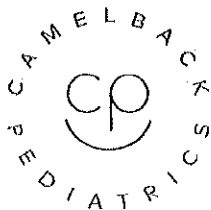
☐ YES ☐ NO

FAMILY HISTORY

	Father	Mother	Brother	Sister	Father's Father (Grandfather)	Father's Mother (Grandmother)	Mother's Father (Grandfather)	Mother's Mother (Grandmother)	Other
Nasal allergy (hay fever)									
Asthma									
Eczema									
High cholesterol									
High blood pressure, stroke									
Heart disease (before 50)									
Heart arrhythmia screen: fainting with exercise, pacemaker before 50, antiarrhythmic medications									
Bleeding disorder									
Anemia									
Celiac disease									
Stomach or intestinal problems (GERD, colitis)									
Liver disease or hepatitis									
Kidney disease									
Bed-wetting (after 10 years old)									
Diabetes (before 50 years old)									
Low thyroid									
Lupus, arthritis, colitis									
Immune problems, HIV, or AIDS									
Epilepsy or convulsions									
Alcohol abuse									
Drug abuse									
Mental illness									
Autism, Asperger's									
Intellectual Disability									
Tuberculosis									
Deafness									
Other genetic illness or family history									

Signature of Parent/Guardian

Date



CREDIT CARD ON FILE AUTHORIZATION

Parents/Guardians:

We are excited to offer a state-of-the-art program to help manage your healthcare dollars. Similar to hotel and car rental agencies, you are asked for a credit card at the time you check in. We will swipe your card with a card reader, which will encrypt the card information and store it securely in our credit card processing company's database. For your protection, only the last four digits of your card will show in our system. This is an advantage for you, as it makes your checkout experience faster, easier, and more efficient. Plus, you will no longer need to write checks or credit card information on your statement remits then mail them to us. An advantage for us is we will be able to decrease the number of statements we send out. All these advantages combined help us all to keep the cost of healthcare down.

As you may know, some insurance plans require copayments, deductibles, and coinsurance in amounts that are not known to you or us at the time of your visit; they are determined after the claim is processed. We will receive an Explanation of Benefits (EOB) from your insurance plan, the same one you receive from them in the mail. The EOB informs us what your insurance plan paid, what their adjustments are, and any patient responsibility. With our Credit Card on File process, once claims are processed by your insurance company, any remaining balance owed by you will be charged to your credit card. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you do not receive an EOB in the mail, please contact your insurance plan to have them send you another copy.

If you don't have a credit card, you are welcome to leave a HSA (Health Savings Account) or Flex Plan card on file. If you would prefer not to leave any type of card on file, we ask for payment with cash or check at the time of service. Any qualified overpayment will be refunded in a timely manner. We will be happy to arrange payment plans for anyone who is unable to pay their balance; however, most payment plans require a credit card or e-check on file in our processing company's database.

If you should have any questions, please do not hesitate to call our billing office at 602-840-3120, option 6, option 2.

AUTHORIZATION

I authorize Camelback Pediatrics to charge all balances applied to copay, deductible, coinsurance, or denied for nonpayment of insurance premiums, or any other reason, to the following credit card:

Last 4 digits of credit card: _____ Expiration Date: _____

☐ If the balance due is more than \$50, I would like to receive a courtesy call prior to my card being charged.

Contact Number: _____

☐ Please charge my card for the full amount due on any claim.

I understand that once my health insurance(s) process my child's claims, I will receive an Explanation of Benefits (EOB) from my health plan. The EOB will show any balances due that are patient responsibility. I agree that Camelback Pediatrics may charge my credit card on file for the balance due when they receive the EOB from my health plan. I further understand that if payment is denied by the credit card on file, I will not be able to schedule any further appointments until the balance has been paid in full.

Date: _____

Print Name: _____

Signature of Cardholder

CAMELBACK PEDIATRICS, P.C.

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CONSENT BY PROXY FOR NON-URGENT PEDIATRIC CARE*

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete if you wish to authorize such treatment for your minor child(ren) in advance.

***All proxy representatives must be at least 18 years of age and present a valid photo ID at the time of check-in.**

Child's name: _____

DOB: _____

Child's name: _____

DOB: _____

Child's name: _____

DOB: _____

Child's name: _____

DOB: _____

Child's name: _____

DOB: _____

I, _____, have the legal right to delegate such consent to the proxy decision maker, who is an adult* and legally and medically competent to exercise the authority so delegated. I am aware that protected patient health information may be shared with the proxy to facilitate informed decision making.

Proxy Name: _____ DOB: _____ Relationship to patient: _____

Proxy Name: _____ DOB: _____ Relationship to patient: _____

Proxy Name: _____ DOB: _____ Relationship to patient: _____

Proxy Name: _____ DOB: _____ Relationship to patient: _____

LIMITATIONS:

Identify any limitations on the kind of medical services for which this proxy is given. If none, state "none."

Identify any limitations on the time frame for which this proxy is given. If none, state "none."

IN WITNESS WHEREOF, the undersigned have executed this instrument:

Printed Name of Parent/Legal Guardian

Parent/Legal Guardian Signature

Date

Witnessed and I.D. verified by