Mesquite
PEDIATRICS

Congratulations on your new baby!

Mesquite Pediatrics thanks you for trusting us with the care of your child. To assure continuity of care please be aware of the following:

- It is very important to add your baby to the insurance immediately after birth.
- Please call your Human Resource department or AHCCCS plan (this includes the United Community Plan and Banner University Family Care) as soon as possible.
- Most insurance plans allow you 30 days to add the baby. If the baby is not added within 30 days, the effective date of coverage might not be back dated to the date of birth.
- Mesquite will bill under the mother's insurance for your child's visits within the first 30 days. If your baby is not added and/or the insurance does not pay for these visits, you will be responsible for payment in full.
- After 30 days, if your baby cannot be verified with insurance you will be considered self pay until the baby is added and verified. Payment for services will be due at the time services are rendered.

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Patient Registration

Patient Last Name _____ First _____MI_____

Address _____ City, State, Zip _____

Date of Birth _____ Sex _____

PCP (circle one) Abdy Couchman McMahon

How did you hear about Mesquite Pediatrics? _____

Parent/Guardian 1 Information

Name_____ DOB_____

Address _____ City, State, Zip _____

Home Phone _____ Cell _____

Employer _____ SS#_____

Relationship to patient _____ Email_____

Parent/Guardian 2 Information

Name_____ DOB_____

Address _____ City, State, Zip _____

Home Phone _____ Cell _____

Employer _____ SS#_____

Relationship to patient _____ Email_____

Emergency Contact _____ Phone# _____

Insurance

Primary Insurance Company_____

Policy Holder Name_____ Date of Birth _____

Relationship to patient_____

Policy Number_____ Group Number _____

Address to mail claims_____

I certify that the information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Mesquite Pediatrics and authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature_____Date_____

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Vaccine Policy Statement

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives. We firmly believe in the safety of our vaccines. We firmly believe that all children and young adults should receive all recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics (AAP).

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age. By 9 months of age patients must have all immunizations recommended by the AAP in the first six months of life. By 18 months of age patients must have all immunizations recommended by the AAP in the first 15 months of life. Additional requirements include 2 Hepatitis A vaccines by age 2, all AAP recommended kindergarten booster vaccines by age 6 and the meningococcal and Tdap vaccines by age 12.

Finally, if you refuse to vaccinate your child despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers nor would we recommend any such physician. Please recognize that by not vaccinating, you are putting your child at unnecessary risk for life-threatening illness, disability, and even death.

Please sign below to indicate that you are aware of and plan to abide by this policy.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date

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CONSENT TO TREAT, PRIVACY NOTICE ACKNOWLEDGMENT, INSURANCE ASSIGNMENTS, & AUTHORIZATION TO RELEASE INFORMATION

CONSENT TO TREAT: I consent to medical care and treatment as may be deemed necessary or advisable in the judgment of my physician, which may include but are not limited to; laboratory procedures medical or surgical treatment or procedures, local anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician. _____**(Initial)**

PRIVACY NOTICE ACKNOWLEDGEMENT: I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations. I hereby acknowledge that I have been presented with a copy of Mesquite Pediatrics' Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information. _____**(Initial)**

INSURANCE ASSIGNMENTS: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Mesquite Pediatrics for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. _____**(Initial)**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Mesquite Pediatrics to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims during my child's treatment. This order will remain in effect until revoked by me in writing. _____**(Initial)**

Patient Name _____ Date of Birth _____

_____ _____ _____
Responsible Party Signature Print Name Date

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MESQUITE PEDIATRICS FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance, co-payments and deductibles for participating insurance companies. Acceptable forms of payment include cash, personal checks (established patients only), VISA, and MasterCard. Please note that there is a service charge of **$25.00** for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We reserve the right to charge a billing fee after 60 days. Any unpaid balances after 90 days could result in collection action. **If this should occur, you will be charged a 35% collection fee.** We realize that financial difficulty is a reality and we are happy to help our families in need. Financial arrangements are encouraged should you be unable to pay your balance in full. If you need assistance in this area, please contact our practice manager.

INSURANCE: We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

REFUNDS: Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. We reserve the right to charge the current no show fee as listed on our website for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

PRIMARY CARE PHYSICIAN ASSIGNMENT: It is your responsibility to ensure that one of the doctors at Mesquite Pediatrics is assigned as your Primary Care Physician if your insurance policy requires you to choose one. Failure to do so may result in additional out of pocket costs for you.

FINANCIAL AGREEMENT: I have requested medical services from Mesquite Pediatrics on behalf of myself and/or my dependents, and understand that by making this request I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement.

I understand and agree to follow the payment policies set forth in the Mesquite Pediatrics Financial Policy and have been given the opportunity to ask questions about this policy.

_____ _____

Patient Name Date of Birth

_____ _____ _____

Responsible Party Signature Print Name Date

Mesquite Pediatrics Contact Preferences

Patient Name _____ Date of Birth_____

Who is the primary contact for the patient?

Name _____Relationship _____

Choose one Patient Confidential Communication Preference:

Method: Cell phone: Call [ ] Text [ ] Email [ ]

Other Authorized Persons

I, _____, hereby give permission to the individuals listed below to bring my child to Mesquite Pediatrics and to make any and all medical decisions at the time of the visit. This permission will remain in effect until such time that I specifically revoke it.

People, **other than parents,** who may bring the child:

Name	Relationship to patient	Phone Number
Name	Relationship to patient	Phone Number
Name	Relationship to patient	Phone Number
Name	Relationship to patient	Phone Number

Responsible Party Signature	Print Name	Date

For children age 16 and older: I give permission for them to present to Mesquite Pediatrics for care without the presence of an adult guardian. This permission will remain in effect until such time that I specifically revoke it.

Responsible Party Signature	Print Name	Date	Child's phone number

Mesquite Pediatrics Family History Questionnaire

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Was your child adopted? Yes No If "yes", at what age? _____ Siblings' Names: _____

Checkmark any relatives who have the following.	Mother	Father	Sister	Brother	Biological Mother's Side				Biological Father's Side			
					Grand-mother	Grand-father	Aunt	Uncle	Grand-mother	Grand-father	Aunt	Uncle
Anemia/Bleeding Disorder (specify)												
High Blood Pressure												
Obesity/Overweight												
High Cholesterol												
Heart Disease (specify)												
Heart Attack before age 50												
Asthma												
Allergies (to what? food, pollen...)												
Vision Problems												
Frequent Ear Infections												
Hearing Loss												
Diabetes (Type 1 or Type 2?)												
Thyroid Problem (specify)												
Cancer (specify type)												
Stomach/GI (specify)												
Migraines/Headaches												
ADD/ADHD												
Developmental Problem												
Mental Health Problem (specify)												
Alcohol/Drug Abuse (which?)												
Skin Conditions (specify)												
Other Significant illnesses												

With which adult(s) does the child reside? _____

Is there a smoker in the household? Yes No

Is there a gun in the household? Yes No If "Yes", is it securely locked? Yes No