Healing Hearts
Pediatrics, P.L.C.

Dear Parents,

Welcome to Healing Hearts Pediatrics, PLC. We are happy to have the opportunity to care for your children and wish to make your child's medical care as easy and pleasant as possible. We wanted to tell you a little about our clinic and provide you with some important information in this letter.

We are currently open Monday through Friday from 8am until 5pm with lunch from 12pm to 1:30pm. We have some extended hours. We also have clinic hours on Saturday. If your child has any urgent problems that cannot wait until the next business day, a doctor or triage nurse is always available to discuss your problems. If it is a life-threatening emergency, we ask that you call 911. When you call our main number, follow the prompts and leave a message with our answering service. Your call will be forwarded to the appropriate person and returned as soon as possible.

We have a large number of forms that we would like you to complete on or by your first visit. We understand it is a lot of information, but it will help us to better care for your child, so please complete the form in its entirety to the best of your ability. You can complete these and fax them to us prior to the visit or bring them in on the day of your visit. Our fax number is (480) 821-2210.

We believe immunizations are very important and have a list of the immunizations that your child will be receiving available at the office. This series of shots will hopefully give your child life long protection from some horrible diseases including liver disease, pneumonia, meningitis, and many others. We support and implement the American Academy of Pediatrics and Center for Disease Control guidelines for immunizations. This fundamental piece of well care protects all of our patients, including newborns that have not yet received their vaccines. Due to a significant rise in vaccine preventable illnesses within our community, Healing Hearts Pediatrics, PLC has decided that we cannot see the children of parents who choose not to immunize them. Vaccine preventable illnesses have spread rapidly in doctor's waiting areas. We do not have the capacity of an emergency department to triage and isolate the spread of disease. Please consider this when you are choosing a pediatrician to take care of your child.

Please feel free to ask our staff or the doctors any question you have and we hope you enjoy your care here with us at Healing Hearts Pediatrics, PLC. Our website has access to important information 24 hours a day. The address is www.healingheartspeds.com.

We look forward to serving you and caring for your children.

Sincerely,

Healing Hearts Pediatrics, PLC

Healing Hearts Pediatrics, P.L.C.

Patient Information

Name (Last, First, Middle Initial)			SSN#	Birthdate	Sex
Address			City, State, Zip		
Primary Phone	Alternate Phone	Does the child have siblings that are patients here? ☐Yes ☐No		Sibling Names:	
Student Status ☐Full-time ☐Part-Time	Smoker (if applicable) ☐Yes ☐No	Mother's maiden name			

Guarantor Information (Financially Responsible Parent or Guardian Patient lives with)

Name (Last, First, Middle Initial)		SSN#	Birthdate	Sex
Address		City, State, Zip		
Primary Phone	Alternate Phone	Employer		
Employer Phone	Marital Status: ☐Single ☐ Married ☐ Divorced ☐Widow		Relationship to Patient	
E-mail Address:				

Other Parent or Guardian Information

Name (Last, First, Middle Initial)		SSN#	Birthdate	Sex
Address		City, State, Zip		
Primary Phone	Alternate Phone	Marital Status: ☐Single ☐ Married ☐ Divorced ☐Widow	Relationship to Patient	

Primary Insurance

Name of Insurance Company (If AHCCCS - Name of Plan)		Policy/Subscriber ID #	Group Number
Name of Owner of Policy (If AHCCCS – **CHILD** is Owner of Policy)		Relationship of Owner of Policy to Patient	
Owner of Policy Date of Birth (If AHCCCS – CHILD'S)	Owner of Policy Sex	Owner of Policy Employer	
Co-payment Amount	Deductible/Co-Insurance Amount	Owner of Policy Social Security Number	

Secondary Insurance (AHCCCS is always secondary to private insurance)

Name of Insurance Company (If AHCCCS - Name of Plan)		Policy/Subscriber ID #	Group Number
Name of Owner of Policy (If AHCCCS – **CHILD** is Owner of Policy)		Relationship of Owner of Policy to Patient	
Owner of Policy Date of Birth (If AHCCCS – CHILD'S)	Owner of Policy Sex	Owner of Policy Employer	
Co-payment Amount	Deductible/Co-Insurance Amount	Owner of Policy Social Security Number	

Other Information

Primary Language: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Unreported ☐ Other_____ Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Multi-racial ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/ Unreported ☐ White	Referred by: ☐ Friend ☐ Previous Patient_____ ☐ Physician, Name_____ ☐ Internet/Insurance ☐ Other_____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/ Unreported

Financial Policy Agreement

Thank you for choosing Healing Hearts Pediatrics P.L.C. for your child's health care. We are committed to providing quality medical care for your children. In order to reduce potential misunderstandings, our office has adopted the following Financial Policy. We require that you read it and agree to abide by it prior beginning treatment.

Insurance

Your insurance policy is a contract between you and your insurance plan. We cannot efficiently bill your insurance company unless you provide us with current and valid insurance information. We will file claims to those plans with which we have a contractual agreement. As a courtesy, we will file claims to those plans with which we do not have a contractual agreement as unassigned and the insurance company will send the payment directly to you, therefore full payment is expected at the time of service.

All health plans are not the same and they do not always cover the same services or facilities. In the event that your health plan determines that a service is "not covered" you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. Payment for services rendered is due by the 1st day of the month after the charge has printed on your statement.

Non-covered or allowed services will only be charged to you per the contract Healing Hearts Pediatrics P.L.C. has with your insurance company. Examples of this would include screening exams and/or telephone encounters.

We expect you to familiarize yourself with the benefits and limitations of your insurance policy including, but not limited to: deductible and co-payment amount as well as approved labs, radiology facilities, well care coverage, vision and hearing screens, vaccines and hospitals contracted with your plan. It is your responsibility to notify our office when either your insurance plan or benefits change. Any cost incurred by this office because of incorrect information you provided to us may be passed on to you.

If you have insurance coverage with a plan with which Healing Hearts Pediatrics does not participate or you currently have no health insurance, charges for your child's care and treatment are due at the time of service, unless prior financial arrangements have been set up with our Office Manager. Should HHP feel it necessary to turn your account over to an outside Collection Agency, you will be held responsible for any fees incurred in that process.

We will do our best to verify your insurance coverage, but this does not guarantee an active policy at the time of your visit/treatment. Should there be a short fall in payment, or a non-payment of services by the insurance company, it is ultimately the responsibility of the patient (or legal guardian) for all outstanding payments relating to services rendered.

No Insurance

If you have no insurance coverage, Healing Hearts Pediatrics has implemented a Payment Plan Option for those services that are "Medically Necessary". Payment Plan arrangements need to be in writing and secured with a credit card, debit card. or post-dated checks. A Payment Plan Option can be arranged with the Front Office, at 480-821-1400.

Deductibles/Co-pays/Payments

Our insurance contracts require us to collect deductible amounts and co-pays at the time of service. These amounts will be collected prior to service being rendered. Your insurance company may require a co-pay for "immunization only" visits. For your convenience we accept VISA, MasterCard, and American Express in addition to personnel checks and cash. If your check is returned to us for insufficient funds, we will assess a service charge equal to the bank fees assessed to Healing Hearts Pediatrics P.L.C.

Well Child Care and Sick Visit" Same Day Charge Notice

Parents, please note, an office visit copay will apply should your child require additional medical attention (i.e., pre-existing problem, illness, abnormality, or new problem) during their scheduled preventative Well Child Care visit.

Appointments

Our goal is to provide the best possible care and physician availability to each of our patients. Our policy is to request you to call and cancel appointments 24 hours prior to scheduled appointment. Please call us, as early as possible, when you know you will need to reschedule and/or cancel an appointment. You may be charged a fee for failed appointments.

Minor Patients

For all services that are rendered to minor patients (under the age of 18), the parent and/or guardian of the patient is held financially responsible for payment and needs to be present for all visits.

Information

I hereby agree that the above enrollment information is correct, and I also agree that any changes to the enrollment information will be communicated to Healing Hearts Pediatrics as required to fulfill the medical and financial obligation for services rendered.

Authorization

I hereby request and consent that my medical records and non-written records be sent to my referring physicians, those physicians or ancillary facilities that I am referred to by the Healing Hearts Pediatrics P.L.C. and to my insurance company or its agents that may be authorizing treatment. I further understand that my medical records may contain sensitive information and hereby authorize the release of all confidential HIV related information, communicable diseases related information, drug and alcohol abuse/treatment information and mental health diagnosis/treatment information to the above.

I also consent to release of immunization records and medication information to my child's school and/or pre-school which is deemed pertinent and necessary for my child's enrollment and/or healthcare in the school district in which my child attends.

Financial Authorization

I hereby authorize payment directly to the attending physician for medical and/or surgical benefits, if any from the insurance carrier to Healing Hearts Pediatrics, P.L.C. If paying cash, I am responsible to pay at the time of service.

Privacy Practices and Patient Rights and Responsibilities

I have been presented with a copy of the Notice of Privacy Practices for the office of Healing Hearts Pediatrics, P.L.C. detailing how my information may be used and disclosed as permitted under federal and state law. I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Notice of Privacy Practices.

I have been presented with a copy of the Patient Rights and Responsibilities and the Non-Compliance Reporting Form(s) for the office of Healing Hearts Pediatrics, P.L.C. and understand the process for reporting Non-Compliance incidents. I understand that the copy presented is a copy for my reading and viewing while in the office and if I request I will be given a copy of the Patient Rights and Responsibilities and reporting forms for Non-Compliance incidents.

Health Current Patient Notification Process

"I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider."

Permission to Treat

I hereby authorize the following individuals to sign authorizations to administer immunizations or bring child in for appointments or make any medical decisions deemed necessary in the event of my absence.

(Persons other than parents or guardians)

*Parents, please keep in mind, emergencies do come up and unless a person is listed on your child's chart, per HIPAA guidelines, they will NOT be able to have your child treated without documentation from you that they have authorization to have child seen without you being present. Please list ANYONE who may EVER need to bring your child in, in the event that you can not! Persons living outside of the state IS acceptable! Thank You!

Examples: (Grandparents, Older Siblings, Aunt/Uncles, Child Care Providers)

Name of Person	Relationship to Child

I agree that the information provided is correct and accurate:

_____
Patient Name (Please print)

_____
Printed Name of Parent or Guardian

_____
Signature of Parent or Guardian

_____
Effective Date

Healing Hearts Pediatrics, P.L.C.

Patient Intake	
Patient Full Name:	Date of Birth:
Previously seen or treated by: (Name of Doctor/Practice)	

Pharmacy	
Name of Pharmacy:	Phone Number:
Address or Crossroads:	

Birth History		
What hospital did you deliver in?		
Delivery Type?	☐ Vaginal ☐ Cesarean	
Approximate time of birth?	_____ am or pm	
How long was your pregnancy?	_____ weeks	
Birth Weight and Length	_____ lbs _____ oz	_____ inches
Was more than one baby delivered?	☐ Yes ☐ No	
Apgar Score	_____ 1 min	_____ 5 min
Vitamin K injection?	☐ Yes ☐ No	
Hepatitis B Vaccine?	☐ Yes ☐ No	
Hearing Test Performed? If Yes, was the result normal?	☐ Yes ☐ No	
Infant's Blood Type?	_____ ☐ Rh positive ☐ Rh negative	
Was your baby jaundiced at birth?	☐ Yes ☐ No	
Was phototherapy (treatment with lights) required?	☐ Yes ☐ No	
Oxygen required for baby?	☐ Yes ☐ No	
Stayed in NICU? If yes, how many days?	☐ Yes ☐ No _____ days	
Were there birth defects?	☐ Yes ☐ No	
Was newborn screen (PKU, sickle cell, etc) done at birth?	☐ Yes ☐ No	
Were there medications given to baby at birth?	☐ Yes ☐ No	
Was your baby circumcised at birth?	☐ Yes ☐ No	
During your baby's 1st year, did you breastfeed or formula feed?	☐ Breastfed ☐ Formula	
What kind of formula?	_____	

If feeding problems, please explain:	

Maternal Illness/Complications

Did you receive prenatal care?	☐ Yes ☐ No
Mother's blood type?	_____ ☐ Rh positive ☐ Rh negative
Have diabetes or sugar in your urine?	☐ Yes ☐ No
Have high blood pressure or other cardiac problems?	☐ Yes ☐ No

Maternal Infections?

☐ Gonorrhea	☐ Syphilis	☐ Chlamydia	☐ Parvovirus	☐ B Strep (GBS)	☐ Rubella	☐ Cytomegalovirus (CMV)

Take any medications?	
Drink alcohol?	☐ Yes ☐ No
Smoke cigarettes?	☐ Yes ☐ No
Use other drugs?	If yes, list: _____

Patient Medical History

Serious illness, accident, surgery, hospitalization	Complications	Age of Child
1		
2		
3		
4		

Any Chronic Diseases (e.g. Allergies, Asthma, Recurrent Ear Infections) _____

Additional Concerns

Circle any ongoing problems that concern you.

Frequent cough	Sleep Issues	Vision concerns
Frequent runny nose	Temper tantrums	Hearing concerns
Frequent constipation	Eats too little	Speaks unclearly
Cries a lot	Eats too much	Small for age

Please list any other problems or concerns you may have.

_____

Current Medications
1
2
3
4
5
6
7
8
9
10

Any concerns for our Care Coordinator regarding:
-Domestic violence -drug or alcohol abuse -suicide -depression -mental illness -loss of job

Other:_____

Family Medical History

No Relevant Family History? ☐ Yes ☐ No	Patient Adopted/Foster Care? ☐ Yes ☐ No

Circle any that apply:

ADD/ADHD	Deafness	Hemoglobinopathy	Scoliosis
Allergies	Depression	Hypertension	Seizure Disorder
Asthma	Developmental Delay	Learning Disability	Strabismus
Birth Defects	Diabetes	Mental Retardation	Sudden infant death
Cancer	Eczema	Migraines	Thyroid disease
Cardiovascular Disease	Elevated Lipids	Obesity	
Coronary Artery Disease	Genetic Disease	Renal Disease	

Please explain any family history or chronic illnesses here:

_____

Social History

Parents Relationship Status	☐Single ☐Married ☐Divorced ☐Widowed
Parents Ages	
Parents Occupations	
Child is oldest/youngest/middle in family.	☐ Oldest ☐ Youngest ☐ Middle ☐Only
Does anyone in your household smoke?	☐ Yes ☐ No If yes, ☐ Inside ☐ Outside
Home Type:	☐House ☐Apartment ☐Condo ☐Townhouse ☐Homeless
What is the age of your home?	
Is there lead in your house?	☐ Yes ☐ No ☐ Removed ☐Unknown
Uses bike/skating helmet	☐ Yes ☐ No
Car restraints	☐ Front Facing Car Seat ☐ Booster ☐ Rear Facing Car Seat ☐ Seat Belt
Carbon monoxide detector:	☐ Yes ☐ No Gas in Home? ☐ Yes ☐ No
Smoke detectors:	☐ Yes ☐ No
Firearms(weapon) in the home:	☐ Yes ☐ No Unloaded and Locked for Storage? ☐ Yes ☐ No

Is there a pool or spa at the home?	☐ Yes ☐ No Fenced? ☐ Yes ☐ No
Pets/animals at home:	☐ Yes ☐ No If yes, details:

TB Risk Assessment	
Is the patient HIV positive?	☐ Yes ☐ No
Has the patient ever had a chest x-ray that was "suggestive" of TB?	☐ Yes ☐ No
Has the patient had close contact with someone who has infectious TB?	☐ Yes ☐ No
Has the patient had an organ transplant?	☐ Yes ☐ No
Is the patient immunosuppressed?	☐ Yes ☐ No
Does the patient have any chronic medical problems that increase their risk?	☐ Yes ☐ No
Was the patient born in a country where TB is prevalent?	☐ Yes ☐ No
Has the patient traveled outside the US since their last TB test?	☐ Yes ☐ No
Does the patient use or have they ever used IV drugs?	☐ Yes ☐ No
Is the patient working or living in a congregate setting? (homeless shelter or nursing home)	☐ Yes ☐ No

_____

Patient Name (Please print)

_____

Signature of Parent or Guardian