TWIN PEDIATRICS, P.C.

Patient Name	Birthdate	Age	Sex [ ] M [ ] F	SS #
Address	City		State	Zip Code
Home Phone				
Responsible Party	Relationship	Daytime Phone	Alternate Phone	
Address	City		State	Zip Code
SS #	Employer			
Address	Phone #			

Insurance - If your coverage is contingent on a second opinion or pre-approval, it is your responsibility to inform us.

[ ] No Coverage	[ ] APIPA	[ ] MCP	[ ] PHP	[ ] Other AHCCCS Ins.	Name:	[ ] BC/BS AZ	[ ] Cigna	[ ] UHC	[ ] Other PVT Ins Name:

Primary Insurance Company Name			
Policyholder	DOB	ID #	Group #
Secondary Insurance Company Name			
Policyholder	DOB	ID #	Group #
[ ] AHCCCS		Claim #	
Emergency Contact		Phone #	
How did you learn about our practice?			

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

AHCCCS

I request that payment of authorized AHCCCS benefits be made to Twin Pediatrics, P.C. I authorize release of medical information to HCFA necessary to determine benefits, and authorize AHCCCS to furnish any information regarding AHCCCS claims to the above doctor.

Date _____ Signature - Parent or Guardian _____

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE PARTY OR GROUP INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier.

Date _____ Signature - Parent or Guardian _____

TWIN PEDIATRICS, P.C.

Health History Questionnaire Page 1 of 2

Patient Name			
Sex [ ] Male [ ] Female	Race	SS #	Birthdate

	NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
FATHER				
MOTHER				
SIBLING				
SIBLING				
Additional Members In Household OTHER				
OTHER				

Have there been any recent major changes or stress in the child's life? ☐ YES ☐ NO

If YES, Please explain: _____

Does child go to a baby sitter, preschool or day care regularly? ☐ YES ☐ NO

Birth History:

Birth Weight: _____ Length: _____ Place: _____

During the pregnancy did the mother: (if YES, please explain)

Have any medical problems?	☐ YES ☐ NO	_____
Smoke or Drink?	☐ YES ☐ NO	_____
Use any medications?	☐ YES ☐ NO	_____
Use alcohol or other drugs?	☐ YES ☐ NO	_____
Have problems with labor and/or delivery?	☐ YES ☐ NO	_____
How long did the baby stay in the hospital after birth?		_____

Past Medical History:

Is the child's general health (please check one)

☐ Good ☐ Fair ☐ Poor

Does the child have any allergies?	☐ YES ☐ NO	_____
Is the child taking any medications?	☐ YES ☐ NO	_____
Use any medications?	☐ YES ☐ NO	_____

Please list any hospitalizations, operations, serious illnesses or accidents with dates:

_____ Date: _____

_____ Date: _____

TWIN PEDIATRICS, P.C.

Health History Questionnaire Page 2 of 2

Has the child ever had any problems with the following: (if YES, please explain)

Patient Name: _____

Eyes / Vision	☐ YES	☐ NO	
Digestion / Nutrition	☐ YES	☐ NO	
Ears / Hearing	☐ YES	☐ NO	
Urine / Kidneys	☐ YES	☐ NO	
Joints	☐ YES	☐ NO	
Skin	☐ YES	☐ NO	
Lungs	☐ YES	☐ NO	
Teeth	☐ YES	☐ NO	
Heart	☐ YES	☐ NO	
Seizures	☐ YES	☐ NO	
Repeated Infections	☐ YES	☐ NO	

Family History:

Has any of the child's brothers or sisters died? ☐ YES ☐ NO

If YES, please give age and cause: _____

Have any of the child's blood relatives had the following diseases: (if YES, please list family member)

			FAMILY MEMBER
Heart Disease	☐ YES	☐ NO	
Tuberculosis	☐ YES	☐ NO	
High Blood Pressure	☐ YES	☐ NO	
Kidney Disease	☐ YES	☐ NO	
Allergies / Asthma	☐ YES	☐ NO	
Cancer	☐ YES	☐ NO	
Diabetes	☐ YES	☐ NO	
Mental / Emotional Problems	☐ YES	☐ NO	
Sickle Cell	☐ YES	☐ NO	
Seizures	☐ YES	☐ NO	

Development:

Do you have any concern about the following? (if YES, please explain)

			EXPLANATION
Development	☐ YES	☐ NO	
Behavior	☐ YES	☐ NO	
Eating Habits	☐ YES	☐ NO	
Sleeping Habits	☐ YES	☐ NO	
School Experience	☐ YES	☐ NO	
Bathroom / Toilet Habits	☐ YES	☐ NO	
Discipline	☐ YES	☐ NO	
Other (Please explain)	☐ YES	☐ NO	

Immunizations:

Is child behind on Immunizations? _____

Please provide our office with a copy of your child's Immunization record.

Reviewed by: _____ Date: _____

TWIN PEDIATRICS, P.C.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I (We), parent, legal guardian of _____,
date of birth_____, acknowledge receipt of the **Notice of Privacy Practices** for Twin Pediatrics, P.C.

Your signature is required by the ruling set forth by the federal government as part of the Health Insurance Portability and Accountability Act. A separate acknowledgement will be required for each child seen in our office.

_____ _____ _____

Signature Relationship Date

Twin Pediatrics P.C.

Patient Eligibility Screening Record
Vaccine for Children Program-VFC

This record must be kept in the healthcare provider's office to reflect the current status of all children 18 years of age or younger declared eligible to receive immunizations through the VFC program. The record may be completed by the parent, guardian, individual of record, or by the healthcare provider. This same record may be used for all subsequent visits as long as the child's VFC eligibility status has not changed. Provider verification of responses is not required, but it is necessary to record on file for a minimum of three years.

Date: _____

Child: _____
Last Name First Name M.I.

Date of Birth: _____

Provider:

Twin Pediatrics P.C.
20033 N. 19th Ave., Bldg 4, Ste 100
Phoenix, AZ 85023
Louis Trunzo, MD, FAAP Alisa Kurth MSN, APRN, FNP-C

This child qualifies for vaccination through the VFC program because he/she ***(Check only one box):***

(A) [ ] is enrolled in KidsCare; or

(B) [ ] is enrolled in AHCCCS; or

(C) [ ] does not have health insurance; or

(D) [ ] is American Indian or Alaskan Native; or

(E) [ ] has health insurance that does not pay for vaccines

[ ] **Check here is this child has health insurance that pays for vaccines. These children do not qualify for VFC.**

Please be advised, if your insurance company does not cover immunizations and you do not let us know at the time of the visit, it is your responsibility to pay the cost involved. We can not make Vaccines for Children Program retroactive and you are only eligible for Vaccines for Children Program at the time of the visit. If you are unsure if immunizations and well check-ups are covered, please contact your insurance company. Thank you.

Signature_____ Date_____

Twin Pediatrics, P.C.

Patient Financial Policy

In order, to reduce confusion and misunderstanding between our parents and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing staff. We are dedicated in providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your child s care and treatment. As a reminder: Your insurance policy is a contract between **you and your insurance company, the doctor is not involved.** You are responsible for knowing your child's benefits.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier, **full payment is due at the time of service.** For your convenience we accept VISA, MasterCard, Discover, Debit Cards, Check or Cash.

A **$30 fee** will be added to accounts for any checks that are returned to us for non-payment.

We are contracted with many insurers and health plans. As a courtesy to you, we will bill your child's health plan and you will only be required to pay the authorized Co-Payment at the time of the office visit. For any Co-Pay or balance that is not paid-in-full at the time of service, a **$10.00 administrative fee will be added to the account.** All other balances determined by your insurance that is applied to deductible, cost share, co-insurance or not covered is due by the responsible party upon receipt of a statement from our office.

We make every effort to accommodate our parents schedule when making an appointment for their child/children, please be considerate in keeping your child's appointment. **For appointments that are not canceled with at least a 24-hour notice, a $25 No Show fee will be added to your child's balance.** Multiple No Shows will be reported to your child's insurance health plan or may result in your child being discharged from our practice.

FMLA/DISABILITY FORMS – There will be a **$40 fee for each child or form** that needs to be completed by the physician.

MVD HANDICAP FORM—There will be a **$15 fee for each child or form** that needs to be completed by the physician.

MEDICAL / SPORTS / PHYSICAL FORMS – There will be a **$30 fee for each child or form** that needs to be completed. Please make sure the parent / employee areas are completed prior to bringing the form. Sports / Physical forms completed at the time of the Office Visit will be No Charge.

RELEASE OF RECORDS – Copy of Medical Record for personal use is **$25.** You can pick up your records in office or have them mailed/faxed. Records needed by a Specialist, Insurance Company (for visit payment), or transferred to another office are available at no charge for the first set. A **$30 fee** will be charged for copies that are needed for Law Firms, Courts, etc.

SHOT RECORDS – Immunization books are **$5.** Copies of immunizations from our office are provided at no charge.

COLLECTIONS – If your child's account goes to an outside collection agency for an outstanding balance. Your child will be discharged from the practice until the outstanding balance is paid in full plus a ***$50.00 collection fee.***

Twin Pediatrics, P.C.

Patient Financial Policy

If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, our charges for your child's care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. A non-covered service example would be: In-house testing & sick visit coverage, after-hours charge, well visit coverage, immunizations, vision screen.

For all services provided in the hospital, we will bill your health plan. Any balance due is your responsibility and is due upon receipt of a statement from our office.

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Divorced Parent's Financial Responsibility:

Except in limited circumstances, such as the case of an emancipated minor, parents are the financially responsible for their child's care. When we provide services, we bill the appropriate insurance carrier. However, the parents remain responsible for any unpaid amounts. Although divorced parents may have a divorce decree that establishes their financial responsibilities with respect to each other, we are not a party to the decree. Therefore, we are not bound by the terms of the divorce decree. Accordingly, we require the parent accompanying the child for treatment to accept primary responsibility for payment of services. This "custodial" parent remains financially liable for any uncollected amounts.

In order, to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Please Print the Name of the Patient	Date of Birth
Signature of Patient or Responsible Party if a Minor	Date
Signature of Co-responsible Party	Date

TWIN PEDIATRICS, P.C.

PARENT (PATIENT) CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

*PLEASE NOTE: For parents with more than one child – a consent form/acknowledgement of receipt of our Notice of Privacy Practices must be signed for **each child** that is a patient of our practice.*

With my consent, **Twin Pediatrics, P.C.** may use and disclose protected health information (PHI) about my child to carry out treatment, payment and healthcare operations (TPO). Please refer to **Twin Pediatrics'** *Notice of Privacy Practices* for a more complete description of such uses and disclosures.

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. **Twin Pediatrics, P.C.** reserves the right to revise its *Notice of Privacy Practices* at anytime. A revised *Notice of Privacy Practices* may be obtained by forwarding a written request to **Twin Pediatrics, P.C.** Privacy Officer at *20040 N. 19th Ave. Ste C. Phoenix, AZ 85027*

With my consent, **Twin Pediatrics, P.C.** may call my home, place of employment or cell phone and leave a message on voice mail, by an automated dialing system or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my child's clinical care, including laboratory results among others.

With my consent, **Twin Pediatrics, P.C.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **Twin Pediatrics, P.C.** restrict how it uses or discloses my PHI to carry out TPO. *However, the practice is not required to agree to my requested restrictions, but if it does, it is* bound by this agreement.

By signing this form, I am consenting to **Twin Pediatrics'** use and disclosure of my child's PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Twin Pediatrics, P.C.** may decline to provide treatment to my child.

_____
Signature of Parent or Legal Guardian

_____ _____/_____/_____
Patient's Name Date

_____ _____
Print Name of Parent or Legal Guardian Twin Pediatrics Staff Initials

rev. 12/23

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

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A second medical opinion from the clinician of your choice, at your expense.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- To make decisions about the care the physician recommend and to have those decisions respected. A patient who has decision making capacity may accept or refuse any recommended medical intervention.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Have your pain evaluated and managed.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The expectation that we will take reasonable steps to overcome cultural or other communication barriers that may exist between you and the staff.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.
- To provide a copy of your Advanced Directive or Living Will if you currently have one, or request assistance with creating one through http://www.azsos.gov/adv_dir/ or https://healthcurrent.org/azhdr/

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g., allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e., herbal or other, therapies, or over-the-counter medications you take. If possible, bring the bottles to your appointment.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the health center at least 24 hours in advance.
- Paying copayments at the time of the visit or other bills upon receipt.
- Following the office's rules about patient conduct; for example, there is no smoking in our office.
- Respecting the rights and property of our staff and other persons in the office.

By signing this document, I acknowledge that I have read and understood my rights as a patient at Twin Pediatrics, PC.

_____ _____

Patient or Guardian Signature Date Signed

TWIN PEDIATRICS, P.C.

TREATMENT AUTHORIZATION

I, _____ hereby authorize _____,
Please print (parent/guardian) Please print name

_____, to bring _____, _____/_____/_____
Relationship to child please print child's name date of birth

For medical care provided by Twin Pediatrics, P.C.

This consent includes the authorization for treatment, medication, injections, Immunizations and laboratory tests as necessary.

_____ _____-_____-_____ _____/_____/_____
Signature of Parent/Guardian Social Security Number Today's Date

_____ _____ _____/_____/_____
Signature of Twin Pediatrics Staffer Title Today's Date

THIS AUTHORIZATION CAN BE REVOKED (IN WRITING) AT ANY TIME.

PERIODIC UPDATES WILL BE REQUIRED.

Update: _____ Initials: _____

Update: _____ Initials: _____

Signature & ID Verified: [ ] Yes [ ] No Twin Pediatrics Rep. Initials: _____

Twin Pediatrics P.C.
20040 N 19th Ave Suite C
Phoenix, AZ 85027
Phone: 623-869-8948 Fax: 623-434-4169

BOARD CERTIFIED PEDIATRICIANS
Louis Trunzo, MD, FAAP
Alisa Kurth MSN, APRN, FNP-C

AUTHORIZATION TO RELEASE RECORDS

( ) ALL RECORDS ( ) IMMUNIZATION REC ( ) BILLING LEDGER

Patient Name: _____
Date of Birth: _____/_____/_____ Phone #: (_____) _____-_____
Address: _____

I hereby authorize the release of Medical records, Immunization records or Billing Ledger concerning the above named patient:

FROM:

_____
Name of Entity (Self, Day Care Center, School, Dr's Office, etc.) Authorized to send records.

_____
Address

_____ _____
Phone Number Fax Number

TO:

_____
Name of Entity or Person to receive records.

_____
Address

_____ _____
Phone Number Fax Number

I authorize the release of the Medical Records, Immunization records or Billing ledger in possession or control of Twin Pediatrics P.C., its employees or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661) CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCHOHOL OR DRUG ABUSE – RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS / TREATMENT AUTHORIZATION.
I understand that when my child's information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule.
I am aware that it is important for me, as the parent/legal guardian to maintain the original immunization record booklet for my child, and to bring the booklet for each well child check visit. I understand and agree that I may be responsible for the following fees associated with my request: copying charge (supply cost, labor and postage or fax fee) related to the reproduction of my child's information. One copy per year is deemed and reasonable and will be provided (upon request) as a courtesy. Any additional requests will have a minimum charge of $5.00.

_____ _____
Signature of Patient; Parent Legal Guardian Date

_____ _____
Printed Name Relationship to patient

For office use only

ID Verified: ( )Y ( )N

Twin Peds Staff Initials:

_____