Advance Pediatrics PLLC
Rakesh Arora, MD.
Sonya Mody, MD.

9836 W Yearling Road F-1300
Peoria, AZ 85383

8232 W Cactus Rd. Ste #124
Peoria, AZ 85381

(PH) 623-328-8664 (FAX) 623-328-9432

PATIENT INFORMATION/ DEMOGRAPHICS

DATE: _____

PATIENT NAME: _____ DOB: _____ SEX: M / F

ADDRESS: _____

CITY/STATE/ZIP: _____

PREFERRED PHONE NUMBER: _____ MAY WE LEAVE A MESSAGE / Text? YES/ NO

E-mail ADDRESS: _____

PREFERRED PHARMACY: _____

PARENT INFORMATION

PLEASE CHOOSE ONE

MOTHER/ STEPMOTHER/ LEGAL GUARDIAN

NAME: _____

CELL #_____

WORK #_____

DOB_____MO/DAY/YEAR

EMPLOYER NAME_____

PLEASE CHOOSE ONE

FATHER/STEPFATHER/ LEGAL GUARDIAN

NAME: _____

CELL #_____

WORK #_____

DOB_____MO/DAY/YEAR

EMPLOYER NAME_____

EMERGENCY CONTACT INFORMATION

NAME/ PHONE #_____ RELATIONSHIP_____

NAME/ PHONE #_____ RELATIONSHIP_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

MEMBER ID _____ GROUP NO._____

POLICY HOLDER NAME _____DOB:_____

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE COMPANY _____

MEMBER ID _____ GROUP NO._____

POLICY HOLDER NAME _____DOB:_____

RELATIONSHIP TO PATIENT_____

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Patient Acknowledge of Receipt of "Notice of Privacy Practices"
Reconocimiento del Paciente de haber recibido un "Aviso de Practicas de Privacidad"

Patient Name/Nombre del Paciente: _____

Date of Birth/Fecha de Nacimiento: _____

English:

1. Acknowledgement of receiving version #__01____ of the providers "Notice of Privacy Practices" on (date)_____. Initials of patient or patient's representative_____

   Reason why Acknowledgement was not obtained_____

   _____

2. Acknowledgement of receiving version #_____ of the providers "Notice of Privacy Practices" on (date)_____. Initials of patient or patient's representative_____

   Reason why Acknowledgement was not obtained_____

   _____

Spanish:

3. Reconocimiento de haber recibido la version #___01___ del " Aviso de Practicas de Privacia" del proveedor en (fecha)_____. Iniciales de paciente o el representante del paciente _____. Razon por lo cual no se obtuvo un Reconocimiento_____

   _____

4. Reconocimiento de haber recibido la version #_____ del " Aviso de Practicas de Privacia" del proveedor en (fecha)_____. Iniciales de paciente o el representante del paciente _____. Razon por lo cual no se obtuvo un Reconocimiento_____

   _____

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Financial Agreement

Please review the financial agreement for our practice. By signing this document, you are agreeing to all the terms in it.

Terms of Financial Agreement with ADVANCE PEDIATRICS, PLLC.

Verification of eligibility and benefits are conducted every time you have an office visit, however, per your insurance carrier, this is not a guarantee of payment. Please be advised that you may be subjected to a deductible, co-insurance amount or co-payment responsibility which we may not be aware of until the claim for the office visit has been processed by your insurance carrier. Should there be a remaining balance due after your insurance has processed the claim, a statement will be sent to you for payment. Also, please be advised that failure to provide correct, new, or additional insurance information in a timely manner may result in additional financial responsibility on your part, this includes any private insurance coverage as well as AHCCCS.

I, _____, the Parent/Guardian of patient, _____, understand that I am obligated to provide payment for any medical services through this office. I understand that while insurance may cover some of my expenses, I will be personally responsible for anything not handled by my insurance.
By signing this document, I am authorizing my insurance to cover any expenses attributed to Advance Pediatrics, PLLC.
I agree to cover any co-pay/ Deductible or Co-insurance at the time of the visit. I will pay any bill received within 30 days time. I understand that any failure to pay will result in a non-refundable late fee charge of $20 and the account will be forwarded to the Collection Agency after 60 days.

Itemized bills can be requested from the office. I understand that it is my responsibility to understand the coverage and limitations of my insurance. By signing this document, I am certifying that all of my billing is correct including my address phone number, and email. I will provide a copy of my insurance card and license/ photo ID when returning this document to the front desk.

_____ (Patient Name) _____ (Patient DOB)

☐ I have read and agree to the Financial Agreement terms stated above.

_____ _____
Parent/ Guardian Name (printed) Parent/Guardian Signature

Date _____

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Parent Permission Form

Patient Name:_____ Date of Birth:_____

Patient Address:_____
Street Apt#

_____
City, State Zip Code

I (we), being parent(s) or legal guardian(s), give permission to Advance Pediatrics, PLLC to consult, immunize or treat my child when they are accompanied by following adults:

Name_____ Relationship to Patient:_____Phone#_____

Name_____ Relationship to Patient:_____Phone#_____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Relationship to Patient Witness (Office Staff)

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

With my consent, Advance Pediatrics, PLLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Advance Pediatrics, PLLC's 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. Advance Pediatrics, PLLC 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 Advance Pediatrics, PLLC, **Attn: Practice Manager at 9836 W YEARLING ROAD F-1300 PEORIA AZ 85383**

With my consent, Advance Pediatrics, PLLC may call my home phone or cell phone on file or other designated location and leave a message on voice mail 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, Advance Pediatrics, PLLC 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 Advance Pediatrics, PLLC 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 Advance Pediatrics, PLLC's use and disclosure of my 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, Advance Pediatrics, PLLC may decline to provide treatment to me.

_____ _____

Patient's Name Date

_____

Signature of Parent or Legal Guardian

_____ Print

Name of Parent or Legal Guardian