Agave Pediatrics
T: (480) 585-5200 F: (480) 585-5233
info@AgavePediatrics.com
www.AgavePediatrics.com
www.TongueTieKids.com

Medical History

Patient Name _____ **Age:** _____ **Sex: M / F**

Allergies: _____ **Date of Birth** _____

Current Medicines: _____

If Newborn: Was baby born in a Hospital: Yes / No If Yes, which Hospital: _____ Other Facility: _____

Medical History

BIRTH HISTORY (Please list birth weight, any pregnancy complications or birth complications.)

_____

ONGOING ILLNESSES (Please list any ongoing medical illnesses. i.e. Asthma, Eczema, Heart Murmurs, etc.)

_____

Hospitalizations / Surgeries

(Please list any hospitalization and/or surgeries, include dates and reasons.)

_____

_____

Family History

(Please list any history of medical conditions or genetic disorders for immediate family members: parents and siblings.)

_____

_____

Medications (Name and Dosage)

_____

Social History

Are birth parents married to each other? Y / N If No, who does child live with _____
Smokers at home? Y / N
Is patient in daycare? Y / N
Pets at home? Y / N
Types of pets? _____

Responsible Party Name Print _____

Responsible Party Signature _____ Date _____

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Patient Information

Child's Last Name _____ Different Last Name from parent: ____Yes ____No
Child's First Name _____ Date of Birth____/____/____
Gender: M____ F____

Additional Children:

Insurance ID# _____ First Name _____ Last Name _____ DOB_____
Insurance ID# _____ First Name _____ Last Name _____ DOB_____
Insurance ID# _____ First Name _____ Last Name _____ DOB_____

Mother/Father/Legal Guardian Information (where you want correspondence/ bills to be mailed):

Last Name _____ First Name _____ DOB_____ Relationship_____
Address _____ City_____ State_____ Zip_____
Cell Phone #1_____ (**Primary number for text reminders**) Cell Phone #2 _____
E-mail address _____ SSN# _____
Employer Name _____ Employer Phone #_____
Can we contact your work? _____Yes _____No

Person who carries Insurance on the child:

Last Name _____ First Name _____ DOB_____
Address if different from above _____ City _____ State _____ ZIP_____
SSN# _____
Employer Name _____ Phone #_____

Insurance Name_____ Address_____
Insurance ID# _____ Group# _____ Effective date___/___/____

Secondary Insurance
Name_____Address_____
Insurance ID# _____ Group# _____ Effective date___/___/_____

Who is responsible for paying the bills? _____

Emergency Contact: Name_____ Relationship_____
Address _____ Phone #_____

Pharmacy Used_____
Cross Streets _____ Pharmacy Phone # _____

Acknowledgement of Receipt of Privacy Notice

I acknowledge that the Office notice of Privacy Practices has been made available to me.

Signature of person filling out this form_____ Relationship to patient_____

Print name_____ Date _____

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Consent For Treatment of a Minor Child

Date of Birth_____/_____/_____

I, the undersigned, parent/guardian of _____, a minor, do hereby authorize and direct Agave Pediatrics to provide ongoing routine and emergency health care.

Initials: _____

Consent from Parents or Guardians for Authorized Persons

As the biological parent or step parent/guardian (court papers necessary) of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and/or care.

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

_____ Initials - I am granting full permissions, meaning the below listed person(s) will be allowed to agree to treatments, and know all health history pertaining to my child.

____ Initials - I am granting permissions, meaning the below listed person(s) is only allowed to bring my child in, and will have access to all health history, but not allowed to agree to treatments without my direct consent.

_____ Initials - I am granting limited permissions, meaning the below listed person(s) is allowed to bring my child in to the office, but is not allowed access to any medical information or treatment of my child. I will be informed of the visit results, and I will be notified prior to any treatment for my child.

Please list person(s) here _____

_____

_____

Consent to Leave Voicemail

I am granting permission to Agave Pediatrics to leave phone messages regarding my child's medical health to the number(s) provided on the registration form. This consent will remain in effect until rescinded in writing.

_____

Parent/Guardian Signature Date

Appointment Reminders

Text Reminder – Please be advised that you must provide a valid **Primary Cell Phone Number to ensure Text Reminders** are sent. Text reminder will be the primary method for appointment reminders. You will be able to confirm or cancel an appointment directly from the texting service message. Email reminders will be sent for yearly checkups through the Agave portal.

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Patient Office Policies Agreement

We, at Agave Pediatrics, strive for excellent patient care in a nurturing environment. We want to maintain an environment that is nice looking, clean, safe and yet enjoyable to our patients. Please read the following established office policies and initial at each indicated line, acknowledging your understanding.

_____ **Initials** - **No children shall be left unsupervised by an adult in the waiting area.** We are not responsible for any injuries incurred while in our office. **Please do not leave any personal belongings in the waiting area.** We will not be responsible for lost or stolen personal belongings.

_____ **Initials** - **Please turn off** all cell phones and/or pagers during your visit with the doctor. Individual uninterrupted attention is very important when it comes to your child's health.

_____ **Initials** - **Any intentional or accidental damage** done to decorations, furniture and/or office equipment will **not** be accepted. Parent will be financially responsible for any repair fees, to be determined by Agave Pediatrics.

_____ **Initials** - **Good communication** is always crucial between the patient and doctor. We will try to make a **courtesy reminder call/text message** the day before any future scheduled appointments**. Do not depend on our call as a reminder; you are still responsible for keeping your child's appointments when scheduled**. Please let us know which communication method you would prefer.

_____ **Initials** - **Constructive Criticism of our practice is welcome. We reserve the right to discharge anyone from the practice in the event of breakdown in communication and/or willful slander / putting derogatory comments about our practice on social media.**

_____ **Initials** - **Treatment of staff.** Any inappropriate treatment of staff, will be a cause for discharge from our practice, this includes but not limited to aggressive or threatening behavior towards staff, use of foul/bad language towards staff and/or any other behavioral, verbal, or written communication, which is deemed inappropriate towards staff.

Preventative Visits with Sick Office Visits

It is common for a provider to address new or chronic health issues at the same time that they are performing a wellness exam. If a problem is discovered and treated during a wellness exam or if a chronic issue is discussed at this time, a **separate office visit will be charged as these appointments need more time.**

The purpose of a preventive/wellness visit is to review the patients' health history, perform a physical examination, and review risk factors, instruct the patient on how to reduce their risk factors and to order labs or other tests for screening reasons.

Examples of new or chronic problems that may incur a separate charge may include but are not limited to sore throat, sprain, ADHD, diabetes, hypertension, cold or flu symptoms and other symptoms outside of a wellness exam.

You may choose to schedule a separate appointment to address your child's health issues. Your insurance may have separate benefits for preventative/wellness visits versus a regular office visit.

Contacting your insurance company to obtain benefit information is recommended. You will be responsible for all copays, coinsurance, deductibles, and/or office visit fees for combining preventative/wellness and regular office visits in one appointment.

_____ Child's name

_____ Name of responsible party

_____ Signature of patient or responsible party

_____ Date

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Financial Policies Agreement

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we contract with, payment in full is expected at each visit. If you are insured by a plan that we accept, we require an up-to-date insurance card. Payment in full for each visit is required until we can verify your coverage. **Knowing and understanding your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. Primary Care Physician Selection. Please be aware that your insurance may require you to select a Primary Care Physician (PCP). This must be done directly by the parent/patient **before** you are seen in our office. Please contact your insurance company directly to select our office as your PCP. Failure to do so will result in the insurance claim not being paid. The balance will automatically be billed to you.

3. Newborns. All newborns must be added to the parent/guardians policy **within 30 days of birth**. Please contact your insurance company directly to make this addition. If newborn/child is not added to your policy, the balance will become your responsibility. Payment will be expected in full if your Newborn/Child is not added to your insurance.

4. Co-payments and deductibles. All co-payments and previous balances must be paid at the time of service. This arrangement is part of your contract with your insurance company. No Checks accepted for copays or balances due at time of service.

5. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by you insurance company. It is your responsibility to know what is covered under your policy. The balance will automatically be billed to you.

6. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your **driver's license and current valid insurance** to provide proof of insurance. If you fail to provide us with the correct insurance information, you may be responsible for the balance incurred at time of visit.

7. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company.**

8. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. You are responsible for services not covered by your insurance company.

9. Returned checks. We charge $50 Service Fee.

10. Non-payment. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise approved by our office and a written and signed payment plan is completed. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, regular and certified mail will notify you that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

11. Missed appointments. Our policy is to charge a **$45 fee for missed appointments** not canceled within 24 hours before scheduled appointment. These charges will be your responsibility and billed directly to you. As a courtesy, our office will confirm via phone/text however, this is not required. Please help us to serve you better by keeping your regularly scheduled appointment.

12. We charge $50 for Medical record services like Transfer of Records, FMLA paperwork or Specialty Letters. Release of Records requires a signed authorization form from Parent or Legal Guardian.

13. Financial Responsibility-If no payment is received due to non-coverage of services, you will be responsible for full payment of all services provided.

14. We will **NOT pay** any Emergency Room/ Urgent Care / Specialists balances that incur if the visit is advised by our facilities, (or you decide to take your child), even if the secondary facility does not agree with our decision for referral. Complications can happen after or during any procedure. We will not pay any bills for Emergency Room or Urgent Care visits, if they happen secondary to any complications or otherwise, after a visit or procedure is performed at any of our facilities. **ANY Health care balances generated elsewhere is completely the parental responsibility.**

Agave Pediatrics is committed to providing the best treatment to our patients.

Our prices are representative of the usual and customary charges for our area and specialty. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns

I have read and understand the payment policy and agree to abide by Agave Pediatrics Financial Policies Guidelines:

Signature of patient or responsible party _____ Date_____

Print name _____

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Authorization for the Use or Disclosure of Health Information

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

I request release of my child's (children's) health information:
Office name: _____
Doctor's name: _____
Address: _____
_____
Phone: _____
Fax: _____

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The health information to be used/disclosed includes: (check all that apply)

1) _____ All health information including but not limited to AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and or drug abuse treatment, if any, unless specifically stated:_____
2) _____ Health information relating to the following condition: _____
3) _____ Health information for the date(s): _____
4) _____ Immunization record

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 Agave Pediatrics and to my insurance company or its agents that may be authorizing treatment. I further understand that I do not have to sign this authorization in order to get health care benefits. I understand that I may revoke this authorization in writing at any time except to the extent that Agave Pediatrics has acted in reliance upon this authorization. Once this office discloses health information, the person or organization that receives it may re-disclose it (dependent on their policy) and Agave Pediatrics does not take responsibility for the protection of this information.

Signature of parent/legal guardian _____
Date _____
Relationship to patient _____