

Today's Date _____

NORTHWEST CLINIC FOR CHILDREN, P.A.

New Patient? Y N

ADULT (18 yrs +) REGISTRATION

I.D. Relationship to Patient _____

Seen in last 3 yrs? Y N

PLEASE COMPLETE ALL INFORMATION

Staff Verified I.D.: _____

NAME: _____ DATE OF BIRTH: _____ HOME PHONE: _____ CELL PHONE: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 EMPLOYER: _____ WORK PHONE: _____ SOCIAL SECURITY: _____
 WORK ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 PREFERRED PHONE# FOR CONFIRMING APPOINTMENTS: _____
 PLEASE LIST ANY KNOWN ALLERGIES: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ IS THE POLICY THROUGH YOUR EMPLOYER? YES NO
 POLICY HOLDER'S NAME: _____ ID# _____ GROUP# _____
 SECONDARY INSURANCE: _____ IS THE POLICY THROUGH YOUR EMPLOYER? YES NO
 POLICY HOLDER'S NAME: _____ ID# _____ GROUP# _____
 ETHNICITY _____ RACE _____ LANGUAGE PREF. _____ NOT PROVIDED TO REPORT

UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA") I HEREBY AUTHORIZE NORTHWEST CLINIC FOR CHILDREN, P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. IN THE EVENT OF DEFAULT, I PROMISE TO PAY COLLECTION COST AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO EFFECT COLLECTION OF THIS ACCOUNT.

I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED THE "HIPAA" NOTICE OF PRIVACY PRACTICES.

SIGNATURE _____ DATE _____

Carl F. Irwin, M.D.
Karen L. Kennedy, M.D.
Kristin K. Kaus, M.D.
Pamela C. Bingham, M.D.
David A. Galles, M.D.



Northwest Clinic for Children, P.A.



Devra W. Spindler, R.N., M.S.N., P.N.P.
Kitty Dessenberger, R.N., C.P.N.P.
Stacey A. Toben, M.S., R.N., C.P.N.P.
Sylvia Matherly, R.N., M.S., C.P.N.P.
Sheri Caiafa, Administrator

BILLING AND FINANCIAL POLICY

Welcome to Northwest Clinic for Children. We are pleased that you chose us to be your child's primary care physicians. Please familiarize yourself with the following financial policies that our office has established to better serve you.

Patient responsibilities at each visit include:

- Patient must have current insurance card/information
- Co-payment, co-insurance, deductible is due at check in
- Past balances are due AT EACH VISIT

No Shows + Rescheduled Appointments

There will be a \$25 charge assessed to your account for any appointment that is not kept, without 4 hour advance notice. This includes rescheduled appts. Giving your advance notice allows us to see children who might not otherwise be able to get a needed appt.

Insurance

We are currently contracted with most insurance plans. Eligibility is based on information you present. All services are billed within 24 hours of service. It is the patient's responsibility to notify our office of any changes to your plan, policy, and/or demographics. New parents are required to notify their insurance plan of their newborn and should have this done within the first 30 days of the baby's life. Failure to do so will result in patient financial responsibility.

Co-payments, Co-insurance, Deductibles

These are always due at the time of each visit. Your insurance company requires you to pay your co-payment or co-insurance at the time of your visit. For those patients with an annual "well" care deductible, a \$100 "deposit" is due at the time of your visit. A statement is then sent to you for any outstanding financial responsibility that exceeds the initial \$100. If you have any deductible, you are responsible for the cost of vaccines until your deductible has been met. Payment is due at the time of service. For those patients with an annual "sick" care deductible, we will collect \$50 at the time of service which would be applied to your visit.

Self-Pay Patients

Payment is due at the end of your visit. If a payment plan needs to be set up, please speak with our billing staff PRIOR to your visit. For convenience, we accept cash, checks and most credit cards. Preventive care visits are not eligible for a payment plan.

Collection Agency + Past Due Balances

Failure to pay balances within 90 days from the date of service will result in your account going to an outside collection agency. These accounts are automatically sent based on the first date of the statement sent to you. Please be aware there is a collection fee that will be added to your collection account balance. Your account will need to be in good standing prior to any future appts. made. This also includes any current balances due in office as well.

Returned Checks

Should our office receive a returned check there is a \$25 returned check fee in addition to the original fees for our services.

Acknowledgment: Please sign below acknowledging that you have read and understood our policies.

Parent/Legal Guardian Signature

Date

Relationship to Patient

Patient Name

Patient DOB

Should you have any questions, or would like further details regarding our billing and financial policies, please call our office at 602-866-1974. Again, *thank you for choosing Northwest Clinic for Children.*

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Northwest Clinic for Children, P.A.



15420 North 32nd Drive
Phoenix, AZ 85053-3998
Phone (602) 866-1974
Fax (602) 375-3949
Website: nwcchildren.com

ADULT CONSENT FOR MEDICAL TREATMENT

I _____ consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered, whether such diagnosis or treatment is rendered at the office of the physicians or at a hospital. I further authorize the physicians to exercise discretion in authorizing the disposal of any severed tissue or member.

May our office leave messages, or discuss on voice mail or answering machine, issues regarding your healthcare, including but not limited to, appointments, test results, or other necessary treatment information? NO YES If yes, list the preferred phone # _____.

The following list of people may receive Protected Health Information (PHI) as outlined in the NWCC Notice of Privacy Practices:

This permission is given in advance of any specific diagnosis or treatment and shall remain valid until revoked in writing.

PATIENT SIGNATURE _____ DATE _____

Patient Eligibility Screening Record Vaccines for Children Program

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 retain this record on file for a minimum of three years.

Please print or type

Initial Screening Date: _____
 Child: Last Name _____ First Name _____ M.I. _____
 Child's Date of Birth: _____
 Parent/Guardian/Individual of Record:
 Last Name _____ First Name _____ M.I. _____
 Provider: _____

This child qualifies for vaccination through the VFC program because he or she: (check only one box)

- (0) is enrolled in KidsCare; or
- (1) is enrolled in AHCCCS; or
- (2) does not have health insurance; or
- (3) is American Indian or Alaskan Native (no matter what the insurance situation is); or
- (4) has health insurance that does not pay for vaccines.
- (5) This child does not qualify for VFC.

Date of Eligibility Changes & Updates

KidsCare	AHCCCS	Uninsured	Native American/Alaska Native	Under-insured

Check here if this child has health insurance that pays for vaccines.

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 cannot make the Vaccines for Children Program retroactive and you are only eligible for the 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.

Please sign below indicating that you understand and agree with the above statement.

Signature _____ Date _____