Arizona Pediatric Clinics **Patient Information**

Your Child's Information

Last Name ______________________ **First Name** ____________________ **DOB**______________

Address __________________________**City, State, Zip** _________________**Phone** _____________

Circle Choice Below

Patient Race: White Undetermined Blk Afr Amer. Amer. Indian AK Nat. Asian HI Native

Ethnicity: non Hispanic Latino Hispanic Latino Undetermined

Language: English Spanish Other, specify _________________

Guarantor

Relationship to Child: _____________________

Last Name: ______________**First** ___________

Address: ______________________________

City, State, Zip: _________________________

SSN: ________________________________

Date of Birth: ___________________________

Home Phone: __________________________

Cell Phone: ____________________________

***email address** __________________________

Other Parent

Relationship to Child: ______________________

Last Name: _______________**First:**___________

Address: ______________________________

City, State, Zip: ___________________________

SSN: __________________________________

Date of Birth: ____________________________

Home Phone: ____________________________

Cell Phone: ______________________________

Insurance Information Primary Policy

Insurance Name: _____________________

Insured's Name: _______________________

Policy / ID # : _________________________

Group # : ____________________________

Insurance Information Secondary Policy

Insurance Name: _______________________

Insured's Name: _________________________

Policy / ID # : ___________________________

Group # : _______________________________

Authorization to pay benefits to physician: 1. I hereby authorize direct payment to be made to the above named corporation. I understand Arizona Pediatric Clinics will file an insurance claim on my behalf as a courtesy, nevertheless, I am financially responsible. **2.** Private Insurances with a deductible will be expected to pay the full office visit amount at the time of visit, until the deductible is met. There are no payments plans in order to meet deductibles. **3.** After 3 statements from APC on unpaid balances the guarantor will be sent to a collection agency and or legal service. **4.** I hereby certify that I do not have any other insurance carrier at this time. **5.** AHCCCS coverage is always the *payor of last resort*, therefore, coinsurance information must be given along with the State Medicaid coverage information. If the parent fails to provide this medical coverage information in a *timely manner*, and APC is not reimbursed by the medical carrier, the Parent will be responsible for total bill. **Authorization to release information:** I hereby authorize the above named corporation to release any information required in the course of my examination or treatment to insurance companies for payment. I hereby authorize any photocopies of this form to be valid as the original, in accordance with HIPAA Privacy Practice.

Parent or Guardian Signature ____________________________________ ***Date*** _____________