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

Mother's Medical History

Mother's Name ________________________________ Age: __________________

Allergies: ____________________________________ Date of Birth ____/____/____

Current Medicines: ____

Medical History

____

____

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

Smokers at home? Y _____ N ______

Pets at home? Y _____ N ______

Types of pets? ____

Responsible Party Name Print ____ Relationship to Patient____________________

Responsible Party Signature ____ Date ___________________________________

© 2020 Agave Pediatrics

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

Mother's Information

Mother's Last Name ________________________________ Different Last Name from child: _____Yes _____No

Mother's First Name ________________________________ Date of Birth____/____/____ Gender: F____

Child's Name:____ Child's Date of Birth ____/____/____

Self/Husband/Partner 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:

Last Name ________________________ First Name __________________ DOB _________ Relationship______________

Address (if different from above) _________________________________ City ___________ State _______ Zip________

E-mail address ____ SSN# _______________________________________

Employer Name ____ Phone #______________________________________

Insurance Name__________________________ Address ____

Insurance ID# ____________________________ Group# __________________________ Effective date____/____/_____

Secondary Insurance

Insurance Name__________________________ Address ____

Insurance ID# ____________________________ Group# __________________________ Effective date____/____/_____

Who is financially responsible for balances? ____

Emergency Contact: Name____ Relationship____________________

Address ____ Phone #_______________________

Pharmacy Used____

Cross Streets ____ Pharmacy Phone # ______________________

© 2020 Agave Pediatrics

Acknowledgement of Receipt of Privacy Notice (HIPAA) and Notice of Health Information Practices (HIE)

I acknowledge that both the Office Notice of Privacy Practices and Health Information Exchange has been made available to me.

Responsible Party Name ____ Relationship to Patient_____________________

Responsible Party Signature ____ Date ____________________________

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 health.

_____ Initials - Any intentional or accidental damage done to decorations, furniture and/or office equipment will not be accepted. Patient 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 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.

_____Initials- Divorced/Separated Parents or Guardians. Agave Pediatrics does not become involved in legal/custody issues with parents. Unless there is a court order in the child's record that restricts a parent's rights, the practice will not limit the other parent's involvement in the child's care. Special requests for non-court ordered activities will not be accepted.

Signature of Responsible Party ____ Date ________________________________

Consent to Leave Voicemail and Receive Text Message Notifications

I am granting permission to Agave Pediatrics to leave phone messages regarding my medical health and/or appointments and receive text message notifications to the number(s) provided on the registration form. This consent will remain in effect until rescinded in writing.

____ ____________________________

Responsible Party Signature Date

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

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. 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.
3. 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 your insurance company. It is your responsibility to know what is covered under your policy. The balance will automatically be billed to you.
4. 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.
5. 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.
6. 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.
7. Returned checks. We charge $50 Service Fee.
8. 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.
9. Missed appointments. Our policy is to charge a $50 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.
10. Financial Responsibility-If no payment is received due to non-coverage of services, you will be responsible for full payment of all services provided.
11. 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 Responsible Party ____ Date ________________________________

© 20 Agave Pediatrics