PT MRN:_____

Children's Medical Center of Tucson

Patient Information Sheet

Please note, to keep information current, we ask that this form be COMPLETED every 6 months or when there are any changes.

Child First Name: _____ Last Name: _____ DOB: _____ ☐ Male ☐ Female

Child Address: _____ Apt/Unit: _____ City: _____ State: _____ Zip: _____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father Other Relationship: _____

Mother/Guardian: _____ Last Name: _____ Last 4 digits SSN: _____ DOB: _____

Address if different: _____ Apt/Unit: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Employer: _____

Father/Guardian: _____ Last Name: _____ Last 4 digits SSN: _____ DOB: _____

Address if different: _____ Apt/Unit: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____ Employer: _____

Do you give Children's Medical Center of Tucson permission to leave a message on your phone? ☐ Yes ☐ No

Do you give Children's Medical Center of Tucson permission to contact you via email regarding appointments reminders? ☐ Yes ☐ No

Name of nearest relative not living with you: _____ Phone #: _____

Whom may we contact in case of an emergency: _____ Phone #: _____

Other than the parents, who is authorized to bring in child for medical treatment, evaluation and/or procedures:
**** We will require identification & must be over 18 years old****

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Do you give permission for the people listed above to leave messages for triage, providers and/or schedule appointments: ☐ Yes ☐ No

Names of your other children that are currently patients of Children's Medical Center of Tucson:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Primary Insurance Information

Insurance Company Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Identification #: _____ Grp #: _____ Phone #: _____

Policy Holder's Name: _____ DOB: _____ Relationship to patient: _____

Secondary Insurance Information

Insurance Company Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Identification #: _____ Grp #: _____ Phone #: _____

Policy Holder's Name: _____ DOB: _____ Relationship to patient: _____

I understand and agree that regardless of my insurance status I am financially responsible for the balance of my account for professional services rendered. I have read all of the information on both side of this sheet and have completed the above questions to the best of my knowledge. I will notify you of any changes in my health insurance status of the above information. I have also read and received a copy of the Notice of Privacy Practices.

Signature of Parent/Guardian: _____ Date: _____

CMCT Financial Policy

We are committed to providing you with the best possible care. If you have medical Insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our patient policy.

Payment and/or co-payments for services are due at the time services are rendered, unless payment arrangements have been approved in advance by the Billing Department. We accept: CASH, CHECK, VISA, MASTERCARD and DISCOVER as forms of payment. Returned checks and balances older than 30 days may be subject to an additional collection fee. The fee for a returned check is $25.00. Returned checked that are not paid in full within 20 days will be reported to Pima County Attorney's Office through their Bad Check Program. A fee of $25.00 will be charged to your account if it is sent to our collection agency. If your account is placed with our collection agency, you may be dismissed from our practice and our relationship with you may end with a 30-day notice at that time.

We will gladly discuss your proposed treatment and answer any questions in relation to your insurance. You must realize however, that:

1. Your insurance company is a contract between you, your employer and the insurance company.
    a. We are NOT a part in that contract.
2. Not all services are covered benefits in all contract. Some insurance companies arbitrarily select certain services that they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While filing of most insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect the timely payment of your account. If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

Signature of Parent/Guardian: _____ Date: _____