MVP KIDS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____4700 N. 51ST Avenue, Suite 4 * Phoenix, AZ 85031 * Phone: 623-846-7575 * Fax: 623-846-3778
_____13015 W. McDowell Rd, #D-100 * Avondale, AZ 85323 * Phone: 623-932-5042 * Fax: 623-932-0332

Patient's Full Name: ______________________________ Date of Birth: ____________

Address: ____

This Authorizes: ____
(Physician name or Facility you requesting records FROM)

To release the information specified below TO: ______________________________

Address: ____

This authorization releases MVP KIDS and any of it's staff, employees and agents of any responsibility for information contained in such record release in case of loss or theft from my person, or distress of any type caused to me or others. MVP KIDS will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

PHOTOCOPIES OF INFORMATION TO BE RELEASED:

_____ Medical records of the past (2) years of treatment. Excluding information listed below unless otherwise specified.

_____ Other (specify)____

I AUTHORIZE RELEASE OF RECORDS PERTAINING TO:
___ All HIV related information and Communicable Disease related to information (A.R.S. 36-661)
___ Information related to psychiatric/psychological treatment.
___ Information related to physical abuse, sexual abuse or molestation.
___ Information related to drug and/or alcohol abuse.

I understand I may revoke this consent at any time, and that upon fulfillment to the above stated request, this consent will automatically expire one (1) year following the date of signature without my express revocation.

______________________________ ______________
Signature of Patient/Guardian Date Signed

Relationship to patient: ______________________________

MVP KIDS CARE

AUTORIZACION PARA SOLICITAR INFORMACION MEDICA

_____4700 N. 51ST Avenue, Suite 4*Phoenix, AZ 85031* Phone: 623-846-7575 * Fax: 623-846-3778
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Nombre de Paciente: ______________________________ **Fecha de Nacimiento:** _________

Direccion del Paciente: ____

Esto da la autorizacion que: ____

____
(Nombre de Clinica que solicita informacion medical)

Para solicitor la informacion especificado abajo a: __________________________________

Direccion: ____

Esto autoriza que MVP KIDS y proveer de personal que no tengan culpa de que en caso que estos documentos o informacion seyan robados o perdidos. MVP KIDS no sera culpable por la informacion mal usada.

FOTO COPIAS DE INFORMACION SOLICITADAS:

_____ **Informacion medica de hace dos anos.**

_____ **Otra informacion (Especificar)**

Yo autorizo la informacion solicitada perteneciente a:

__ **Toda la informacion relacionada al HIV y enfermedades transmisibles (A.R.S.-366)**
__ **Informacion relacionado al tratamiento de siquiatrico o sicologico.**
__ **Informacion relacionado al abuso fisico o abuso sexual.**
__ **Informacion relacionado a drugas o abuso de bebidas alcoholicas.**

Yo entiendo que puedo revocar este consentimieno a cualquier momento y sobre complimiento a la informacion especificada arriba. Yo tambien entiendo que estoy de acuerdo que esta forma automaticamente se vencera un ano despues de que firme.

____ ________________
Firma de paciente or Guardian **Fecha de hoy**

Relacion al paciente: ____

Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name ______________________________ Birthdate ____________

Reviewed by ______________________________ Date ____________

1. Do you experience any of these symptoms more than twice per year? (Check all that apply)
   - ☐ Cough
   - ☐ Cold
   - ☐ Congestion
   - ☐ Difficulty breathing
   - ☐ Headaches
   - ☐ Wheezing
   - ☐ Runny nose
   - ☐ Sore throat
   - ☐ Itchy/irritated eyes
   - ☐ Sinus pain
   - ☐ Ear pain
   - ☐ Unexplained fatigue
   - ☐ Skin irritation
   - ☐ Snoring

2. Have you ever been diagnosed with asthma or bronchitis? ☐ Yes ☐ No

3. Do you experience symptoms of allergies? ☐ Yes ☐ No

4. Regarding possible food allergies, do you experience any of the following? (Check all that apply)
   - ☐ Bloating after eating
   - ☐ Diarrhea
   - ☐ Cough
   - ☐ Constipation
   - ☐ Upset stomach
   - ☐ Wheezing
   - ☐ Stomach pain
   - ☐ Indigestion
   - ☐ Nausea
   - ☐ Vomiting
   - ☐ Tingling of the mouth or any other unusual sensation

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Allergy Questionnaire - Part 2

To be filled out with allergy counselor after initial screening

1. What symptoms are you experiencing? (From #1 on intake form) ______________________________
2. How often do you experience these symptoms? ______________________________
3. Do you have any of these symptoms?

❑ Cough ❑ Wheezing ❑ Shortness of breath ❑ Chest tightness ❑ Sneezing ❑ Phlegm/sputum (Color__________)
❑ Runny Nose ❑ Nasal Congestion ❑ Itchy Nose ❑ Itchy / Watery Eyes ❑ Postnasal Drip
❑ Nasal Polyps ❑ Poor Sense of Smell ❑ Ear Infections ❑ Sinus Infections ❑ Blocked Ears ❑ Other__________
❑ Eczema ❑ Hives / Swelling ❑ Headaches ❑ Snoring ❑ Fatigue

4. Which of the following seems to bother you or trigger/cause the above symptoms?

❑ Grass ❑ Nervousness ❑ House Dust ❑ Perfumes ❑ Other Animals ❑ Leaves ❑ Latex (rubber)
❑ Cats ❑ Hay ❑ Cold Air ❑ Smoke ❑ Insecticides ❑ Alcoholic beverages
❑ Cosmetics ❑ Dogs ❑ Mold & Mildew ❑ Humidity ❑ Pollution ❑ Odors
❑ Drafts ❑ Aerosol sprays ❑ Horses ❑ Basements ❑ Weather changes ❑ Exercise
❑ Insect bites/stings. Describe reaction: ______________________________
❑ Foods. List foods and reactions: ______________________________
❑ Other. List sources and reaction: ______________________________

5. When are your symptoms worst?
❑ Year Round ❑ Jan. ❑ Feb. ❑ Mar. ❑ Apr. ❑ May ❑ Jun. ❑ Jul. ❑ Aug. ❑ Sep. ❑ Oct ❑ Nov. ❑ Dec.
6. Are symptoms better away from home? ❑ Yes ❑ No If yes, when? ______________________________
7. Do you have any family history of allergies? Explain______________________________
8. Have you ever had an allergy skin test or blood test? ❑ Yes ❑ No If yes, results: ______________________________
9. Have you ever had allergy injections? ❑ Yes ❑ No If yes, when? ______________________________
10. Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? ❑ Yes ❑ No
If yes, when? ______________ How much? ______________________________
11. Are you on allergy medications? ❑ Yes ❑ No If yes please list meds, dosing and frequency______________________________
____
____
12. What is your occupation? (current or former) ______________________________

OFFICE USE ONLY

Is patient...
• Suffering from uncontrolled asthma • History of anaphylaxis
IF YES TO ABOVE, REFER OUT TO SPECIALIST

• Required to take beta blockers within 24 hours of test • Pregnant • Heavily tattooed
• Significantly immunocompromised or have malignancy or severe chronic illness?
IF YES TO ABOVE, SELECT BLOOD TEST

• Currently taking antihistamine (must be off for 72 hours) • Wheezing or having difficulty breathing?
• Experiencing active hives, sunburn or extensive dermatitis?
IF YES TO ABOVE, TREAT SYMPTOMS AND SCHEDULE FOR ANOTHER DAY

• Having symptoms consistent with food allergies?
IF YES TO ABOVE, CONSIDER SKIN PANEL AND FOOD PANEL

Indications: Inhalant Panels: ❑ Skin Test ❑ Blood Test **Food Panels:** ❑ Skin Test ❑ Blood Test
Schedule skin test for (date): ______________

Patient Name Birthdate Reviewed by Date

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Allergy Questionnaire - Part 3

To be filled out by patient during test development

ENVIRONMENTAL SURVEY

1. How long have you lived in your house/apartment? ____________________
2. Do you live in a ❑ House ❑ Apartment/duplex ❑ Condominium/townhouse
3. Approximately how old is your home? ____________________
4. Do you live in ❑ City ❑ Suburbs ❑ Rural area
5. Do you have a basement? ❑ Yes ❑ No
6. Type of heating: ❑ hot air ❑ steam (radiator) ❑ electric ❑ hot water (baseboard)
7. Do you have: ❑ Wood /coal stove or fireplace ❑ Humidifier ❑ Dehumidifier ❑ Air cleaner
8. Number of pets (indoor or outdoor) ____Cats ____Dogs ____Birds ____Other
9. Are there any tobacco smokers in your home? ❑ Yes ❑ No
10. Is your bedroom in the basement? ❑ Yes ❑ No
11. Do you have allergy-proof encasing for pillow or mattress? ❑ Yes ❑ No
12. What type of pillows do you have? ____________________
13. What type of comforter do you have? ____________________
14. What type of floor covering do you have in your bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor
15. How old is your mattress?__________ What's inside your mattress? (i.e. cotton/horse hair)____________________
16. Do you have air conditioning? ❑ Yes ❑ No If yes, is it: ❑ Window unit ❑ Central
17. Do you have problems with roaches or mice? ❑ Yes ❑ No
18. Do you have water leaks, mold contamination? ❑ Yes ❑ No
19. Is your home/apartment excessively humid? ❑ Yes ❑ No
20. Do you experience runny nose or sneezing in response to eating? ❑ Yes ❑ No
21. Do you experience runny nose or sneezing in response to strong odors? ❑ Yes ❑ No
22. Do you experience runny nose or sneezing in response to exercise? ❑ Yes ❑ No
23. Do you experience runny nose in response to emotional upset? ❑ Yes ❑ No

MEDICAL HISTORY

1. Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic ulcer	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems/murmur	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/blood disorder	❑ Asthma	❑ Hay fever	❑ Depression
❑ Kidney/bladder disease	❑ Gynecological problems	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Glaucoma	❑ Cataracts	❑ Loss of hearing
❑ Emphysema	❑ Eczema		

2. If yes to any of above, please explain: ____________________
3. If asthmatic, have you ever been hospitalized or incubated? Please explain:____________________
____
4. Have you had your tonsils or adenoids removed? ❑ Yes ❑ No
5. Have you had ear, nose or sinus surgery? ❑ Yes ❑ No
6. If yes, please explain: ____________________
7. Who in your family has had: (NOT including yourself)
   ❑ Asthma ____________________ ❑ Eczema ____________________
   ❑ Seasonal /year round allergies ____________________ ❑ Sinus problems ____________________
   ❑ Other allergies (drugs/bee sting/food etc) ____________________
8. Do you smoke? ❑ Yes ❑ No If yes, how much?____________________
9. Have you smoked in the past? ❑ Yes ❑ No How long ago did you stop? ____________________
10. How many years did you smoke?____________________

Patient Name ____________ Birthdate ____________ Reviewed by ____________ Date ____________

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Allergy Skin Test Consent

Allergy skin testing is an important diagnostic tool used by medical providers to accurately diagnose the source of allergic reaction. Correct diagnosis through testing that identifies the specific antigens causing your symptoms is an important first step to providing you with the best and most complete range of treatment options.

By managing allergic conditions, you may reduce the number of days you miss work or school, and you may eliminate (or lessen the severity of) symptoms such as attention deficit and impaired ability to concentrate.

The skin test is performed by the same process used in an allergist's office: placement of multiple antigens on the back or other body part, to be determined by your provider, with a plastic skin test applicator. This test is extremely accurate and results are read in 15 minutes.

There is a low risk of persistent itching or discomfort, and an extremely low risk of anaphylaxis associated with skin testing.

The cost of test varies by health plan, but most health plans cover the test in-network. Please note that insurance deductibles, co-insurance and co-payments may apply. If the test is not covered by your insurance plan, you will be responsible for the cost of the test.

Please confirm that you understand the reasons for the test as well as the potential benefits and risk involved:

Date ____________________ Time ______________________________

Patient Name ____

Signature of Patient or Parent/Guardian________________________________

Name of Parent/Guardian___________________________________

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Financial Policy/Consent to Treat/Authorization and Release

Name of Person Completing the form:______________________________ Relation to Patient:____________________

Patient Name::____ Date of Birth:________________________

Consent for Treatment of a Minor:

I, the parent or guardian of the above child , who is a minor, authorize MVP Kids Care to provide medical treatment to him/her, including diagnostic and/or surgical procedures, preventative care and immunizations.

Authorization & Release

I authorize MVP Kids Care to release any information , forms & records necessary to refer the above referenced child to other healthcare agencies if such care is required.

Assignment of Benefits

I authorize & request any and all of my health insurance companies, disclosed or undisclosed, to pay medical benefits directly to MVP Kids Care for services rendered. I also authorize MVP Kids Care to release any medical information my insurance company requests to process claims.

Financial Policy

Your clear understanding of this policy is important to our professional relationship. We strongly suggest contacting your insurance carrier to find out what your benefits are and how they relate to pediatric care. I understand & agree to the following:

- Co-payments: By law we must collect your carrier designated co-pay. Payment is required at the time of service. Your policy may cover routine/well visits differently that other services. Please be aware you may incur additional costs when more than routine care is provided during one visit.
- Co-insurance & Deductibles: You will be responsible for any balance your plan indicates as patient responsibility on their explanation of benefits form.
- Non-Covered Services: Some services provided by MVP Kids Care may not be covered by your insurance plan (ie. Behavioral treatments, routine vision & hearing screenings, circumcisions and other procedures). Treatment decisions at MVP Kids Care are not based on individual insurance coverage; our providers follow the American Academy of Pediatrics and American Medical Association guidelines for the standard of care. Please be aware that if one of these services is provided and your plan does not cover it, you will be financially responsible.
- Out of Network Plans: If MVP Kids Care is not contracted with your insurance carrier, you must pay in full at the time of service. We will file a claim to your insurance company as a courtesy.
- Self Pay Patients: Payment is expected at the time of service. We offer a 20% discount to all uninsured patients and those paying for non-covered services. If you have applied for AHCCCS and are in the "pending" status and your AHCCCS request is declined, you will revert to self pay status and payment in full will be required.
- Responsible Party: The person bringing the child in for case is responsible for payment of the co-pay, co-insurance, deductible, and/or office visits st the time of service.

You are responsible for the timely payment if your account. Should it become necessary for us to use an outside agency to collect payment, you will be additionally held responsible for any and all charges that MVP Kids Care incurs as a result. If you account is sent to collections you will be discharged from the practice and given30 days to find alternate care.

Divorced/Separated Parents

The parent who brings the child to the visit is consenting for treatment and therefore, responsible for services rendered. This may or may not be the parent who holds the insurance policy, MVP Kids Care will not be involved in separation or divorce disputes and will not bill a third party.

______________________	______________________	______________________
Guarantor Signature	Guarantor Name	Date

Poliza Financiera/Consentimiento de Tratamiento/Autorizacion y Distribucion

Nombre de la persona llenando la forma:________________________ Relacion al Paciente:________________

Nombre del Paciente:____________________________ Fecha de nacimiento:____________________

Consentimiento de Tratamiento de un Menor

Yo, Padre/Madre o Guardian del niño/niña citado anteriormente, el cual es un menor de edad, autorizo que MVP Kids Care le suministre tratamiento medico, incluyendo procesos diagnosticos y/o quirurgicos, cuidado preventivo & vacunas.

Autorizasion & Distribusion

Yo autorizo que MVP Kids Care tenga permiso de distribuir cualquier forma, record e informacion necesaria para poder referir al paciente citado previamente a otras agencias de salud si se denomina que es necesario.

Garante de Beneficios

Yo autorizo & tambien le pido a todas mis compañias de seguro, divulgadas o no, que beneficios medicos de servicios rendidos sean pagados directamente a MVP Kids Care. Yo tambien autorizo a MVP Kids Care permiso de poder proveer cualquier tipo de informacion medica que pida mi compañia de seguro para poder procesar los cobros.

Poliza Financiera

Es importante para nuestra relacion profesional que usted pueda comprender claramente esta poliza. Le sugerimos comunicarse con su seguro para saber cuales son sus beneficios & como se relacionan con su cuidado pediatrico. Yo entiendo & estoy de acuerdo con lo siguiente:

- Co-pagos: Por ley, debemos cobrar el co-pago designado por su aseguranza. Su pago es requerido al tiempo de servicio. Su poliza puede cubrir visitas de rutina o consultas de forma diferente a otros servicios. Porfavor tome en cuenta que costos adicionales pueden ser incluidos cuando se le provee mas que servicios rutinarios en una visita.
- Co-seguro & Deducible: Usted sera responsible por cualquier cobor que sea indicado en la forms de explicacion de beneficios como la responsabilidad del paciente.
- Servicios no cubiertos: Puede que algunos servicios que le provee MVP Kids Care no sean cubiertos por su plan de seguro (eje. Tratamiento de comportamiento, revision de ojos & oidos, circuncisiones & otros servicios). La decision de tratamiento en MVP Kids Care no es determinado cobertura de seguro individual; nuestros provedores siguen las guias de la "Academia Americana de Pediatria" & la "Asociacion Medica Americana". Porfavor tome en cuenta que si alguno de los servicios proveidos no son cubiertos por su plan, usted sera responsible por los cobros.
- Fuera de Red: Si MVP Kids Care no esta contatado con su provedor de seguro, usted debe pagar la cantidad total al tiempo de servicio. Nosotros haremos el tramite de cobro a su compañia de seguro como cortesia.
- Pagos por si mismo: Contamos con su pago al tiempo de servicio. Ofrecemos un descuento de 20% para pacientes sin seguro & para pagos a servicios no cubiertos. Si su aplicacion para AHCCCS esta pendiente y le notifican que a sido rechazada, entonces su estado de pago se revertira a pago por si mismo & su pago total sera requerido.
- Partido Responsable: La persona que trae al paciente a consulta sera responsible de pagar el co-pago, co-seguro, deducible, y/o visita de consulta al tiempo se servicio.

Usted es responsible de hacer los pagos de su cuenta de forma puntual. Usted sera responsable por cualquier cobro adicional si se denomina necesario utilizar un tercer partido. Usted sera responsable por cualquier cobro que MVP Kids Care incurra como resultado. Si su cuenta es enviada a una agencia de colecciones, se le dara de baja de la oficina & se le daran 30 dias para encontrar cuidado medico alternativo.

Padres Separados/Divorciados

La persona que trae al niño/niña a la visita es la que conciente el tratamiento & por esta razon es la persona responsable por los servicios rendidos. Esta persona puede que sea o no sea pariente que guarda la poliza de seguro. MVP Kids Care no se involucrara en cuestiones de separacion o disputas de divorcio & no cobrara a un tercer partido.

____________________	____________________	____________
Nombre del Garante	Firma del Garante	Fecha