

Arizona Sun Family Medicine, P.C.

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ Zip: _____

DOB: ____/____/____ Marital Status: _____ SS#: _____

Home Number: _____ Work Number: _____ Cell Number: _____

At Which Number Is the Best to Reach You At (please circle) HOME WORK CELL

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Email: _____ Do you have Advanced Directives? _____ (Yes or No)

Primary Insurance Information

Insurance Company: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: ____/____/____ SS#: _____ Employer: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Secondary Insurance Information

Insurance Company: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____

DOB: ____/____/____ SS#: _____ Employer: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Treatment Consent of a Minor

I, _____ (parent/guardian) authorize Arizona Sun Family Medicine, P.C. to examine and treat _____ in the event I cannot accompany him/her to the office for his/her appointment.

Assignment of Insurance Benefits

I hereby authorize my insurance benefits direct payment to Arizona Sun Family Medicine, P.C. for services rendered. I understand that I am financially responsible for any balance not covered. I also authorize Arizona Sun Family Medicine, P.C. to release any information required to process my claims.

Signature: _____ Date: _____

ARIZONA SUN FAMILY MEDICINE, P.C.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Authorization to Use and Disclose Health Information

I _____ understand that under HIPAA regulations, my health information will be used and disclosed to any health care provider who is involved with my medical treatment or services, my health insurance plan, and any medical billing clearance house involved in my insurance claims fulfillment.

Under HIPAA regulations, the following people must be authorized to have access to my health information (For example: spouse, other family members, friends, life partners, nurse or home aide, or any other person not involved in your medical treatment, insurance plan or payment).

Name: _____

Name: _____

Phone: _____

Phone: _____

Address: _____

Address: _____

Relationship to patient: _____

Relationship to Patient _____

Are there limitations on what information can be disclosed Yes No

 If Yes, what information do you wish to restrict: _____

Is there a date that this person's authorization will expire? Yes No

 If Yes, what date will this authorization expire: _____

I understand that I may revoke this authorization at any time by giving written notice to Arizona Sun Family Medicine, PC.

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates of Arizona Sun Family Medicine, PC who are part of the health care process. These business associates will also keep your health information confidential. I have also been presented with a copy of the Notice of Privacy Practices for Arizona Sun Family Medicine, PC

By signing this document, I understand and authorize Arizona Sun Family Medicine, to contact me at the telephone numbers that I have provided. I understand and authorize Arizona Sun Family Medicine, PC to leave detailed messages about lab and diagnostic results, appointment reminders and any and all other information which may be relative to my care.

Patient's signature

Date: _____

Parent/Custodian of Patient

Date: _____

Arizona Sun Family Medicine, P.C.

Financial and Office Policy

Payment: Payment is due at the time of service. We accept cash or card payments. We DO NOT ACCEPT CHECKS. If your insurance has a deductible, you will be required to pay towards that balance at the time of your visit.

Billing: As a courtesy we will bill the insurance you have provided us, however it is your responsibly to update your insurance with us at every visit. If you fail to update your insurance and your claims are denied, a reprocessing fee of \$25.00 will be assessed.

Appointments: As a courtesy our office will call and remind you of your appointment the day before. If you do not show up for your appointment or do not cancel your appointment at least 24 hours prior you will be charged a \$40.00 missed/late cancel fee. The fee for missed physicals and procedures is \$60.00.

Respect: Our staff is committed to treating our patients in a courteous and respectful manor and we expect the same from you. Abusive and vulgar language will not be tolerated. If you do not choose to follow our office policy regarding respect, you will be asked to find another provider to care for you.

Medication Refills: All pain or narcotic type medications will only be filled at an appointment and only when those medications are due for refills. Early refills and refills by phone will not be addressed. Medications for ADHD will be filled every month however an office visit will only be required every three months. All other prescriptions will need to go through your pharmacy. Please call them for any refills and they will contact our office.

HIPAA: We will only release information, prescriptions or records to those individuals you have listed on your HIPAA form. If another company requests information regarding your health record, a signed release must be sent over by that company on letter head. Specific dates and which records must also be included on the request.

Thank you for choosing Arizona Sun Family Medicine for your healthcare needs. If you have any questions please feel free to ask.

By signing below I have read and understand these policies:

Patient Signature

Date