

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, PC**  
**Financial Policy**

Thank you for choosing our office as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment agreement. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

Payment is due at the time of service. We accept cash, Visa, Mastercard or American Express.  
**WE DO NOT ACCEPT CHECKS.**

If you do not have insurance, if you are insured by a company that we are not contracted with, or if we are unable to verify your coverage, payment in full will be required at the time of service.

If you are covered by insurance, we accept assignment of insurance benefits from many plans and will bill your insurance carrier for your visit. Co-pays are due at check-in. **In the event that your insurance changes, it is your responsibility to provide the most recent and correct insurance information. Failure to keep your information current may lead to you being billed for the entire amount of services. Additionally, if you are covered by more than policy, it is your responsibly to provide BOTH INSURANCE CARDS before the time of your visit.**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any contracted insurance company's arbitrary determination of usual and customary fees.

**UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE \$25.00 FOR MISSED OFFICE VISITS AND \$50.00 FOR MISSED PHYSICALS, WELL-WOMAN EXAMS, OR SCHEDULED PROCEDURES. PATIENTS WHO CANCEL APPOINTMENTS LATE (LESS THAN 8 HOURS) OR MISS MORE THAN 2 SCHEDULED APPOINTMENTS WILL BE DISCHARGED FROM OUR PRACTICE.**

Thank you for attention and cooperation to these matters. Please let us know if you have any questions.

**I have read, understand, and agree to this Financial Policy:**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date