FAMILY MEDICINE OF SCOTTSDALE

Let's face it, we all hate filling out forms. We don't like them either but some are governmental regulation and some are for your safety. So bear with us and please fill them out.

Name		DOB	
Address		SS#	
City, ST Zip		Gender	
Phone		Marital Status	
Email			
Resp. Party	☐ Self		
Relationship		Pharm Name	
Address		Pharm Address	
City, ST Zip		Pharm Phone	

Insurance Information:	**Primary Insurance**	
Insurance Carrier		
Insured Name	Insured Date of Birth	
Group Number (medical)		
Member ID		

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Family Medicine of Scottsdale has a commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Family Medicine of Scottsdale.

Name: ______________________ Signature: _________________________ Date: __________________

Consent to Release Protected Health Information Contact List

	Emergency Contact	Other Contact (if we can't reach you)	Other Contact (if we can't reach you)
Name			
Relationship			
Primary Phone			
Alternate Phone			
Permission to Share Information? **(Initial)**	Yes/No	Yes/No	Yes/No

I hereby authorize Family Medicine of Scottsdale to use and disclose my personal health information to the individuals identified on this form. I understand this authorization does not expire unless written notice is mailed to 18801 N. Thompson Peak Parkway #110, Scottsdale, AZ 85255. I understand this may include information relating to communicable diseases, such as HIV/AIDS, sexually transmitted diseases, behavioral or mental health, alcohol and/or drug abuse treatment, and genetic testing information, if any records exist. I understand that Family Medicine of Scottsdale will treat the individuals identified on this form as individuals involved directly in my care and as such, Family Medicine of Scottsdale will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations. I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Family Medicine of Scottsdale will not be affected if I refuse to sign this authorization.

Name: ______________________ Signature: _________________________ Date: __________________

Financial Policy/Assignment of Benefits for Patients

(Please Initial Each Line)

_____ I understand that I have medical insurance which is billed on my behalf as a courtesy and I am financially responsible for services rendered should insurance not pay for my office visits and treatment charges.

_____ I will inform Family Medicine of Scottsdale of a change in my insurance coverage at the day of service.

_____ I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract with the insurance company.

_____ I understand that it is my responsibility to pay all past balances, co-pay, deductible and estimated co-insurance amounts at the time of service rendered.

_____ I understand that my credit card information will be kept on file and, I acknowledge that Family Medicine of Scottsdale will charge the balance to the credit card on file after receipt of the insurance determination.

_____ I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on file.

_____ I thereby assign all medical benefits directly to Family Medicine of Scottsdale for services rendered at their facilities.

_____ Family Medicine of Scottsdale may request proof of insurance premium payment.

_____ I understand that if I do not place a credit card on file I will pay for all services rendered at the time they are rendered.

_____ I understand there will be a $50 fee charged for any appointment missed and for appointments that are cancelled with less than 12 hours notice as it prevents the office from scheduling other patients. I agree to pay this fee before attending the next appointment.

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Name: ______________________ Signature: _________________________ Date: __________________