Date:____________ e-mail: ____________________

Patient: ________________________________
last first middle

Address: ________________________________

City: ____________________ Zip: __________

Phone:________________ Cell:______________

SS#: ________________________________

Sex M ☐ F ☐ Birthdate:____________________

Marital Status M ☐ S ☐ W ☐ D ☐

Employment: FT ☐ PT ☐ Retired ☐ Disabled ☐ Unemployed ☐

Employer name, address & phone: ________________

____

____

Insured's name: ________________________________

Insured's birthdate & SS#:________________________

Insured's employer: ____________________________

EMERGENCY CONTACT NAME, PHONE # & RELATIONSHIP (mandatory)

____

Which dr referred you to us? ____________________

Primary care dr name: __________________________

Primary care dr address and phone: ______________

____

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

Home telephone #: We may leave a message with a callback number or appt reminder on voicemail

Work telephone #: We may leave a message with a callback number or appt reminder on voicemail

Written communication: We may mail postcards to your home address or send you an e-mail

I have received the NOTICE OF PRIVACY PRACTICES and I have been provided an opportunity to review it.

I understand that the last four digits of my social security # will be used as a password to identify persons seeking information regarding my health care, e.g. for test results, prescription refills, billing info. If I would like a different code assigned, I will list it here ____________________. I will give this code to my family members or friends who may need to call the practice on my behalf. Without this code the physicians or staff members will not be able to speak with anyone except myself.

Patient Signature: **X** ________________________________

Office only

Acct#____________________

☐ JOS (8) ☐ PUD (4) ☐ DWP (5) ☐ DYK ☐ EJQ ☐ JRG

☐ KNJ ☐ DTG

☐ PHX (1) ☐ SC (2) ☐ MESA (3) ☐ FG ☐ SL (5) ☐ CT(6)

☐ LH (7) ☐ PY (8) ☐ SDL2 ☐ PRH ☐ PRM (14) ☐ PRG (15)

☐ KG (17) ☐ YU ☐ SED ☐ SCW ☐ TC ☐ GY

☐ SA (10) ☐ EM ☐ GIL ☐ GLD

PLEASE HAVE YOUR MEDICARE AND INSURANCE CARDS READY FOR US TO COPY.

Circle 1 IF THE INS IS PRIMARY, 2 IF THE INS IS SECONDARY

1	2	AARP	1	2	Humana
1	2	ADMAR	1	2	Indian Health
1	2	AETNA	1	2	Industrial
1	2	Arizona Physicians IPA	1	2	Maricopa County
1	2	AHCCCS	1	2	Medicare
1	2	Blue Cross	1	2	Mercy Care
1	2	Capp Care	1	2	Pacificare
1	2	Community Care	1	2	PHCS
1	2	CIGNA	1	2	Phoenix Health Plan
1	2	CMPD (Foster Children)	1	2	Principal
1	2	Children's Rehab	1	2	Prudential
1	2	Foundation	1	2	Secure Horizons
1	2	Healthcare Compare	1	2	Tricare
1	2	Health Net	1	2	United Health Care

Other________________________________

Is your plan an HMO ☐ PPO ☐ EPO ☐ POS ☐

Indemnity (Check your insurance card) ☐ Other __________

Does your insurance require a referral or prior authorization?

YES ☐ NO ☐ How much is the copay? ______________

LIFETIME INSURANCE AUTHORIZATION

I AUTHORIZE AND REQUEST THAT PAYMENTS UNDER MY MEDICAL INSURANCE PROGRAMS BE MADE DIRECTLY TO PAY PROVIDER FOR ANY SERVICES FURNISHED TO ME. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION NEEDED FOR PAYMENT OF CLAIMS. I FURTHER PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

X ____________________ ____________

Patient or responsible party signature Date

FINANCIAL AGREEMENT

THE FINANCIAL POLICY OF THE PRACTICE HAS BEEN FULLY EXPLAINED TO ME AND I ACKNOWLEDGE FULL RESPONSIBILITY FOR ALL CHARGES INCURRED INCLUDING ANY ADDITIONAL CHARGES INCURRED IN THE COLLECTION OF THIS ACCOUNT, IF MY INSURANCE LATER DETERMINES MY SERVICES TO BE NONCOVERED OR NOT A BENEFIT.

X ____________________ ____________

Patient signature Date

____________________ ____________

Employee witness Date

All reverified, updated & patient update sent to CBO

Date/by ________ ________ ________ ________ ________