

 **Richard Ohanesian, MD \* Jeffrey Osburn, MD \* Katie Campuzano, MD**

 **AnnMarie Massimo, OGNP \* Victoria Cahill, OGNP**

**PRESCOTT WOMEN’S CLINIC – FINANCIAL POLICY**

Thank you for choosing our office as your health care provider. Your clear understanding of our financial policy is important to our professional relationship. In order to avoid any confusion in the future we have outlined our policy for you.

Our practice is committed to providing the best treatment for our patients. We must emphasize that as medical care providers our relationship is with you, our patient, not with your insurance company. We cannot accept the responsibility of negotiating the claims with insurance companies or any other persons. While the filing of insurance claims is a “courtesy” that we extend to our patients, all charges are your responsibility from the date of the services rendered.

Although an insurance claim is filed, you will receive a monthly statement if your account has a balance due. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. The patient is responsible for payment of the account within the limits of our credit policy. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, or in circumstances where a claim is pending or when treatment will be for an extended period of time, it is recommended that a payment plan be initiated. We encourage you to contact the Collection Department for assistance in the management of your account as we are willing to accept half of the balance at the time of service and the balance due and payable within thirty (30) days.

It is your responsibility to update our office with your new insurance information if you change insurance companies. We also need to know if you have a secondary coverage with another company (especially AHCCCS).

**CANCELLATION POLICY**

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT OUR OFFICE MUST BE NOTIFIED AT LEAST TWENTY FOUR (24) HOURS IN ADVANCE OF YOUR APPOINTMENT OR YOU MAY BE SUBJECT TO CHARGES FROM OUR OFFICE.

**PRESCRIPTION AND REFILL POLICY**

Prescott Women’s Clinic asks that you allow 48 hours to refill your prescription. When you need your prescription refilled, please call your pharmacy. The pharmacy should then fax our office with your refill request. Our fax number is (928)771-0920. Please avoid running out of your medications by calling your pharmacy at least three (3) days before your prescription runs out. Also, please remember that your prescription is only good for one (1) year – your doctor cannot refill your medication after that time if you have not been seen by our office.

**OFFICE HOURS**

Our office hours are Monday through Friday 8:00 a.m. to 5:00 p.m. If you have a life threatening emergency, please call 911. If you have urgent questions after the office is closed, please call (928)778-4300 and the answering service will page the doctor on call for you.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF PRESCOTT WOMEN’S CLINIC AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME BY THE PRACTICE.

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Patient or Responsible Party Date

 919 Twelfth Place, Suite 1, Prescott, Arizona 86305 7600 E. Florentine Road, Prescott Valley, AZ 86314

 (928)778-4300 (928)778-4300

02/2020

**PRESCOTT WOMEN’S CLINIC PATIENT REGISTRATION**

(PLEASE PRINT)

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| **PATIENT INFORMATION** |
| Last Name | Social Security # | Date of Birth |
| First Name Middle Initial | Former Last Name(s) | Marital Status |
| Mailing Address | Street Address (if different from mailing address) |
| City, State, Zip | City, State, Zip |
| Employed/Unemployed/Retired? | Occupation |
| Employer | Primary Care Physician |
| Home Phone # | Work Phone #  | Cell Phone # |
| Please Check Best Phone Number to Contact you Between 8:00 a.m. and 5:00 p.m. Home Work Cell Other \_\_\_\_\_\_\_\_\_\_ | E-mail Address |
| Spouse/Significant Other Name | Social Security # | Date of Birth |
| Spouse’s Employer | Occupation |
| **INSURANCE INFORMATION** |
| **Primary Insurance** | **No Insurance/Self Pay** |
| Insurance Company Name |
| Name of Insured | Insured ID # |
| Relationship to Patient | Group # |
| Insured Date of Birth | Effective Date |
| Insured Employer | Insured Social Security # |
| **Secondary Insurance** |
| Insurance Company Name |
| Name of Insured | Insured ID# |
| Relationship to Patient | Group # |
| Insured Date of Birth | Effective Date |
| Insured Employer | Insured Social Security # |
| **EMERGENCY CONTACT INFORMATION** | **PARENT/GUARDIAN INFORMATION** |
| Emergency Contact | Minor’s Parent/Legal Guardian Name |
| Patient Relationship to Contact | Address (if different than patient) |
| Contact Home Phone/Cell Phone | Parent/Guardian Home Phone |
| Contact Work Phone | Parent/Guardian Work Phone |
| **MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION** |
| Who May Receive Your Protected Health Information? | Relationship |

I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. Any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. I also understand that Prescott Women’s Clinic will charge additional collection and/or attorney fees in the event this bill becomes delinquent. I hereby authorize Prescott Women’s clinic to furnish the insured’s insurance company all information which said insurance company may request concerning my present illness or injury. I hereby authorize Prescott Women’s Clinic to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and be in full force and effect until revoked in writing by me.

I have received Prescott Women’s Clinic’s Notice of Privacy Practices for Protected Health Information and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

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Signature of Patient or Responsible Party Relationship to Patient Date 02/2020