## patients account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| (Please fill entire packet completely. Incomplete paperwork will not be accepted. Return completed packet to front desk receptionists.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | PCP: | | | | | | | | | | | | | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | First: | | | | | | | | | | | | | Middle: | | | | | |  | | ❑ Mrs  ❑ Miss  ❑ Ms. | | | | | | | Marital status (circle one) | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid / Partner | | | | | | | | | | | | |
| Race (Check all that apply): ❑ African American ❑Caucasian ❑ Hispanic ❑ Asian  ❑ Pacific Islander ❑ Refuse to report ❑Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | Ethnicity: ❑ Hispanic ❑ Not Hispanic  ❑ Refuse to report | | | | | | | | | | | | |
| Is this the name on your insurance? | | | | | | If not, what is the name on your insurance? | | | | | | | | | | | | | | | | | | | | | | (Former name): | | | | | | | | | | | | | | | Birth date: | | | | | | | Age: | | | | Sex: | | | | |
| ❑ Yes | | ❑ No | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | / / | | | | | | |  | | | | ❑ M | | | ❑ F | |
| Street address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Social Security no.: | | | | | | | | | | | | | | Cell phone no.: | | | | | | | | | | | | |
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| P.O. box: | | | | | | | | | City: | | | | | | | | | | | | | | | | | | | | | | | | | | | State: | | | | | | | | | | | | ZIP Code: | | | | | | | | | | |
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| Occupation: | | | | | | | | | Employer: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | |
|  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | |  | | | | | | | | |  | | |
| Chose clinic because/Referred to clinic by (please check one box): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ❑ Dr. | | |  | | | | | | | | | | | | | | ❑ Insurance Plan | | | | | | | | | ❑ Hospital | | |
| ❑ Family | | | ❑ Friend | | | | ❑ Close to home/work | | | | | | | | | | | | | | | | | | ❑ Yelp | | | | | | | | | | | ❑ Other | | | | | | | |  | | | | | | | | | | | | | | |
| Other family members seen here: | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PLEASE NOTE:** If you have a primary AND secondary insurance, you are required to inform us to avoid having your secondary insurance terminated. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Please give your insurance card to the receptionist.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Person responsible for bill: | | | | | | | | Birth date: | | | | | | | | | | | | | Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | | Home phone no.: | | | | | | | | | | | | |
|  | | | | | | | | / / | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | ( ) | | | | | | | | | | | | |
| Is this person a patient here? | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Occupation: | | | | Employer: | | | | | | | | | | | Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: | | | | | | | | | | | | |
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| Is this patient covered by insurance? | | | | | | | | | | | | ❑ Yes | | | | | | | | ❑ No | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please indicate primary insurance | | | | | | | | | | ❑ United Health Care | | | | | | | | | | | | | | ❑ BlueCross BlueShield | | | | | | | | | | ❑ Aetna | | | | | | | | | | | ❑ Cigna | | | | | | | | ❑ HealthNet | | | | | |
|  | | | | | ❑ Mercy Care | | | | | | | | | | | | ❑ APIPA | | | | | | | | | | ❑ Care First | | | | | | | | | | | | | | | | | | ❑ Other: | | | |  | | | | | | | | | |
| Subscriber’s name: | | | | | | | | | | Subscriber’s S.S. no.: | | | | | | | | | | | | | | | | Birth date: | | | | | | | | | Group no.: | | | | | | | | | | | Policy no.: | | | | | | | | | Co-payment: | | | |
|  | | | | | | | | | |  | | | | | | | | | | | | | | | | / / | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | $ | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | ❑ Self | | | | | | | | | | ❑ Spouse | | | | | | | ❑ Child | | | | | ❑ Other | | | | | |  | | | | | | | | | | | | | | | | | |
| Name of secondary insurance (if applicable): | | | | | | | | | | | | | | | | | | | Subscriber’s name: | | | | | | | | | | | | | | | | | | | | | | Group no.: | | | | | | | | | | | Policy no.: | | | | | | |
|  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | |
| Patient’s relationship to subscriber: | | | | | | | | | | | | | | ❑ Self | | | | | | | | | ❑ Spouse | | | | | | | ❑ Child | | | | | ❑ Other | | | | | |  | | | | | | | | | | | | | | | | | |
| Pharmacy Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pharmacy Name: | | | | | | | | | | | | | | | | | | | | | | Pharmacy Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Zip Code: | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | | | | Home phone no.: | | | | | | | | | | Work phone no.: | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | ( ) | | | | | | | | | | ( ) | | | | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | | | | | | |  |

**PATIENT MEDICAL AND FINANCIAL AGREEMENT**

Thank you for choosing SHAHealth |Arizona Women’s Specialists. We are committed to providing you with affordable, quality health care. We also believe in keeping our patients up to date with any new changes to office policy. To keep you aware of our current financial policies, we ask that you read and sign this document prior to any treatment. We will provide a copy of this document for your records upon request. (Please check off boxes off as you read)

The medical services you seek here imply an obligation on your part to ensure payment is full is made for services you receive. This **Patient Financial Responsibility Agreement** will assist you in understanding that financial responsibility.

**MEDICAL TREATMENT:** By signing this agreement, you are giving SHAHealth | Arizona Women’s Specialists and its providers the permission to establish medical care for you, to perform physical examination, order laboratory and/or radiology tests, and to start necessary treatment. Patient authorizes SHAHealth | Arizona Women’s Specialists to perform services ordered by the doctor with the understanding that any service comes with potential risk. Special consent forms may be needed. This Medical and Financial Treatment Agreement is effective for this outpatient visit and/or for recurring outpatient services of the same type for the duration the patient is seen by the provider(s) following its execution.

By signing this document you are also stating that you understand that the practice of medicine is an art and not an exact science, therefore no warranty, promise, or guarantee of any results or anticipated outcome of any service can be given, written, or implied in regard to utility, appropriateness, or anticipated outcome of any service provided by the physician and received by the patient.

**CONSENT:** I consent to treatment and services ordered by my Physician or Mid-Level Provider at SHAHealth and/or its associates. I understand my healthcare provider may perform medically necessary services, as well as “elective” services, according to current standard of care guideline. I do have the right to consider or decline services prior to them being performed. My consent to undergo such treatment and/or services will be considered a non-verbal agreement to pay for the services provided to me.

**RESPONSIBILITY:** I understand I am ultimately responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. I am responsible for deductibles, Co-payment, Co-insurance or any other patient responsibility amounts indicated by my insurance carrier or for any services not covered by my insurance.

**INSURANCE POLICY:** It is my responsibility for knowing and understanding my insurance policy, both the coverage benefits and policy limitations. I understand I am personally responsible for payment when: (i) my health plan requires prior authorization/referral by a primary care physician (PCP) before receiving services, and I have not obtained such an authorization or referral; (ii) I receive services in excess of the authorization/referral; (iii) my health plan determines the services I received are not medically necessary and/or not covered by my insurance plan; (iv) my coverage has lapsed/expired at the time services are rendered; (v) I have chosen to utilize my out-of-network benefits; or (vi) I have chosen not use my health plan coverage for services I receive.

**PAYMENT ARRANGEMENTS.** Whether or not I have insurance or are self-pay, payment of my account balance is due within thirty (30) days of receipt of my billing statement. I understand if I need to make special payment arrangements, I may contact the Patient Accounts Staff to arrange a mutually agreeable payment plan. I agree to make payments on this plan pursuant to the plan agreement until my account is paid in full. If my account is over sixty (60) days past due, my account will be in default and may be referred to a collection agency or attorney.

**PAYMENTS ACCEPTED:** I understand I can make payments by check, cash, money order, debit card, or credit card (Visa, MasterCard, American Express or Discover).

**PAYMENT BY CHECK:** If my check payment is returned or declined for any reason, my account will be charged a surcharge of $35.00 in addition to any costs assessed or charged by the bank. After two (2) returned checks have been received by SHAHealth, my personal checks will no longer be accepted, and I will be responsible for using another method of payment.

**ANCILLARY SERVICES:** I may receive ancillary medical services while a patient of SHAHealth such as anesthesia; interpretation of test; imaging services (e.g., ultrasound and mammogram); diagnostic testing, etc. I understand some physicians may not provide services directly in my presence but are actively involved in the course of my diagnosis and treatment. I authorize payment directly for these services under the policy issued to me by my insurance carrier. I may incur additional charges as a result of ancillary services. I agree to pay all remaining charges for services after benefits paid on my behalf are credited to my account as determined by my insurance carrier.

**COLLECTION OF ANTICIPATED CHARGES:** For maternity care/services, office and surgical procedures, SHAHealth will collect my anticipated financial responsibility for such services prior to delivery for prenatal care; and prior to delivery or prior to scheduling an office or surgical procedure. SHAHealth will contact my insurance carrier to determine an estimate of the anticipated amounts owed based on the current contracted amounts and fee schedules. I will not hold SHAHealth responsible for incorrect/inaccurate information provided by my insurance carrier regarding my insurance benefits or benefit plans. If an account balance remains due after the claim has been processed and amounts collected for anticipated charges have been applied, I understand I will be held responsible for the remaining amount and am ultimately responsible for payment.

**NON-PAYMENT ON ACCOUNT:** Should collection proceedings or other legal become necessary to collect my overdue or delinquent account, I understand SHAHealth has the right to disclose to an outside collection agency attorney to relevant personal and account information necessary to collect payment for services rendered. I am responsible for all costs of collection including, but not limited to: (i) late fees and charges and interest due as a result of such delinquency; (ii) a $50.00 administrative default fee will be added to outstanding balances placed with a collection agency or attorney; (iii) interest of 18% per year will be accrued on the principal balance owing; (iv) all attorney/court costs and fees incurred in the collection process; and I acknowledge that if my account is referred to a collection agency, attorney, court, or when the past due status is reported to a credit reporting agency, it may have an adverse effect on my credit history. Once my account is placed with a collection agency attorney, I am responsible for communicating with their offices for payment. I may lose my ability to be seen at SHAHealth as a result of my account being sent to a collection agency or attorney.

**CHOICE OF VENUS:** All legal action will be filed in Maricopa County, Arizona in accordance with Arizona law.

**MINOR PATIENTS:** The patient/guardian presenting with a minor for care is the responsible party for payment of the minor’s account balance regardless of any court order or arrangement the parents may have agreed to between themselves. SHAHealth will not act as administrator to resolve my financial agreements. According to state law and in certain situations, a minor can seek and will be provided treatment in SHAHealth offices without parental consent or knowledge. Minors can choose to utilize their insurance coverage provided by their parent for claims submission or they can choose to be self-pay. Depending on the circumstances of the visit, SHAHealth may or may not share information upon parental request. State law allows minors the right to patient confidentiality under certain circumstances.

**AUTHORIZATION TO CONTACT:** I authorize SHAHealth, collection agency, attorney, agent and/or servicer of my patient account to communicate with me by mail, answering machine messages, text message and/or email SHAHealth, collection agency, attorney, agent, and/or servicer of my patient accounts, may use any information I have provided, including contact information, email addresses, cell phone numbers, and landline numbers, to contact me for purposes related to my health any my account, including debt collection.

**ACKNOWLEDGEMENT:** I understand I am ultimately responsible for payment for the services I receive at SHAHealth, regardless of my health insurance coverage, I understand SHAHealth will not act as administrator to resolve my personal financial agreements in regards to my medical care. I have had the opportunity to read this Patient Financial Responsibility Agreement in its entirety and have had the opportunity to ask questions regarding the details of this agreement. Any questions have been answered to my satisfaction.

I consent and agree to the above policies of SHAHealth and understand they may be changed without notice.

Signed and agreed to this date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Parent/Guardian Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Signature

**Office Policies**

(By checking the boxes below, you are stating that you have read and understood the information in this document. You will also be required to sign at the bottom.)

❑ **Patient Portal:** As a practice, we are required by federal law to give our patients access to their medical records online. This means that you, as a patient, **must** provide us with a valid email address so that we can web enable you to give you access to your records.

❑ **Medical Records:** As of February 2018, we will no longer be printing patient medical records. All patients will have access to their medical records on our Patient Portal. We are required by federal law to provide patients with their medical records without withholding any information to the patient. Signing up for the patient portal is mandatory as per Meaningful Use.

❑ **Cell Phones:** As of February 2018, cell phone use in patient rooms is *PROHIBITED*. This means that there will be no photography, videography, snapchat, texting, or phone calls in our office to protect the privacy of our patients.

❑ **Ultrasounds:** Ultrasounds must be ordered by a physician, physician’s assistant, or nurse practitioner. We do, however, offer *elective* 3D/ 4D ultrasound packages. Pricing and information on these packages is available upon request. Cell phones are *PROHIBITED* in all ultrasound rooms, regardless of the type of ultrasound being performed. Please refer to the **Cell Phones** section above. Patients are not allowed to be more than 10 minutes late. If you arrive later than 10 minutes, you will be asked to reschedule.

❑ **No-show/ Late Arrival:** Patients are expected to show up to their appointments on time. We recommend showing up 5 minutes early for regular checkups to give you, the patient, time to fill out your encounter form and leave a urine sample before being called to your room. If you are here for an ultrasound, we ask that you arrive *ON TIME,* as our ultrasound schedules are frequently full and do not have room to fit late patients in. If you are later than 10 minutes for any appointment, you may be rescheduled. Please keep in mind that it is *your* responsibility as a patient to arrive on time for your appointments, as well as knowing when and where your appointment will take place. Our patient coordinators will call two days in advance to remind you of your appointment and text messages will be sent the day before an appointment. IF YOU ARE UNSURE OF YOUR APPOINTMENT DATE AND TIME please call our office and ask a staff member to check for you. Again, you are responsible for knowing when and where your appointments will be.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_