SPECTRUM MEDICAL GROUP, P.C.

52 East Monterey Way
Phoenix, AZ 85012
Phone: (602) 604.9500 / Fax: (602) 631.9303

PATIENT REGISTRATION FORM

Thank you for choosing our office. In order to serve you properly, please provide us with the following information. Please print. All information will be confidential.

PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Marital Status: _____ Gender: □ Male □ Female □ MTF □ FTM

Home Phone: _____ Cell Phone: _____ Email: _____

Language: _____ Race: _____ Ethnicity: _____ □ Declined

HOW DID YOU HEAR ABOUT US? (Please check all that apply.)

□ Advertising _____

□ Yellow Pages / Directory _____

□ Internet - Website / Search Engine: _____

□ Other _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Previous Physician Name: _____ Phone: _____

INSURANCE INFORMATION (*WE REQUIRE A COPY OF YOUR INSURANCE CARD(S)*)

Primary: _____	Secondary: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____	Phone: _____
Policy Holder Name: _____	Policy Holder Name: _____
Relationship to Patient: _____	Relationship to Patient: _____
Employer: _____	Employer: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Policy Holder Gender: □ Male □ Female	Policy Holder Gender: □ Male □ Female
Policy Holder Date of Birth: _____	Policy Holder Date of Birth: _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize Spectrum Medical Group, P.C. to release any medical information necessary to referring physicians or to process insurance claims in relation to the medical care rendered by Spectrum Medical Group, P.C.

Patient Signature or Legal Guardian: _____ Date: _____

FINANCIAL AGREEMENT

I acknowledge **full responsibility** for **all charges** incurred, regardless of possible insurance coverage. I hereby authorize Spectrum Medical Group, P.C. to obtain, on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) file(s). I hereby authorize payment directly to the physician(s) for medical and/or surgical benefits.

Patient Signature or Legal Guardian: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: _____ DOB: _____

I authorize Spectrum Medical Group, P.C. to:

☐ Obtain information ***FROM***:

☐ Release information from Spectrum Medical Group, P.C. ***TO***:

_____
Organization / Agency

_____
Address Area Code and Phone

_____
City State Zip Code

Dates of Service From _____ to _____

**Please release the following information from my medical record:

□ Complete Records	□ Physician Notes / Dictation	□ History and Physical
□ Therapy Notes	□ EKG	□ Imaging
□ Emergency Department	□ Path Reports	□ Lab
□ Operative Notes	□ Face Sheet	□ Other _____

**I hereby consent to the release of records pertaining to treatment / diagnosis of the following:

Confidential Alcohol or Drug Abuse-Related Information (as defined in 42 CFR Section 2.1 ET SEQ)
Confidential HIV Related Information (as defined in A.R.S. Section 36-661)
Confidential Mental Health Diagnosis / Treatment Information
Confidential Communicable Disease Related Information (as defined in A.R.S. section 36-661)

Except as follows: _____

**The purpose of this request is for (please check all that apply):

□ Further Medical Care	□ Insurance	□ Legal
□ Other (please specify) _____		

** I ☐ DO authorize the Facsimile (FAX) transmission of above records.
☐ DO NOT

I understand that this authorization shall expire, without my express revocation, six (6) months from the date written below [sixty (60) days for drug / alcohol abuse treatment records]. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

_____
Signature of Patient Date

FOR OFFICE USE ONLY

Authorization added to patient's medical record on _____

SPECTRUM
MEDICAL
GROUP, P.C.

Advance Directives

To comply with Medicare, Managed Health Care Plans, and hospital admission requirements, we are required to provide to you information about federal and state laws that allow you to accept or refuse treatment to formulate advance directives. Advance directives are documents that enable you to give directions about your future medical care.

Before making any decision about advance directives, please speak with your family, physician, and/or attorney if you need assistance with your plans. If you already have advance directives, or have decided to develop advance directives, please provide copies to your family, close friends, and your physician so that they will be aware of your wishes.

Please be assured that this is not a mandatory process, and you may elect not to have advance directives. However, in the event of a medical emergency, all measures, including life support, will be afforded to those who do not sign advance directives. This form is not intended to provide you legal advice, but merely to provide information only.

Please sign the bottom of this form, stating that you have been given this information and offered the opportunity for advance directives. Your signature does not signify any decision on your advance directives, but simply shows that you have been given the information.

Thank You,

Thanes Vanig, M.D.

Patient Signature: _____

Date: _____

SPECTRUM MEDICAL GROUP, P.C.

Financial Policy

MEDICARE PATIENTS

This office accepts Medicare assignment. Medicare assignment means that we accept, as full payment for services rendered, the amount that Medicare approves. Medicare pays 80% of its' allowable fee, after you have met your required deductible per calendar year. The patient is then responsible for the 20% of Medicare's allowable fee that Medicare did not pay. The 20% balance is the responsibility of the patient, either through payment from their supplemental / secondary insurance, or through direct payment from the patient. **It is your responsibility to know and confirm your benefits *before* receiving treatment.** You will receive an explanation of benefits directly from Medicare, outlining what was allowed and paid by Medicare, and what will be your responsibility. You will also receive a statement from our office if there is a balance due directly from you, the patient. Certain services, particularly routine foot care, orthotics, and wart removal, are not covered by Medicare and patients are responsible for 100% of these charges. You will be notified in advance of any treatment or service that is not covered by Medicare. **You have the right to be informed of and refuse any treatment recommended by the Doctor.**

CASH PATIENTS

As with all professional services, payment is expected at the time that services are rendered. We will make every effort to work out a payment arrangement that is feasible to you and to our office. **You have the right to be informed of and refuse any treatment recommended by the Doctor.**

PRIVATE INSURANCE PATIENTS

Your insurance policy is a contract between you and your insurance company. **It is your responsibility to know and confirm your benefits *before* receiving treatment. You have the right to be informed of and refuse any treatment recommended by the Doctor.** ***We cannot guarantee payment of your claim***. If it is not paid, you should receive an explanation of benefits directly from your insurance company with detail advising why your claim was denied. ***We do look to you for final payment of any denied claims.***

As a courtesy, our office will bill your primary and secondary insurance carrier(s) for you. You, however, are ultimately responsible for the entire balance. You will be asked to sign an Assignment of Benefits. This assignment provides for the payment of benefits directly to us for the services billed.

If we are billing your insurance, we will set aside the portion of the balance estimated to be paid by your insurance carrier for sixty (60) days. We require that your co-pay and deductibles be paid at the time of your visit. If your insurance carrier does not remit payment within sixty (60) days, we have the prerogative to request the full balance from you.

Since we are not a party to your agreement with your insurance carrier (other than "Participating Provider"), it is not our policy to contact carriers to establish why they haven't paid, or why they paid less than originally indicated. Subsequently, if a payment is made by your insurance carrier in excess of the balance, we will promptly credit your account and/or refund you the excess amount per a written request.

If you anticipate a large bill or are having financial difficulties, it is important that you contact our office. We can make payment arrangements if we are aware that there is a problem.

******Accounts over 120 days past due may be turned over to an outside collection agency. Any fees incurred by our office associated with collection on a past due account, including administrative or legal costs, will be the patient's responsibility.***

Patient Signature: _____ Date: _____

Office Information and Policies

OFFICE HOURS

- Monday, Tuesday, Thursday: 8:30 am – 4:00 pm / *Closed for lunch 12:00 - 1:00 pm*
- Wednesday: 10:00 am – 6:00 pm / *Closed for lunch 1:00 - 2:00 pm*
- Friday: 7:00 am – 2:00 pm / *Closed for lunch 11:00 am - 12:00 pm*
- Email (*non-medical issues only*): Jennifer@spectrummedgroup.com

APPOINTMENTS

We see all patients on an appointment basis. If you are more than 10 minutes late for your appointment, you will need to reschedule your appointment for another time. ** **Appointment cancellations require 24 hours advanced notice** by phone, portal &/or email. **Same day cancellations will incur a missed appointment fee*.

A fee of **$75.00 per missed appointment** will be assessed for:

- No-show appointments
- Appointments cancelled with less than 24 hours' notice

Patients who accrue three or more no-show visits risk being discharged from the practice.

Due to the unpredictability of an internal medicine office, there are times when our physicians may be delayed by various emergencies. Although every effort is made to see patients promptly, sometimes the schedule must be adjusted.

COPAYMENTS AND INSURANCE CARDS

All copayments are due at the time services are rendered. We will be happy to take your copayment upon check-in. We accept cash, check, or most major debit/credit cards *(with the exception of American Express)*.
Please note that our office charges a $25.00 fee for any returned checks.

Additionally, to ensure we have the most up-to-date information for billing purposes, we must verify your insurance *at each appointment*. Please have your insurance card available upon check-in at each appointment.

EMERGENCIES AND HOSPITALS

For a life-threatening emergency, call "911." For other after-hour emergencies, please dial 602-604-9500, and the answering service will forward your message to our physician on-call. Our physicians are on staff at Scottsdale Healthcare Osborn Hospital.

By signing below, you acknowledge having read and agreed to the above policies.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Patient's Bill of Rights

As a patient of Spectrum Medical Group, P.C., you have the right to:

1. Considerate and respectful care.
2. Personal dignity.
3. Confidentiality.
4. Know the identity of all persons involved in your care.
5. Be informed in clear, understandable language, about your diagnosis, treatment options, and prognosis.
6. Communicate with the people outside the facility, and the right to an interpreter, if necessary.
7. Refuse treatment, and be told of the medical consequences.
8. Be informed of research projects involving my care, and the right to refuse participation in them.
9. Receive a full explanation of my bill.
10. Make a complaint.

I have read and received a copy of "Spectrum Medical Group, P.C. Patient's Bill of Rights."

Patient Signature: _____

Date: _____

Patient Consent Form

I, _____, understand that as part of my health care, and under the Health Insurance Portability & Accountability Act of 1996, **Spectrum Medical Group, P.C.** originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand, and have been provided with, a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that **Spectrum Medical Group, P.C.** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I further understand that **Spectrum Medical Group, P.C.** reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should **Spectrum Medical Group, P.C.** change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and ■ accept / □ decline the terms of this consent.

I authorize **Spectrum Medical Group, P.C.** to release information concerning my medical care ***only*** to:

Name: _____ Relationship to Patient: _____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

□ Consent received by _____ on _____

□ Consent refused by patient on _____

□ Consent added to the patient's medical record on _____