Arizona Center for Chest Diseases

PATIENT INFORMATION

NAME: LAST, FIRST, MI, _____, _____, _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE#: _____ HOME PHONE#: _____

EMAIL ADDRESS:_____ SOCIAL SECURITY #: ____-____-____

DRIVERS LICENSE#: _____GENDER: ___ RACE: _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____DATE OF BIRTH: _____

AGE: _____ EMPLOYER: _____

EMPLOYER PHONE#: _____SPOUSES NAME: _____

SPOUSES PHONE #: _____EMERGENCY CONTACT: _____EMER-

GENCY PHONE#: _____

WHO MAY WE THANK FOR THE KIND REFERRAL? _____

PRIMARY CARE PHYSICIANS NAME: _____ PHONE#: _____

PHARMACY: _____ LOCATION: _____ PHONE#: _____

MEDICAL INSURANCE INFORMATION

INSUREDS NAME: _____ SSN: ____-____-____ D.O.B. _____

INSUREDS EMPLOYER: _____

INSURANCE CARRIER: _____

INSURANCE ID.#: _____ GROUP#: _____

PLEASE READ CAREFULLY AND SIGN

I _____ assign directly to the Arizona Center for Chest Diseases LTD, insurance benefits, if any, for services rendered to me. I understand that I am responsible for ALL charges that are incurred by me that are not covered by my insurance company.

Our practice is committed to securing the privacy of our patients health information. We are giving you copy of our "Notice of Privacy Practices" today and encourage you to read it. In addition, as part of our commitment to your privacy, please rest assured that your Social Security nor Drivers License Number will be used for any Purposes other then identification, billing, or collections.

By Signing below, I acknowledge that I have been given copy of the offices "Notice of Privacy Practices and that I agree to the above financial statement. I also acknowledge that the information I have provided is true to the best of my knowledge.

PATIENT/ RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

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It is your responsibility to be aware of your benefits. If you are unsure of your insurance benefits, you will need to contact your insurance carrier for clarification of your benefits.

This office bills only for services performed by our providers. The laboratory will bill you or your insurance company for all labs performed. If you have any questions regarding your lab bill please contact the laboratory directly or your Insurance Carrier.

Please bring your insurance card to each appointment. If you change insurance companies or benefits, you must call our office with the new information at least 48 hours prior to your appointment. If you do not, you will be responsible for the bill.

All insurance information, including referrals, and claim forms when necessary, must be provided at time of service. Please be sure to check to be certain that a referral has been received 2 days prior to your appointment We can not see you without a valid referral if a referral is required by your insurance company.

All co-pays, deductibles, and payments are due at time of service,with co-pays being collected prior to you seeing the Doctor. We accept cash, personal checks, Visa, Mastercard and Discover credit and debit cards as forms of payment. We do not bill secondary insurances for copays.

Any personal checks returned to us from your bank will be subject to a fee of $25.00.

Once your insurance has paid, any balance remaining after the first billing will accrue a finance charge of $1.50 to 1% monthly on the balance due. ·Any account left unpaid after 120 days will be turned over to an outside collection agency. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go to our collection agency, any arrangements/ payments will need to be made directly with/to the collection agency. In addition once an account has been turned over to the collection agency, the patient will receive a letter of discharge from our practice.

We understand that situations arise that you must cancel your appointment, we do request a 48 hour notice of such cancellation. We will charge a $ 50.00 fee for any appointments that have not been canceled within this time frame.

A charge of $25.00 per form will be charged for any forms that need to be filled out by our physicians and should be paid when the form is dropped off.

Please keep your copies of all patient receipts (superbills). A $20.00 charge will be made for an end of year statement for tax purposes.

Although we will require you to fill out an "update" on your first appointment of each New Year, it is your responsibility to notify our office immediately of any change of name, address, phone#, or Insurance coverage,either by phone or via secure messaging though our patient portal.

I have read the above patient information,and understand and agree to these terms.

DATE _____ PRINTED NAME OF PATIENT _____ PATIENT SIGNATURE _____