□ **NEW REGISTRATION** □ **UPDATED** **EIN 20-1505116**

ARIZONA ASSOCIATED SURGEONS, PLLC

□ **Allen Agapay, M.D.** □ **Ravia Bokhari, M.D.** □ **Jeromy Brink, M.D.** □ **Charles Castillo, M.D.** □ **Adrienne Forstner-Barthell, M.D.**
□ **Tracy Freeborn, D.O.** □ **William Friese, M.D.** □ **Jordan Glenn, D.O.** □ **Richard Harding, M.D.** □ **David Johnson, M.D.**
□ **Jon King, M.D.** □ **Tafadzwa Makarawo, M.D.** □ **Cole McEwen, M.D.** □ **Jennifer O'Neill, M.D.** □ **Brett Siegrist, M.D.**
□ **David Smith, M.D.** □ **Neeraj Singh, M.D.** □ **Martin Zomaya, MD**

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX □ MALE □ FEMALE □ TRANSGENDER

HOME PHONE #	EMAIL	CELL PHONE #	MARITAL STATUS: □ MARRIED □ SINGLE □ WIDOWED DIVORCED □ OTHER

REFERRING PHYSICIAN NAME AND PHONE NUMBER	PRIMARY CARE PHYSICIAN NAME & PHONE#

HOW DID YOU HEAR ABOUT US: □ PROVIDER REFERRAL □ INTERNET □ WORD OF MOUTH □ PREVIOUS PATIENT □ CURRENT PATIENT □ BROCHURE □ INSURANCE □ HOSPITAL □ CONCENTRA □ MAGAZINE □ RADIO □ OTHER

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE	**ETHNICITY**	**RACE**	
□ ENGLISH □ SPANISH	□ LATINO/HISPANIC	□ ASIAN □ NATIVE HAWAIIAN	□ OTHER PACIFIC ISLANDER
□ RUSSIAN □ CREOLE	□ NON LATINO/NON HISPANIC	□ BLACK/AFRICAN AMERICAN	□ AMERICAN INDIAN/ALASKA NATIVE
□ OTHER _____		□ WHITE	□ REFUSE TO REPORT

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI		HOME PHONE

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY □ SELF □ SPOUSE □ CHILD □ OTHER

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO –	PHONE

PHARMACY

NAME AND CROSS STREETS	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**			DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER			
ADDRESS	CITY	STATE	ZIP	PHONE

SECONDARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**		DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER		

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY TERMS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, agree to and signed the Arizona Associated Surgeons Financial Policy. I agree I will be responsible for any unpaid balances for any reason.

I hereby authorize direct payment to Arizona Associated Surgeons PLLC of any medical benefits payable to me for the services provided at Arizona Associated Surgeons.

X_____

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Arizona Associated Surgeons PLLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X_____

Patient Signature or Signature of Guardian or Parent Date

Name_____ **Age**_____ **Sex** ☐Male ☐Female ☐ Transgender

Referring Physician _____ **PCP** (if different) _____

Chief Complaint _____**When did it start?** _____

How did you hear about us_____

Review of Systems (Are you experiencing any of the following?)

Yes	No		Yes	No	
____	____	Fever / chills / night sweats **(circle)**	____	____	Decreased sensation
____	____	Daytime drowsiness/Somnolence	____	____	Bruising
____	____	Exercise regularly	____	____	Rash / skin lesions
____	____	Weight loss	____	____	Swollen lymph nodes, if yes where_____
____	____	Vision disturbances	____	____	Abdominal Pain
____	____	Hearing difficulties	____	____	Diarrhea / constipation **(circle)**
____	____	Cough	____	____	Nausea / vomiting **(circle)**
____	____	Difficulty climbing a flight of stairs	____	____	Rectal bleeding
____	____	Snoring / nighttime breathing difficulty **(circle)**	____	____	Joint pain
____	____	Chest pain	____	____	Muscle weakness / sensation loss
____	____	Irregular heart beat	____	____	Bleeding problems
____	____	Shortness of breath	____	____	Blood clots / embolism / DVT **(circle)**
____	____	Painful or abnormal urination	____	____	History of anesthesia problems

Have you ever been treated for: ☐ sleep apnea **If yes…Do you use a CPAP No _____Yes_____ Other_____**
☐ heart disease ☐ congestive heart failure ☐ hypothyroid ☐ asthma ☐ high blood pressure
☐ diabetes type 1 ☐ high cholesterol ☐ COPD ☐ heart attack ☐ diabetes type 2 ☐ CVA/strokes

Other Medical Problems_____

_____

Allergies to Medications: (include reactions) ☐ **No known allergies to medications**
Medication_____ Reaction_____ Medication _____Reaction_____
Medication_____ Reaction_____ Medication _____Reaction_____

Family History-has any blood relative ever had: (list which family member) (circle sibling)

Heart Disease	High Blood Pressure	diabetes	cancer	emphysema	birth defects	anesthesia problem
☐ mother	☐ mother	☐ mother	☐ mother	☐ mother	☐ mother	☐ mother
☐ father	☐ father	☐ father	☐ father	☐ father	☐ father	☐ father
☐ brother/sister	☐ brother/sister	☐ brother/sister	☐ brother/sister	☐ brother/sister	☐ brother/sister	☐ brother/sister

Any family history of bleeding problems? No ____Yes_____ Other_____

Social History
Have you ever smoked? No ____Yes____: If yes: #packs per day_____ for _____ #years. If you quit, when? _____(date)
Ever consistently drank > 2 drinks/ day? No ____Yes____ If yes: #drinks/day_____ for ____#years. If you quit, when? _____(date)
Occupation_____

Medications you are currently taking: ☐ **None** **Do you take aspirin? 81mg_____ 325mg_____**

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

GYN History
Last menstrual period_____ # pregnancies_____ # births_____ # miscarriages/abortions_____ # c-sections_____
Are you pregnant? No_____ Yes _____ Maybe _____ Age at first menses_____ Age at menopause _____last PAP_____

Prior Surgeries (include dates)_____

_____

Screening Height_____ (inches) Weight_____ (lbs) **---- patient reported -must be completed**

When was your last: **colonoscopy** _____ (date) **mammogram** _____(date)

When was your last (dates) colonoscopy_____ mammogram _____flu shot _____pneumonia shot_____

arizona associated surgeons
Arizona's Choice for Surgery

THUNDERBIRD VEIN

Allen Agapay MD William Friese MD Jordan Glenn DO

Patient Name:_____ **Date of Birth:** _____

Please initial below to acknowledge that you have received a copy of Arizona Associated Surgeons HIPAA policy.

Initial: _____

Please initial below to acknowledge that you have read our financial policy, which reflects that you as the patient are ultimately responsible for the charges associated with your care.

Initial: _____

Please initial below to acknowledge that you are aware of our appointment cancelation/no-show policy which states:

If **48-hour** notice is not given prior to an **office appointment**, you will be charged a $25 fee.

Initial: _____

If **72-hour** notice is not given prior to a **scheduled surgery**, you will be charged a $250 fee.

Initial: _____

To access our financial policy, please visit our website at www.aasaz.com Or call the office to have a copy sent to you.

Patient Signature:_____ Date: _____

Staff Signature: _____ Date: _____

Allen Agapay MD, William Friese MD, Jordan Glenn DO

Financial Policies

Thank you for choosing Arizona Associated Surgeons for your surgical needs. We are committed to providing you with the highest quality medical care. Maintaining a good physician-patient relationship is our primary goal. Patients are ultimately responsible for the charges associated with their care. We realize you have choices for your medical care and appreciate you choosing Arizona Associated Surgeons.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your identification, insurance car(s) and Social Security number to enable us to submit your claims timely and accurately.
- Knowing your insurance benefits and limitations.
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral.
- Providing us with copies of any requested medical records, including tests and x-rays.
- Paying your estimated portion of the charges at the time of service and paying any additional amount owed when due.
- Providing us with at least 48-hour advance notice should you need to cancel or reschedule an office appointment to avoid $25.00 fee.
- Providing us with at least a 72-hour advance notice should you need to cancel or reschedule a procedure/ surgery to avoid $250.00 fee

Please note that co-payment, co-insurance, and deductible are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

For our patient's convenience we participate in most major health plans and have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid (AHCCCS). Our business office will submit claims for services rendered to a patient who is a member of one of these plans and assist you in any way we reasonably can to help get your claims paid.

It is the patient's responsibility to provide all necessary information at the time the appointment is scheduled. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you are insured by a plan, we contract with but don't have an insurance card with you, payment in full for each visit is required until you furnish us with a copy of the card and your coverage can be verified.

Motor Vehicle Accidents (MVA Insured and Third-Party Patients- We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier on time; the bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while the case settles.

New Policy Effective 2020 Credit Card on File for Co-Pays/Deductibles/Co-Insurance
You will be asked to leave a credit card on file to be run after your insurance has processed your claim for any outstanding balances, refusal to do this will result in you paying your estimated patient responsibility such as copay, co-insurance and/or deductible amounts as required by your insurance carrier at the time of your appointment. Your insurance company requires us to collect co-payments at time of service. Waiver of co-payments may constitute fraud under state and federal law. **We do not accept cash or checks**. We do accept the following credit cards: Visa, Master Card, Discover and American Express. If you do not have your co-payment your appointment may be rescheduled.
Surgery-If surgery is indicated, our office will either collect as a pre-payment any remaining deductible and/or co-insurance you may have prior to your surgery or you will be asked to leave a credit card on file to be run after your insurance has processed your claim. Your out of pocket cost is estimated based on your benefits and our fees. Anesthesia, facility, and other providers are separate fees. Our office will provide written notification to you detailing anticipated charges for **your surgeon ONLY**. If your remaining deductible is not applied to our claim by your insurance company, a credit will appear on your account and a refund will be promptly processed.

Workers' Compensation-If your visit is work-related, we will need the case number, date of injury, carrier name and phone number prior to your visit to bill the workers' compensation insurance carrier. If your claim is not yet accepted, we will bill your private insurance and if uninsured payment in full is expected.

Other Charges-No Show - Please provide us with at least **48 hours'** advanced notice if you need to cancel or reschedule an office appointment. **Procedure/surgery cancels** require a **72 hours'** advanced notice. Failure to cancel a scheduled office appointment will be subject to a **$25.00** fee and failure to cancel a scheduled surgery/procedure will be subject to a **$250.00** fee.

Forms-There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow 5 business days for us to complete the forms.

Payment Options - We only accept the following major credit/debit cards Visa, Master Card, Discover and American Express we will accept checks as a form of payment after your Insurance has processed your claim and you receive a statement indicating you have a balance due. We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts - We allow 30 days from date of filing for an insurance company to process and/or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. It is your responsibility to provide your insurance company with requested information needed to process a claim. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional services. Patient balances are billed immediately on receipt of your insurance company payment or receipt of Explanation of Benefits (EOB). Your remittance is due within 10 business days of your receipt of your bill.

Alternative Payment Arrangements - If you are unable to pay your balance when due, please contact our business office at 602-258-9900 option 1 to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Prior Bad Debt - Patients, who have previously never satisfied their payment obligations for prior episodes of care with Arizona Associated Surgeons, will be required to pay those in full before receiving additional care.

arizona associated surgeons
Arizona's Choice for Surgery

THUNDERBIRD VEIN

Allen A. Agapay, M. D. William R. Friese, M.D. Jordan Glenn DO

Patient Name: _____Date of Birth_____

I authorize and agree that Arizona Associated Surgeons may disclose my protected health information to the following individuals and / or answering devices unless and until I object to such disclosures, which must be provided in writing:

1._____ Relationship._____ Phone #_____

2._____ Relationship_____ Phone#_____

3._____ Relationship_____ Phone#_____

4. _____ DO NOT speak to any family members
(initial)

PREFERRED METHOD OF CONTACT ☐ Cell Phone ☐ Home phone ☐Email

_____ May leave detailed messages _____ DO NOT leave detailed messages
(initials) (initials)

APPOINTMENT CONFIRMATIONS ☐ Cell Phone ☐ Home phone ☐Email

_____ May leave detailed messages _____ DO NOT leave detailed messages
(initials) (initials)

Preferred language ☐ English ☐ Spanish ☐ other_____

EMAIL ADDRESS_____

Date: _____ _____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative

FOR WILIAM FRIESE PATIENTS ONLY

State law A.R.S. 32-1401(25)(ff) requires that we notify you of the following: Dr. Friese has a financial interest in Metro Surgery Center. This may be a center at which your surgery could be scheduled.

Date: _____ _____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative

arizona associated surgeons
Arizona's Choice for Surgery

THUNDERBIRD VEIN

Credit Card Authorization Form

Patient Name: _____ DOB: _____

The purpose of this form is to authorize Arizona Associated Surgeons to retain a valid credit card number on file for you. This information will be kept secure and can only be accessed by authorized staff. Your credit card will ONLY be charged under the following circumstances:

Copays/Coinsurance/Deductible: AAS reserves the right to charge the credit card on file for all patient balances including copays, coinsurance, deductibles and any patient responsibility not collected at the time of service. A receipt will be sent/emailed to you for all transactions. This notice serves as your consent to being charged for all current patient balances on your account.

No Show Appointment Fee: If a patient misses a scheduled appointment in the office without a 48-hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $25.00 fee. If a patient misses a scheduled surgery appointment without a 72-hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $250.00 fee.

Returned Payment Fee: If we receive notice that a payment is returned to us for any reason, AAS reserves the right to charge the card on file a $40 returned payment fee.

Self-Pay Patients: If you are a self-pay patient without insurance, AAS reserves the right to charge the credit card on file for services performed.

Refusal to sign: You have the right to opt out of credit card on file. You will receive **ONE** statement for any remaining balances. If the balance is not paid within 14 days, you will incur a $25.00 service fee for each additional statement.

Other than the conditions mentioned above, under NO circumstances will AAS charge your credit card for anything not discussed with you personally. In conjunction with HIPAA regulations, all credit card information will be confidential and securely kept within our PCI compliant merchant service system. Only authorized staff will be able to access this information.

By signing the credit card authorization form, you understand that as soon as your EOB (explanation of benefits) is received by our office from your insurance company your credit card will be charged for the balance due on your account. As a courtesy we will text you prior to running the card on file. If you would like your balance charged to a different card or need to set up a payment plan you will have 2 days to contact us before we run the card on file.

Acknowledged, Agreed, & Accepted. Having read this form, my signature below acknowledges that I give my authorization and consent for my credit card to be charged for the conditions listed above.

_____ _____

Patient Signature Date Staff Signature Date