□ **NEW REGISTRATION** □ **UPDATED** □

Arizona Advanced Surgery, LLC Thunderbird Vein

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX □ MALE □ FEMALE

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

REFERRING PHYSICIAN NAME AND PHONE NUMBER	PCP 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 □ RUSSIAN □ CREOLE □ OTHER _____	□ LATINO/HISPANIC □ NON LATINO/NON HISPANIC	□ ASIAN □ NATIVE HAWAIIAN □ OTHER PACIFIC ISLANDER □ BLACK/AFRICAN AMERICAN □ AMERICAN INDIAN/ALASKA NATIVE □ 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 LOCATION	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 Advanced Surgery's Financial Policy. I agree I will be responsible for any unpaid balances for any reasons

I hereby authorize direct payment to Arizona Advanced Surgery, LLC of any medical benefits payable to me for the services provided at Arizona Advanced Surgery

X_____

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Arizona Advanced Surgery, LLC 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

Allen A. Agapay, M. D. **Jordan Glenn DO**

6750 W. Thunderbird Road, Suite B108 Peoria, AZ 85381

Patient Name: _____Date of Birth_____

I acknowledge that I have been provided the Arizona Advanced Surgery, LLC Notice of Privacy Practices:

- It tells me how the organization will use my health information for the purpose of my treatment, payment for my treatment and its health care operations
- The notice explains in more detail how the practice may use and share my health information for purposes other than treatment, payment and health care operations.
- The organization will also use and share my health information as required/permitted by law.

_____ _____

Printed Patient Name **Patient's Date of Birth**

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Client / Personal Representative **Relationship to Patient**

☐ **I consent to receive calls from AAS providers/staff for my protected healthcare and other services at the phone numbers provided by myself, including my wireless number I provided, I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.**

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please list all:

1._____ Relationship._____ Phone #_____
Medical Only ☐ Billing Only ☐ Both ☐

2._____ Relationship_____ Phone#_____
Medical Only ☐ Billing Only ☐ Both ☐

3._____ Relationship_____ Phone#_____
Medical Only ☐ Billing Only ☐ Both ☐

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

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Arizona Advanced Surgery, Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Arizona Advanced Surgery actually received it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.
To access our complete Notice of Privacy Practices, please visit our website at ArizonaAdvancedSurgery.com Or call the office to have a copy sent to you.

Financial Policies

Thank you for choosing Arizona Advanced Surgery 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 Advanced Surgery.

Patient Responsibilities

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

- Providing us with your picture identification, insurance card(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 72-hour advance notice should you need to cancel or reschedule a procedure/surgery to avoid $250.00 fee

Please note that co-payments, co-insurance, and deductibles 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.

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.

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 one 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 a case settles.
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 Advanced Surgery, will be required to pay those in full before receiving additional care.

Financial Policy Acknowledgment:

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

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 ArizonaAdvancedSurgery.com
Or call the office to have a copy sent to you.

Patient Signature: _____ Date:

Staff Signature: _____ Date:

Patient Email/Texting Informed Consent Form

1. **Risk of using email/texting**

The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Email and texts can be used as evidence in court.
g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. **Conditions for the use of email and texts**

Arizona Advanced Surgery, LLC. cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Arizona Advanced Surgery, LLC. is not liable for improper disclosure of confidential information that is not caused by Arizona Advanced Surgery, LLC. intentional misconduct. Patients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time. Email and text messages should not be time sensitive.
b. Email and texts should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c. Email and text messages may be filed into your medical chart.
d. Arizona Advanced Surgery, LLC will not forward patient's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
e. Patients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
f. Arizona Advanced Surgery, LLC is not liable for breaches of confidentiality caused by the patient/parent/legal guardian or any third party.
g. It is the patient's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. **Patient Acknowledgement and Agreement**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and/or text messaging as a form of communication between Arizona Advanced Surgery and myself. I consent to the conditions and instructions outlined, as well as any other instructions that Arizona Advanced Surgery may impose to communicate with me by email or text.

Patient Name: _____ Patient Date of Birth: _____

E-Mail: _____

Patient Signature: _____Date: _____

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

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

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

How did you hear about us_____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Have you ever been treated for: ☐ sleep apnea **If yes…Do you use a CPAP No_____Yes_____ Other**_____
☐ heart disease ☐ congestive heart failure ☐ hypothroid ☐ 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_____

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)_____

_____

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)

Currently drink alcohol? No ____Yes____ If yes: # drinks/day:_____ for_____#years If you quit, when?_____(date)
Occupation_____

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 / varicose veins **(circle)**
____	____	Painful or abnormal urination	____	____	History of anesthesia problems

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

When was your last (dates): **colonoscopy** _____ m**ammogram** _____ **flu shot**_____ **pneumonia shot**_____