ARIZONA
PREMIER SURGERY

575 W. Chandler Blvd, SUITE 120
CHANDLER, AZ 85225-5600
8415 N. Pima Rd, SUITE 280
SCOTTSDALE, AZ 85258-4519
P: 480-245-4425 F: 480-245-4426

PATIENT REGISTRATION

Thank you for choosing our office. In order to serve you properly, we will need the following information. Information will be strictly confidential. **(PLEASE PRINT)**

Patient's Last Name:_____ First Name:_____ MI:_____

Legal Guardian/Health Care Proxy:_____ Living Will or Advanced Directive ☐ Completed ☐ Recorded

Birth Date:_____ Age:_____ ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Div Soc.Sec.#:_____

Local/Mailing Address:_____ City:_____ State:_____ Zip: _____

Local/Home Phone #:_____ Business Phone #:_____ Cell Phone #: _____

Referred by: ☐ Primary Physician _____ ☐ Specialist Physician _____

☐ Other Health Care Provider _____ ☐ Self ☐ Family/Friend ☐ Other _____

Ethnicity:_____ Race:_____ Preferred Language: _____

Email:_____ Current or Previous Occupation:_____ Drivers License Number: _____

Local Pharmacy Utilized for Prescriptions:_____ Phone #: _____

Location: _____

Insurance Company Name: _____

Address:_____ City: _____

State:_____ Zip Code:_____ Policy #:_____ Group #: _____

Subscriber Name:_____ Birth Date:_____ Social Security #: _____

Secondary Insurance Company Name: _____

Address:_____ City: _____

State:_____ Zip Code:_____ Policy #:_____ Group#: _____

Subscriber Name:_____ Birth Date:_____ Social Security #: _____

Person financially responsible for this account: ☐ Self ☐ Other : Name:_____ Phone:_____

Emergency Contact: _____

Relationship to Patient:_____ Address: _____

City:_____ State:_____ Zip Code:_____ Home Phone #: _____

Consent for Treatment and Authorization to Release Information

I consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending physician. I authorize Arizona Premier Surgery, PLLC to furnish my insurance carriers information regarding history, physical findings and treatment rendered as allowed by HIPAA. I further authorize any holder of medical or other information about me to release such information to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment or medical insurance benefits to the party who accepts assignment.

Authorization to Pay Benefits to Provider

I request and authorize that payments for authorized Medicare/Other Insurance company benefits be made directly to Arizona Premier Surgery, PLLC on my behalf for any services furnished to me by Arizona Premier Surgery, PLLC who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B0 of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Patient Responsibility

I agree that I am responsible for all charges incurred in this office. If my insurance coverage does not provide full benefits, I will pay any patient responsibility balance due within 30 days unless I have made other arrangements with Arizona Premier Surgery, PLLC Further, I agree that this visit is not related to a litigation matter as it is my understanding that Arizona Premier Surgery, PLLC does not see this type of case for evaluations and treatments. If cancellation of my appointment becomes necessary, I will contact Arizona Premier Surgery, PLLC no later than twenty-four (24) hours prior to my scheduled appointment time. I understand that failure to follow the cancellation of appointment policy that I may be subject to a charge of fifty dollars ($50.00) and such charge is not payable through my insurance. I have read the Arizona Premier Surgery, PLLC Office Policy Statement and all my financial questions were answered.

Signature:_____ Today's Date: _____

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OFFICE POLICIES

In effort to make your visit with us as easy as possible, we ask that you make note of the following office policies. We thank you in advance for your cooperation.

- Please notify of us of any changes you have not already made through your Patient Portal prior to your visit, at the time of your visit:
    1. Address
    2. Insurance Information
    3. Medical illness, injury, or surgery since your last visit
    4. Medications added or discontinued since the last visit

- Please allow 72 hours for prescription refill requests to be completed. Generally, if you find you have run out of a medication, you are likely late for a follow up appointment and refills will be limited to a single 30-day refill pending your return to the office for re-evaluation. Please note that we will not refill any prescriptions for controlled substance medications outside of an office appointment or after normal office hours. You must be seen at an office appointment for any controlled substance refills.

- All co-pays and deductibles are due at the time of visit.

- There will be a **$30.00** returned check charge.

- There will be a **$25.00** charge for providing copies of your medical records to third parties.

- For all FMLA and disability forms, there is a **$25.00** charge. This is a flat fee and will only be charged once per open claim. Additional forms for a different claim will be charged $25.

Sincerely,

The Staff
Arizona Premier Surgery, PLLC

Patient Acknowledged:_____Date: _____

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FINANCIAL POLICY

Thank you for choosing our office. We are committed to the success of your medical treatment and care. Payment of your bill is part of this treatment and care; we want you to completely understand our financial policies. Please read carefully.

- The patient's insurance policy is a contract between the patient and the insurance company. For patients **insured through a health plan in which we participate,** applicable co-payments are due at the time of the visit and all covered services are billed to the health plan.
- If you are paying for your own healthcare or have a health plan we do not participate in, we ask that you pay in full at the time of the visit.
- If you have Medicare only, payment of your 20% coinsurance is requested at the time of the office visit.
- Any service we provide you that is deemed a "non-covered service" by your insurance will be your responsibility to pay.
- If your insurance changes in any way during your treatment it is **your responsibility** to notify our office.
- Any past due accounts will need to be resolved with our business office before you next appointment.
- All patients who reside outside of the United States are required to pay cash at the time of services regardless of the dollar amount.
- If your health plan requires a referral from your primary care physician it is **your responsibility** to obtain that referral. If the referral is not here at your appointment your appointment will be rescheduled.
- Secondary insurance claims are filed as a courtesy, and become the responsibility of the patient if payment is not received within 30 days of filing the claim.
- All accounts 30 days past due will incur a 3% interest charge.
- Acceptable methods of payment are; cash, check, money order, VISA or MasterCard.

OTHER FEES

Delinquent accounts will be assigned to a collection agency or attorney. The **patient** will be liable for collection fees and court costs.

Dishonored checks will be charged back to the patient's account with a service fee of $30 plus any bank fees that are charged to Arizona Premier Surgery, PLLC

For the completions of any and all forms by our physicians there is a $25 fee per form.

At the time of your office visit if you are not prepared to pay your co-pay your appointment may be rescheduled or a $10 "statement processing" fee may be charged to you.

The Office or Billing Office are available to meet or discuss any questions or concerns that you may have.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand that such terms may be amended by the practice from time to time.

Sincerely,

The Staff
Arizona Premier Surgery, PLLC

Patient Acknowledged:_____Date: _____

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Please answer the following questions. All information provided is strictly confidential.

Patient Name: _____ DOB: _____ Date _____

Reason for Consult/Visit? _____

Primary Care Physician (PCP) _____

Referring Physician (if not PCP) _____

Current & Past Medical History (*Please check if you have been diagnosed with any of the following conditions*)

☐ Anemia	☐ Depression	☐ Irregular Heart Rhythm	☐ Sleep Apnea
☐ Anxiety	☐ Emphysema	☐ Legally Blind	☐ Stroke / TIA
☐ Asthma / Allergies	☐ Enlarged Prostate	☐ Liver Disease	☐ Stomach Ulcers
☐ Atrial Fibrillation	☐ GI Disorders	☐ Lung Disease	☐ Thyroid Disease
☐ Bleeding Disorder	☐ Heart Attack	☐ Lupus	☐ Hyperthyroid
☐ Crohn's Disease	☐ Heart Disease	☐ Macular Degeneration	☐ Hypothyroid
☐ Cirrhosis	☐ Heart Failure	☐ Migraines	☐ Tuberculosis
☐ COPD	☐ Hepatitis	☐ Osteoporosis	☐ Ulcerative Colitis
☐ Chronic Heart Failure	☐ High Blood Pressure	☐ Phlebitis or Blood Clots	☐ Valley Fever
☐ Chronic Kidney Disease	☐ High Cholesterol	☐ Pneumonia	
☐ Diverticulitis	☐ HIV/AIDS	☐ Psychological Disorders	
☐ Diabetes	☐ IBS	☐ Seizures or Epilepsy	

Other Medical Conditions (Please List):			
☐ Cancer Type:		Date:	Biopsy?
Previous Treatment?		Last Chemo Date?	
Please Provide Dates for:	Last Colonoscopy:	Last EGD:	Last Mammogram?
	Last Flu Vaccine:	Last Pneumonia Vaccine:	Last EKG:
Have you Ever Had Anesthesia? ☐ Yes ☐ No		Did You Have Problems? ☐ No ☐ Yes What?	
Have You Ever Had a Blood Transfusion? ☐ Yes ☐ No		Did You Have a Reaction? ☐ No ☐ Yes What?	

Reproductive History (*Female patients only)*

Age at first period?_____Number of Pregnancies? _____ Number of Births? _____ Age at 1st Birth? _____

Have you gone through menopause? ☐ Yes ☐ No If yes, at what age? _____

Have you ever taken oral contraceptive pills? ☐ Yes ☐ No When? _____

Have you ever taken hormone replacement therapy? ☐ Yes ☐ No When? _____

Patient Name _____

(Rev. 10/22/15)

Social History (*Please answer all questions below*)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation:_____ Religious Preference: _____

Have you ever used tobacco? ☐ Yes ☐ No ☐ Current Use ☐ Past Use (Quit_____years ago)

If so, which types? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chewing Tobacco

How much per Day?_____ For How Many Years? _____

Do you consume alcohol? ☐ Yes ☐ No If so, what type(s)? _____

How often? ☐ Daily ☐ Weekly ☐ Socially Number of drinks per week? _____

Have you ever used recreational or illegal drugs? ☐ Yes ☐ No Type:_____

Do you use recreational or illegal drugs currently? ☐ Yes ☐ No Type: _____

Family History (*Please indicate any medical problems. If deceased, indicate age and cause of death.*) ☐ Adopted

Mother: ☐ Living ☐ Deceased Age:_____ Cause of Death:_____

Father: ☐ Living ☐ Deceased Age:_____ Cause of Death:_____

Sibling: ☐ Living ☐ Deceased Age:_____ Cause of Death:_____

Sibling: ☐ Living ☐ Deceased Age:_____ Cause of Death:_____

Sibling: ☐ Living ☐ Deceased Age:_____ Cause of Death:_____

Other: ☐ Living ☐ Deceased Age:_____ Cause of Death:_____

Other Significant Family Health Conditions:

Surgical History (*Include details such as date, type of surgery, hospital, outcome, etc.*)

Surgery (Type)	Details (*Include details such as date, hospital, outcome, etc.*)

Patient Name _____

(Rev. 10/22/15)

Previous Hospitalizations (*List only hospital admissions and exclude E R visits*)

Date / Hospital	Reason for Admission

System Review (*Please check if you are experiencing any of the following symptoms*)

GENERAL:

☐Yes/☐ No Chills
☐Yes/☐ No Fever
☐Yes/☐ No Fatigue
☐Yes/☐ No Generalized Weakness
☐Yes/☐ No Night Sweats
☐Yes/☐ No Trouble Sleeping
☐Yes/☐ No Weight Gain
☐Yes/☐ No Weight Loss

SKIN:

☐Yes/☐ No Bruising
☐Yes/☐ No Itching
☐Yes/☐ No Lesions/Boils
☐Yes/☐ No Nail Changes
☐Yes/☐ No Rashes
☐Yes/☐ No Sores

HEAD / NECK:

☐Yes/☐ No Discharge from Ears
☐Yes/☐ No Dry Mouth
☐Yes/☐ No Frequent Sore Throats
☐Yes/☐ No Hearing loss
☐Yes/☐ No Hoarseness
☐Yes/☐ No Nose Bleeds
☐Yes/☐ No Ringing/Pain in ears
☐Yes/☐ No Sores/Ulcers in mouth
☐Yes/☐ No Vision Changes

BREASTS:

☐Yes/☐ No Lumps / Masses
☐Yes/☐ No Nipple Discharge
☐Yes/☐ No Pain
☐Yes/☐ No Skin Changes

HEART / LUNG:

☐Yes/☐ No Murmur
☐Yes/☐ No Pain in Legs
☐Yes/☐ No Palpitations
☐Yes/☐ No Swollen Ankles
☐Yes/☐ No Cough
☐Yes/☐ No Coughing Blood
☐Yes/☐ No Shortness of Breath
☐Yes/☐ No Sputum/Mucus
☐Yes/☐ No Wheezing

ENDOCRINE / LYMPHATIC:

☐Yes/☐ No Cold Intolerance
☐Yes/☐ No Excessive Hunger
☐Yes/☐ No Excessive Sweating
☐Yes/☐ No Excessive Thirst
☐Yes/☐ No Heat Intolerance
☐Yes/☐ No Hot Flashes
☐Yes/☐ No Joint/Bone Pain
☐Yes/☐ No Painful Lymph Nodes
☐Yes/☐ No Swollen Lymph Nodes
☐Yes/☐ No Sexual Dysfunction

KIDNEYS / BLADDER:

☐Yes/☐ No Blood in Urine
☐Yes/☐ No Cloudy Urine
☐Yes/☐ No Frequency of Urination
☐Yes/☐ No Getting up at Night
☐Yes/☐ No Hesitancy of Urination
☐Yes/☐ No Incontinence
☐Yes/☐ No Leakage/Retention
☐Yes/☐ No Pain when Urinating
☐Yes/☐ No Passed Stones
☐Yes/☐ No Urgency of Urination

GASTROINTESTINAL:

☐Yes/☐ No Black/Tarry/Clay Stools
☐Yes/☐ No Bloating
☐Yes/☐ No Constipation
☐Yes/☐ No Diarrhea
☐Yes/☐ No Difficulty Swallowing
☐Yes/☐ No Heartburn
☐Yes/☐ No Hemorrhoids
☐Yes/☐ No Nausea
☐Yes/☐ No Painful Swallowing
☐Yes/☐ No Poor Appetite
☐Yes/☐ No Rectal Bleeding
☐Yes/☐ No Vomiting
☐Yes/☐ No Vomiting Blood
☐Yes/☐ No Yellowing of Skin/Eyes

MUSCULOSKEIETAL:

☐Yes/☐ No Back Pain
☐Yes/☐ No History of Fractures

NEUROLOGIC:

☐Yes/☐ No Balance Problems
☐Yes/☐ No Dizziness
☐Yes/☐ No Fainting
☐Yes/☐ No Headaches
☐Yes/☐ No Numbness/Tingling
☐Yes/☐ No Seizures
☐Yes/☐ No Tremors

PSYCHOLOGIC:

☐Yes/☐ No Anxiety
☐Yes/☐ No Depression
☐Yes/☐ No Memory Changes
☐Yes/☐ No Nervousness

Patient Name _____

(Rev. 10/22/15)

Medications (*Please list all medications including prescription, over-the-counter, and supplements.*)

Name	Dose	Frequency

Allergies (*Please list all allergies to medications)*

Allergy	Reaction

Are you Allergic to Iodine ☐ Yes ☐ No

If you have No Known Allergies, please circle: NO ALLERGIES

Preferred Pharmacy	
Mail-In Pharmacy	

Patient Name _____

ARIZONA PREMIER SURGERY

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Arizona Premier Surgery, PLLC is dedicated to protect your "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:

Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:

We collect this information so that we can treat your medical condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:

To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION?:

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:

We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities who need this information for claims processing have access to your Protected Healthcare Information.

YOUR RIGHTS:

You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your record.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlined in this notice.

COMPLAINT/COMMENTS:

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington D.C. 20201.

You also may contact the Privacy Officer of Arizona Premier Surgery, PLLC at 485 S. Dobson Road, Suite 115, Chandler, AZ 85224-5600.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of November 1, 2015.

Received and Read:_____ Date: _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I have been presented with a copy of the **Notice of Privacy Practices,** detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signed:_____Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only
If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

Please name all person(s) we can contact and/or discuss your medical information:

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

☐ Yes ☐ No The office may leave health/medical or billing messages via email, text or voice, on any telephone or computer device (including answering machine or voice mail associated with any direct or cellular telephone numbers identified by me in my patient information. List any restrictions to the information that may be left on answering machine or voice mail.

_____.

Following HIPAA patient confidentiality regulations, please check how you would like us to address you:

_____Mr. And/or _____First Name

_____Mrs. _____Last Name

_____Miss _____Other_____

_____Ms.

Signature:_____Date: _____

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Patient Acknowledgement:
Controlled Substance Medication and Medication Refill Policy

The care of many illnesses, injuries or surgical interventions or procedures can be painful or require the prescription of potentially dangerous and addictive medications. It is understood that your doctor(s) may consider, or you may request, the use of controlled substance medication to help ease pain or assuage other uncomfortable or troublesome problems.

The risk of developing medication addiction and the high incidence of controlled substance abuse and diversion along with Drug Enforcement Administration rules and regulations drive the following policy: Arizona Premier Surgery, PLLC and its providers will only **issue a maximum thirty-(30) day prescription for controlled substance medication.**

I further understand that refills for any controlled substance medication must be approved by my provider and can only be refilled during regular office hours at a scheduled appointment. I am aware that **there will be no controlled substance medication refills authorized for me after regular office hours or without being seen by my provider. Covering providers, local Emergency Rooms and Urgent Care facilities will be advised that I do not recommend any other providers refilling controlled substance prescriptions for my patients.**

Controlled substance medications include but are not limited to many prescription pain medications, male hormones, sleep aids, anti-anxiety medications, and medications used to treat narcolepsy and attention disorders.

Arizona Premier Surgery, PLLC

Acknowledged: _____ _____
Patient Signature Date

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

As required by the Health Information Portability and Accountability Act of 1996 and Arizona law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request will not be granted. Your right to access does not extend to information complied in reasonable participation of, or for use in , a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than another health care provider.

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____

to release healthcare information of the patient named above to:

Name: **Arizona Premier Surgery, PLLC**

Address: **655 S. Dobson Rd, Suite A105**

City: **Chandler** State: **AZ** Zip Code: **85224-5600**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information

☐ Other: _____

I understand and hereby also consent to the release of any and all alcohol and/ or drug abuse information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or psychiatric treatment records under the same conditions outlined below. I understand that such informatio0n cannot be release without my specific consent.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED