

arizonapainreatmentcenters.com

McDowell Ambulatory Surgery Center

Referred by _____

How did you find out about our practice? _____

PATIENT INFORMATION

Patient name _____ Birth date _____ Age _____

Street address _____ Apt # _____

City _____ State _____ Zip code _____

Home # (_____) _____ Cell # (_____) _____ Alt/work # (_____) _____ Email _____

Driver's lic _____ SS # _____ Male/Female _____

Marital status: Single () Divorced () Widowed () Married () Name of spouse _____ Student: PT () FT ()

EMPLOYMENT INFORMATION

Employer _____ Occupation _____

Emergency contact _____ Phone # (_____) _____

Who is your primary care physician? _____

Address _____ City / State / Zip _____ Phone # (_____) _____

Are your symptoms related to an accident? Yes () No () Don't know () Date of accident _____

If yes, what type? Auto () On the job () Other () _____ Date reported _____

Is there an open claim related to this injury? No _____ Yes _____ State in which accident occurred _____

APPOINTMENTS

We ask that our patients come to their appointments 15 minutes before their scheduled time in order to fill out needed paperwork. If you are late, we will need to reschedule your appointment for a later time and date at our discretion.

PERMISSION FOR TREATMENT

I authorize the staff at Arizona Pain Treatment Centers to examine me and render treatment they deem necessary.

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Arizona Pain Treatment Centers and its member physician to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate treatment and payment by third parties, collection of data for purpose of utilization review, quality assurance, or medical outcome evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, Managed Care organizations, IPAs or third party payers or any organizations contracting with any of the entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary or specialist physician that is directly or indirectly responsible for my medical care or the payment thereof.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, reviewed and agree to the Notice of Privacy Practices of Arizona Pain Treatment Centers/McDowell Ambulatory Surgery Center, which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received or maintained by the Practices. I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information.

Print Name

Signature

Date

Date _____

Patient's Name: _____

Patient Billing Information

HEALTH INSURANCE PRIMARY:

Insurance Co _____ Telephone # to verify benefits: _____

Name of Insured: _____

Insured's Soc. Sec. # _____ DOB _____

Group/Policy # _____

Mail claims to: _____

HEALTH INSURANCE SECONDARY:

Insurance Co _____ Telephone # to verify benefits: _____

Name of Insured: _____

Insured's Soc. Sec. # _____ DOB _____

Group _____ Policy # _____

Mail claims to: _____

Med-pay Insurance: (Insurance for vehicle you were in)

Insurance Co: _____ Name of Insured: _____

Claims office Address: _____

Phone: _____ Date of Injury: _____

Med Pay Limits: \$ _____ Is claim open? _____

Policy # _____ Claim # _____

Adjustor's name: _____ Phone: _____

Attorney's name:

Attorney's Name: _____ Law Firm: _____

Phone: _____ Date of Injury: _____ Contact Person _____

Address: _____ Liens to file: _____ County _____ Attorney _____

Third Party/Liability Insurance Company: (Insurance info for at fault vehicle)

Insurance Co _____ Address: _____

Phone: _____ Date of Injury: _____ Claim Adjuster: _____

Insured's name: _____ SS#: _____ DOB _____

Policy/Claim #: _____ Is claim still open? _____

Workers' Compensation Insurance Company:

Insurance Company _____ Insured's Name: _____

Address: _____ Employer: _____

Phone: _____ Employer Phone: _____

Case Manager: _____ Address: _____

Claim #: _____ Date of Injury _____

Is Claim still open? _____ Policy #: _____

McDowell Ambulatory Surgery Center

1301 E. McDowell Rd. #100 Phoenix, AZ 85006

5656 S. Power Rd. #139 Gilbert, AZ 85295

Phone: (602) 265-8800 Fax: (602) 265-8151

Financial Policy

Our office files insurance claims as a courtesy for all of our patients. Please bring your insurance card with you and keep our office informed of all insurance changes. **Payment is expected at the time of service** by cash, credit card or money order. Patients are responsible for the appropriate deductible and co-insurance. You are **responsible** for all bills regardless of the type of insurance coverage you may have. Please contact your insurance company for any questions you have regarding coverage for our services as it is your responsibility to know your benefits. We allow 60 days for your insurance carrier to pay. After that time, the unpaid balance may be due and payable by the patient.

You are expected to pay all charges at the time of service if:

1. You have no insurance coverage
2. Your insurance carrier sends payment directly to you.
3. Proper authorization/referral has not been received.

Delinquent Accounts

1. Accounts past due will be noted and all charges must be paid in full at each visit until account is brought current
2. **Accounts past due are subject to collection.** All fees including, but not limited to collection fees, attorney fees and court fees incurred shall become your responsibility in addition to the balance due this office.

Payment

Payment may be made with cash, credit card or money order. We do **NOT** accept personal checks at APTC.

Personal Injury

Our office will accept personal injury cases. If we accept your case on a lien basis, lien filing fees of \$20 will be expected at the beginning of treatment. Payment for treatment is not contingent on any settlement, judgment or verdict which you may eventually recover. Lien cases will be reviewed periodically and you may be required to make payments for continued care as determined by our office. You will be notified in advance.

Verification of Benefits

Our office will verify your insurance benefits as a courtesy. This verification is not a guarantee of payment. Your insurance is a contract between you and your insurance company. You are liable for all expenses incurred whether or not the expenses are covered by your insurance. Should any expenses remain unpaid for any reason, including but not limited to insurance deductible, policy limits or exclusions, you agree to pay any amounts remaining and owed to our office.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND ACKNOWLEDGE LIABILITY FOR ALL MEDICAL EXPENSES INCURRED AND AGREE TO ABIDE BY THE TERMS OF THIS POLICY.

Patient Name (please print)

Signature (responsible party)

Date