ARIZONA
MEDICAL CENTER, P.L.L.C.
Healthcare With a Human Touch

(Last) _____ **(First)** _____ **(MI)** _____

Date of Birth ____/____/____ ☐ Female ☐ Male Social Security Number_____-____-_____

Phone Numbers Home_____ Cell_____ Work _____

Mailing Address _____

City, State, Zip_____

Physical Address (if different from mailing)_____

E-Mail Address_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Island ☐ African American ☐ Caucasian

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Preferred Language**: _____

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer_____ Occupation_____

Emergency Contact Name_____**Phone Number**_____

Emergency Contact Relationship to Patient ☐ Mother ☐ Father ☐ Other _____

RESPONSIBLE PARTY INFORMATION ***Statements will be addressed to the Responsible Party***

Responsible Party Name: (Last) _____ (First) _____ MI)_____

Date of Birth____/____/____ ☐ Female ☐ Male Social Security Number_____-_____-_____

Patient Relationship to Responsible Party_____ (provide your insurance card to the front desk at check-in)

PRIMARY INSURANCE INFORMATION

Name of Subscriber_____ Patient Relationship to Subscriber _____

Date of Birth____/____/____Social Security Number_____-_____-_____

Phone Numbers Home_____Cell_____Work_____

SECONDARY INSURANCE INFORMATION

Name of Subscriber_____Patient Relationship to Subscriber_____

Date of Birth____/____/____Social Security Number_____-_____-_____

Phone Numbers Home_____Cell_____Work_____

PREFERRED PHARMACY

Primary Pharmacy:_____Secondary Pharmacy:_____

Patient (or Responsible Party) Signature_____**Date**_____

ASSIGNMENT-RELEASE AND HIPPA COMPLIANCE FORM

I certify that the information above is current and correct. I request that payment under my insurance company be made on my

behalf to Arizona Medical Center (Manjunath Nathan, MD) for any services rendered to me by Dr. Nathan or his associates. I authorize the release of any or all medical information necessary for the purpose of evaluating benefits for the processing of an insurance claim or as necessary to recover balance due if any. I understand that I am responsible for payment of my account regardless of insurance coverage. In the event that I do not pay for the services provided by this office and the account is placed for collection, I agree and understand that an additional amount equal to 40% of the balance owing may be added to the balance if the account is placed for collection. In addition, I agree to pay an interest rate which may be up to 18% per annum until the amount is paid in full. I agree to pay any and all attorney's fees and court costs necessary to collect this debt.

By signing below I agree and understand the above statements.

Patients Signature:_____
Date:_____

Missed appointments: I agree to pay a $25.00 charge for missed appointment, not cancelled, or rescheduled at least 24 hours in advance of the date of my scheduled appointment. I am aware that this charge cannot be billed to my insurance.

_____

Initials

Return Check Fee: I agree to pay a fee of $35.00 for any check returned unpaid to this office.

_____

Initials

HIPPA PRIVACY PRACTICE

Acknowledgement of receipt of the notice of our Privacy Practices.

You are asked to provide an acknowledgement of receipt of the Notice of our Privacy Practices; our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will no way be conditioned upon your acknowledgement.

If you decline to provide a signed acknowledgement, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, healthcare operations when necessary, and as required by law. Should you have any questions? Please speak with our **Hippa Compliance Officer.**

The signature below is only acknowledgement that you have received the Notice of our Privacy practices.

_____ _____

Signature of Patient or Legal Representative Date