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

ARIZONA ADVANCED SURGERY, LLC

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

Adrienne Forstner-Barthell MD **Tafadzwa Makarawo MD**
18275 N 59th Ave Suite M176 Glendale, Az 85308

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 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
- Copays are subject to $25.00 surcharge if not paid at time of service
- 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.

Co-Copays/Deductibles/Co-Insurance – Please be prepared to pay for your portion on the date of service.

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. For your convenience we accept cash, or the following credit cards: Visa, Master Card, Discover and American Express. We do not accept checks. If you do not have your co-payment your appointment may be rescheduled. Additionally, you may have co-insurance and/or deductible amounts due as required by your insurance carrier.

Surgery- If surgery is indicated, our office will collect as a pre-payment any remaining deductible you may have and any co-insurance due prior to your surgery. 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 and mailed to you.

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-Our office does not accept workers compensation claims.

Other Charges-No Show - Please provide us with at least 48 hours' advance notice if you need to cancel or reschedule an office appointment. Procedure/surgery cancels require a 72 hours' 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 is a $20 charge associated with our completion of disability forms. We require payment of the charge before returning the completed form to you. There is a $25 fee charges for copies of your medical records. A signed Release of Information may also be necessary. Please allow 5 business days for us to complete the forms.

Payment Options - We accept cash and major credit/debit cards for payment. Our office does not accept 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 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.

Colon and Rectal Center of Arizona

DISCLOSURE FORM

Patient Name: _____ Date of Birth_____

I authorize and agree that Colon and Rectal Center of Arizona 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#_____

I may be contacted in the following manner (circle all that apply)

OK to leave message with detailed information: Home Work Cell No

OK to leave call back number only Home Work Cell No

Initial

Medical Records
When requesting copies of your medical records, please allow 48-72 business hours to process _____

Disability Forms
There will be a $20.00 completion and processing fee for all forms needing to be completed related to disability that will cover the entire year. Please allow 48-72 business hours to file _____

Office Cancellation/Reschedule
If you cancel or reschedule an office visit more than 2 times without notifying our office at least 48 hours in advance, you will be released from our practice and we will no longer be able to provide care for you. Failure to show at your appointment is subject to a $25.00 fee. _____

Surgery Cancellation/Reschedule
If you are scheduled for a procedure of any kind and you need to cancel or reschedule, you may be subject to a $100 surgery rescheduling fee. You must give at least 72-hours prior notice to avoid a $250 cancellation fee. Weekend, holiday and/or messages left after-hours are not acceptable. _____

Unnecessary Behavior
If there is inappropriate, threatening and/or abusive or profanity directed at staff, the relationship with the provider may be terminated immediately _____

Acknowledgement of Receipt of Privacy Notice
Original to be maintained in patient's permanent medical record.
I acknowledge that the office's Notice of Privacy Practices has been made available to me. _____

Anoscopy
Your provider may peform an anoscopy procedure during your evaluation as this may be necessary for your diagnosis and treatment. This will be billed to your insurance separately form the the office visit, however many insurance plans apply this fee towards the patient's outpatient surgical benefits. This could result in you owing an addition fee for this service. _____

Date: _____

_____
Signature of Patient or Patient's Personal Representative

_____
Relationship (self, parent, legal guardian)

_____
Print Name of Patient or Patient's Personal Representative

AAS ARIZONA ADVANCED SURGERY

Date_____ Patient Name_____ Primary Doctor_____

Please list any current medications you take

Prescription Name	Amount

Medical History:

History		History		History	
COPD	Yes or No	Seizures	Yes or No	Stroke	Yes or No
Atrial Fib	Yes or No	Diabetes	Yes or No	Hepatitis	Yes or No
Kidney Disease	Yes or No	Liver Disease	Yes or No	HIV	Yes or No
History of Heart Attack	Yes or No	Thyroid Disease	Yes or No	Depression	Yes or No
High Blood Pressure	Yes or No	Asthma	Yes or No	Anxiety	Yes or No
Arthritis:	Yes or No	Do you use blood thinners (aspirin/Plavix/Coumadin/Eliquis)?	Yes or No	Sleep Apnea	Yes or No
Have you used steroids in the last year?			Yes or No		

Please List any Medication Allergies:

Medication	Type of Reaction (hives, rash, problem breathing)

Please list any Surgeries you have had:

Surgeries	Date & Reason

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

Family History:

Please circle if there is a family history of the following conditions and list the family members that have this condition

Disease (Please Circle)	Family Member (s)
Colon Polyps	
Colon/ Rectal Cancer	
Breast/Ovarian/ Gastric Cancer	
Ulcerative Colitis/ Crohn's Disease	

Social History:

Please circle YES or NO to the following, if YES, please provide details

Do you smoke tobacco now or have you Recently quit?	Yes or No	How much per day? How many years? When did you quit?
Do you drink alcohol?	Yes or No	
Do you use "Illegal "drugs?	Yes or No	
Sexual Orientation (please circle)	Heterosexual Homosexual Bisexual Asexual	
Do you use medical marijuana?	Yes or No	

Past Medical and Surgical History

Last Colonoscopy-Date:_____

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

Review of Systems- Please circle items that relate to your health

General
Weight loss Fatigue Fever
Skin
Rash/sores Lesions Itching
Burning
HEENT
Ringing in ears Vertigo Hearing loss
Glasses/Contacts Eye Pain Double Vision
Glaucoma Cataracts Hay Fever
Hives/Eczema HIV/AIDS
Respiratory
Shortness of Breath Coughing Blood Wheezing
Asthma Chills
Cardiovascular
Chest Pain Palpitations Hypertension
Fainting Spells Swelling ankles/other_____
Gastrointestinal
Heartburn Nausea/Vomiting Difficulty Swallowing
Jaundice
Genitourinary
Pain Urinating Burning Frequency
Difficulty Urinating Blood in Urine Abnormal Discharge
Sexually transmitted diseases
Female: Vaginal discharge #Pregnancies _____
#Living births ____ #Miscarriages _____
#Vaginal Deliveries ____ #C-Sections _____
Last PAP Smear_____
Musculoskeletal
Arthritis Claudication
Neurological
Seizures Weak/Paralysis Numbness
Memory Loss
Psychiatric
Difficulty Sleeping Anxiety Depression
Mood Swings
Endocrine
Loss of Hair Heat/Cold Intolerance Change in Nails
Diabetes Thyroid Problems
Hematology
Easy Bruising Gums Bleed Easily Enlarged Glands
Prolonged Bleeding