APEX PHYSICIANS
INFECTIOUS DISEASES SPECIALISTS
7312 E. Deer Valley Road, Suite 100 • Scottsdale, Arizona 85255
Phone: (480) 454-4185 • Fax: (480) 745 2420

New Patient Registration Form

Last Name: _____First Name: _____M.I._____

Date of Birth: _____/_____/_____ Sex: M/F Social Security Number: _____/____/_____

Address:

_____
(Street) (City/State/Zip)

Preferred Phone: _____ Secondary Phone:_____

Email Address: _____

Who may receive information regarding your protected health information?

_____
(Name) (Relationship to You)

Who do we call for an emergency? _____ Phone: _____

May we leave messages regarding test results and appointments on your phone's voicemail? ___ Yes ___ No

How did you hear about our Practice?_____

Primary Care Physician: _____ Phone Number: _____

Employer Name: _____ Employer Phone: _____

Employer Address: _____
(Street) (City/State/Zip)

Pharmacy Name: _____

_____
(Address of Cross Streets) (Phone Number)

Where would you like your LABS to be drawn? _____

_____
(Address or Cross Streets) (Fax or Phone Number)

Guarantor Information: (Person Responsible for Payment)

Guarantor Name: _____ Social Security Number: ____-__-_____

Relationship to Patient: (Circle one) Self/Spouse/Parent Date of Birth:___/____/____

Address: (if different from above)_____

Employer Name: _____ Employer Phone: _____

Employer Address:

_____

(Street) (City/State/Zip)

Primary Insurance Information:

Insurance Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date:_____

Policy Holder's Social Security Number: _____-____-_____ Policy Holder's DOB:

==========

Secondary Insurance Information:

Insurance Name: _____ ID Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-____-_____ Policy Holder's DOB:
____/___/___

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Apex Physicians. I acknowledge that I am financial responsible for payment whether or not covered by insurance.

Signature: _____ Date: ____/____/_____

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Appointment Policies and Financial Responsibility Agreement

Appointment Policies

Our administrative office hours are Monday through Friday 8:00am until 4:30pm. Clinic hours vary by provider but are generally four half-days each week. We make every effort to schedule your appointment at the most convenient time for you. If you cannot keep your appointment, please let us know of your cancellation as soon as possible so that we may offer the slot to another patient.

A $50 fee will be applied to all missed appointments or late cancellation (appointments cancelled within 24 hours of the scheduled time.) To help remind you of your upcoming appointment, we will send out reminders vi text or email. If need be, you will have the opportunity to cancel your appointment by replying to any of these reminder messages.

Please bring your insurance card and a photo ID to every list. Please also include proof of a physical address (i.e. no P.O. box addresses allowed.)

Insurances and Associated Fees

We must collect all fees and co-payments that your insurance may require at the time of your visit, including a pre-payment toward any unmet deductible - this is a contractual obligation we have with the insurance companies and these fees cannot be waived. Please make every effort to make sure we are in-network with your specific insurance plan. If we do not participate with your insurance plan, you must make full payment for all services rendered at the time of your visit. In those cases, as a courtesy, we will still try to file a claim on your behalf, though your insurance carrier may or may not reimburse you according to its practices and polices.

If your insurer required a pre-authorization for you to see one of our provides, then you are responsible for obtaining that referral or authorization from your primary care physician. We will assist as able, but is an authorization is required and not obtained, then you will be responsible for the full payment of the visit and any associated service fees.

We are considered to be a third party with your insurance company. Please understand that the Explanation of Benefits that we receive from your insurer is how we apply any payment or deductible to your account. We are not responsible for any discrepancies with your insurance company. We will help provide any necessary medical records (from our physicians) if you need to file an appeal with your insurer.

Delinquencies and Other Fees

After 120 days, any delinquent debts will be referred to an outside collections agency, at which time they will assume fill responsibility for your account. If it looks like you will be unable to fulfill your debt within 120 days, please contact our office immediately so that we can help set up a payment plan or make other arrangements. Returned check are subject to a $35.00 insufficient funds charge. This fee is assessed to us by our bank which we then forward on to you.

By signing below I indicate that I have read and understood the policies described above.

_____ _____

Signature of Patient or Legal Surrogate **Date** **Time**

_____ _____

Printed Name of Patient or Legal Surrogate **Relationship (if Legal Surrogate)**

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND PAYMENT OF BENEFITS

I HEREBY AUTHORIZE the release of any medical information, including information related to psychiatric care, drug and alcohol use, HIV/AIDS status, or other confidential information , as necessary to process insurance claims, or any other medical information that is required for any healthcare related utilization review or quality assurance activities.

I hereby assign and authorize payments to Apex Physicians of medical and surgical benefits, including major medical benefits, to which I am entitled under any health insurance policy, self0insurance program, or other medical benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including but not limited to payment of those fees and charges not directly reimbursed to Apex Physicians by any insurance policy, self-insurance program, or other medical benefit plan.

The authorization shall remain valid during my care at Apex Physicians. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

By signing below I indicate that I have read and understood the policy described above.

_____

Signature of Patient or Legal Surrogate Date Time

_____

Printed Name of Patient or Legal Surrogate Relationship (if Legal Surrogate)

ACKNOWLEDGEMENT OF HIPAA PATIENT PRIVACY POLICY

I acknowledge that a copy of the office HIPAA patient policy was made available to me and that I had ample time to review the document and ask questions. I also acknowledge that printed copies of this policy are available upon request. I understand that any questions or concerns I have about the privacy policy should be directed to the practice administrator.

_____

Signature of Patient or Legal Surrogate Date Time

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Consent To Communicate Health Information

As a patient, you may designate a partner, family member, friend, or other persons with who Apex Physicians can communicate about your health care status. This form is not required in all circumstances for your doctor or others at Apex Physicians to be able to communicate with your family about your health care. However, by designating on this form certain individuals who you want to be informed about your care, you can ensure that your provider can communicate without delay with the person(s) you designate below.

I,_____ hereby consent to have my health information and care discussed with the following:

Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number

I understand that this consent can be revoked by submitting a written request to Apex Physicians. I understand that I have the right to revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. This consent shall remain in effect until such time as I revoke it in writing.

By signing below I indicate that I have read and understood the policy described above.

Signature of Patient or Legal Surrogate	Date	Time
Printed Name of Patient or Legal Surrogate	Relationship (if Legal Surrogate)	

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Authorization for Release of Protected Health Information

*****From our specialists to your providers*****

Patient Name: _____ DOB: _____

Address: _____ SS# _____

_____

Phone # _____

To (for staff ONLY): Dr. _____

_____

_____

Phone: _____

Fax:_____

Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

I _____ do I _____ do NOT authorize the release of this type of information.

I understand:

- I may revoke this authorization except to the extent it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released it may be redisclosed by the recipient and may no longer be protected information.

This authorization will expire on _____ (date) or one year from date signed.

_____ Date: _____

Patient or Personal Representative's Signature