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

ARIZONA ASSOCIATED SURGEONS, PLLC

Jeromy Brink, M.D. Wilson Harrison, M.D. Brett Siegrist, M.D. Martin Zomaya, M.D.

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 □ 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 – OTHER THAN SPOUSE/RELATIONSHIP	PHONE

PHARMACY

NAME AND LOCATION	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	SUBSCRIBERNAME 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 AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, agree to and signed the Arizona Associated Surgeons Financial Policy. I agree I will be responsible for any unpaid balances for any reasons.

I hereby authorize direct payment to Arizona Associated Surgeons PLLC of any medical benefits payable to me for the services provided at Arizona Associated Surgeons.

X_____

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Arizona Associated Surgeons PLLC 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

Vascular Surgery Specialists

Patient History Questionnaire

Please help us be as efficient as possible with your first visit to our program. This health history questionnaire **must** be completed prior to your appointment. Should you need assistance with answers to any of the questions asked, feel free to contact our office and we will be happy to help you. You may fax the completed form to our office prior to your appointment. Health history questionnaires that are incomplete or forgotten at the time of your appointment and/or arriving late for your appointment may result in rescheduling a portion of or your entire appointment.

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

Reason for your visit: *What is the main reason you are seeing the doctor today?*

_____

_____

_____

Past Medical History: *Have you ever been **DIAGNOSED** with any of the following Problems?*

	No	Yes	Date of Onset	Comments
Cardiovascular				
Do you have a pacemaker	☐	☐	_____	_____
High Cholesterol	☐	☐	_____	_____
High Blood Pressure	☐	☐	_____	_____
Heart Attack	☐	☐	_____	_____
Blood Clots	☐	☐	_____	_____
Other Heart Problems	☐	☐	_____	_____
Respiratory				
Asthma	☐	☐	_____	_____
COPD	☐	☐	_____	_____
Emphysema	☐	☐	_____	_____
Pneumonia	☐	☐	_____	_____
Tuberculosis	☐	☐	_____	_____

PAST MEDICAL HISTORY (Continued)

	No	Yes	Date of Onset	Comments
Endocrine				
Diabetes	☐	☐	_____	_____
Insulin Dependent (Type I)	☐	☐	_____	_____
Non-Insulin Dependent (Type II)	☐	☐	_____	_____
Thyroid Disorder	☐	☐	_____	_____
Adrenal Disorder	☐	☐	_____	_____
Other Endocrine	☐	☐	_____	_____
Gastrointestinal				
Liver Disorder	☐	☐	_____	_____
Stomach Problems	☐	☐	_____	_____
Kidney				
Kidney Disorder	☐	☐	_____	_____
Currently on Dialysis	☐	☐	_____	_____
Mental and Emotional				
Depression (requiring treatment)	☐	☐	_____	_____
Anxiety (requiring treatment)	☐	☐	_____	_____
Drug Dependency	☐	☐	_____	_____
Alcohol Dependency	☐	☐	_____	_____
Neurologic				
Epilepsy	☐	☐	_____	_____
Fainting	☐	☐	_____	_____
Dizziness	☐	☐	_____	_____
Stroke	☐	☐	_____	_____
Hematologic/Immunity				
Anemia	☐	☐	_____	_____
HIV/AIDS	☐	☐	_____	_____
Syphilis	☐	☐	_____	_____
Cancer				
Please indicate type:	☐	☐		
Injuries				
Please List:	☐	☐		
Other Not Listed Above				
Problem:	☐	☐		

ALLERGIES:

□ No Known Drug Allergies

Allergen	**Reaction**	**Allergen**	**Reaction**
Aspirin	No Yes _____	Latex	No Yes _____
Codeine	No Yes _____	Adhesive Tape	No Yes _____
Morphine	No Yes _____		
Penicillin	No Yes _____	Other……	
Sulfa	No Yes _____	_____	No Yes _____
Warfarin/Coumadin	No Yes _____	_____	No Yes _____
Any other Drug…			
_____	No Yes _____		
_____	No Yes _____		
_____	No Yes _____		

□ No Known Food Allergies

FAMILY HISTORY: *Please list any medical problems in your relatives.*

□ Family Medical Unknown

	Not Present	**Mother**	**Father**	**Sister(s)**	**Brother(s)**
Cancer - Type:					
Deep Vein Thrombosis (DVT)					
Clotting Disorder					
Aneurysms					
Peripheral Arterial Disease					
Stroke					
Transient Ischemic Attack					
Varicose Veins					
Heart Disease Type: _____					

Other Conditions:

SOCIAL HISTORY:

Tobacco Use: □ Never □ Former Smoker – When did you stop? _____ □ Smoker – Packs per day? ____

Alcohol Use: □ Never □ Rarely □ Socially □ Occasionally □ Moderate □ Rarely

How much? _____

Drug Use: □ Never □ Type and frequency _____

Please enter the date for the last time you had any of the following

Mammo _____ Pap Smear _____ Colonoscopy _____Flu Shot_____ Pneamovax_____

MEDICATIONS: *Please list any medication including aspirin, vitamins, over-the-counter, or herbal medication.*

Medication Name	Dose	Frequency (How Often Taken)

PAST SURGICAL HISTORY:

Year	Procedure	Surgeon

ANESTHESIA HISTORY:

Have you ever had any problems with anesthesia (being numbed or put to sleep)? □ No □ Yes

If **YES**, Please indicate which type of anesthesia and check reaction(s) below:

Type	Reaction
General Anesthesia	□ No Problems □ Nausea □ Vomiting □ Slow Awakening □ Difficult Intubation □ Other
IV Sedation	□ No Problems □ Nausea □ Vomiting □ Slow Awakening □ Other
Epidural/Spinal	□ No Problems □ Nausea □ Vomiting □ Bleeding □ Headache □ Other
Regional Block	□ No Problems □ Insufficient □ Prolonged □ Systemic Reaction □ Other
Local	□ No Problems □ Insufficient Block □ Heart Palpitations □ Systemic Reaction □ Other

REVIEW OF SYSTEMS

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Please place a check mark in the box next to any **current symptoms** you are experiencing

General
- ☐ Fevers
- ☐ Migraines

Skin of Extremities
- ☐ Loss of hair on legs/arms
- ☐ Discoloration of legs
- ☐ Toenail changes
- ☐ Discoloration of toes
- ☐ Ulcers of legs
- ☐ Varicose Veins
- ☐ Rash
- ☐ Cold Skin
- ☐ Bruising
- ☐ Burning

Head and Neck
- ☐ Blurred Vision

Respiratory
- ☐ Shortness of breath

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Previous heart attack
- ☐ Blood clots
- ☐ Leg pain while exercising
- ☐ Swelling of extremities
- ☐ Elevated blood pressure

Gastrointestinal
- ☐ Abdominal pain
- ☐ Abdominal mass

Musculoskeletal
- ☐ Muscle weakness
- ☐ Pain in extremities
- ☐ Muscle cramps
- ☐ Difficulty in walking

Neurological
- ☐ Dizziness
- ☐ Previous Stroke
- ☐ Decreased memory
- ☐ Sensation loss
- ☐ Headaches
- ☐ Tremor
- ☐ Seizures
- ☐ Numbness
- ☐ Tingling

Endocrine
- ☐ Appetite changes

Hematology
- ☐ Prolonged bleeding

Genitourinary-Male only
- ☐ Impotence

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I acknowledge that I have been provided the Arizona Associated Surgeons PLLC's Notice of Privacy Practices:

- It tells me how the Practice will use my health information for the purpose of my treatment, payment for my treatment and Practice's Health care operations
- The Notice explains in more detail how the practice may use and share my health information for purposes other than treatment, payment and healthcare operations.
- The practice will also use and share my health information as required/permitted by law

I consent to receive calls from AAS providers/staff for my protected healthcare and other services at the phone numbers provided by myself, including my wireless number I provided. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please List ALL:

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Arizona Associated Surgeons., Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Arizona Associated Surgeons actually receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Printed Patient Name _____ Patient's Date of Birth _____

Signature of Patient _____ Date _____

Signature of Client/Personal Representative _____ Relationship to Patient _____

To access our complete Notice of Privacy Practices, please visit our website at www.VascularSurgeryDocs.com Or call the office to have a copy sent to you.

Please note, this form expires one year after signed. You will be asked to complete this form annually.

Financial Policy Acknowledgment:

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

Please initial below to acknowledge that you have read our financial policy, which reflects that you as the patient are ultimately responsible for the charges associated with your care.

Initial: _____

Please initial below to acknowledge that you are aware of our appointment cancelation/no-show policy which states:

If 48-hour notice is not given prior to an office appointment, you will be charged a $25 fee.

Initial: _____

If 72 hour notice is not given prior to a scheduled surgery, you will be charged a $250 fee.

Initial: _____

To access our financial policy, please visit our website at www.VascularSurgeryDocs.com
Or call the office to have a copy sent to you.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Credit Card Authorization Form

Patient Name: _____ DOB: _____

The purpose of this form is to authorize Arizona Associated Surgeons to retain a valid credit card number on file for you. This information will be kept secure and can only be accessed by authorized staff. Your credit card will ONLY be charged under the following circumstances:

Copays/Coinsurance/Deductible: AAS reserves the right to charge the credit card on file for all patient balances including copays, coinsurance, deductibles and any patient responsibility as directed from your insurance company. A receipt will be sent to you for all transactions. This notice serves as your consent to being charged for all current patient balances on your account.

No Show Appointment Fee: If a patient misses a scheduled appointment in the office without a 48 hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $25.00 fee. If a patient misses a scheduled surgery appointment without a 72 hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $250.00 fee.

Returned Payment Fee: If we receive notice that a payment is returned to us for any reason, AAS reserves the right to charge the card on file a $40 returned payment fee.

Self-Pay Patients: If you are a self-pay patient without insurance, AAS reserves the right to charge the credit card on file for services performed.

Refusal to sign: In the event you opt not the sign the credit card authorization form you will be required to pre pay for all services according to your benefit plan. You will receive **ONE** statement for any remaining balances. If the balance is not paid within 14 days, you will incur e a $25.00 service fee for each additional statement.

Other than the conditions mentioned above, under NO circumstances will AAS charge your credit card for anything not discussed with you personally. In conjunction with HIPAA regulations, all credit card information will be confidential and securely kept within our PCI compliant merchant service system. Only authorized staff will be able to access this information.

By signing the credit card authorization form, you understand that as soon as your EOB (explanation of benefits) is received by our office from your insurance company your credit card will be charged for the balance due on your account.

Acknowledged, Agreed, & Accepted. Having read this form, my signature below acknowledges that I give my authorization and consent for my credit card to be charged for the conditions listed above.

_____ _____

Patient Signature Date Staff Signature Date

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
- 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.

New Policy Effective 2020 Credit Card on File for Co-Pays/Deductibles/Co-Insurance

You will be asked to leave a credit card on file to be run after your insurance has processed your claim for any outstanding balances, refusal to do this will result in you paying your estimated patient responsibility such as copay, co-insurance and/or deductible amounts as required by your insurance carrier at the time of your appointment.

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. **We do not accept cash or checks**. We do accept the following credit cards: Visa, Master Card, Discover and American Express. If you do not have your co-payment your appointment may be rescheduled.

Surgery

If surgery is indicated, our office will either collect as a pre-payment any remaining deductible and/or co-insurance you may have prior to your surgery or you will be asked to leave a credit card on file to be run after your insurance has processed your claim. 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.

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

If your visit is work-related, we will need the case number, date of injury, carrier name and phone number prior to your visit to bill the workers' compensation insurance carrier. If your claim is not yet accepted, we will bill your private insurance and if uninsured payment in full is expected.

Other Charges

No Show - Please provide us with at least **48 hours'** advanced notice if you need to cancel or reschedule an office appointment. **Procedure/surgery cancels** require a **72 hours'** advanced 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 may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow 5 business days for us to complete the forms.

Payment Options - We only accept the following major credit/debit cards Visa, Master Card, Discover and American Express we will accept checks as a form of payment after your Insurance has processed your claim and you receive a statement indicating you have a balance due. We charge a $40.00 NSF fee for any returned 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 option 1 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.