20940 N. Tatum Blvd. Ste 270
Phoenix, AZ 85050
Ph: 844-436-7874 / Fax: 877-828-6834

Office and Financial Policy Agreement

Thank you for choosing Surgical Group of Arizona for your medical care. We are committed to providing you with quality, personal health care and appreciate your commitment to adhering to this Office and Financial Policy Agreement. By understanding our policy, we can provide you with the best service. Agreement with this policy is required for all medical care.

Office Hours – By Appointment Only

Except as indicated below, payment is required at the time of service. We accept cash, personal instate checks, Visa, MC, Discover and American Express. There is a $50.00 service fee for returned checks.

Insurance

We practice with most insurance plans and will bill your insurance as a courtesy to you. If we are NOT participating with your plan, payment in full is required at the time of service, unless other arrangements have been made in advance. Knowing your insurance benefits is your reasonability, please contact service at your insurance company for any questions you may have regarding your coverage. You are responsible for any charges by your insurance.

Proof of Insurance

All patients must bring their insurance card to each visit. You must furnish valid and up to date proof of insurance and a Photo ID. If you provide false or expired insurance information you will be responsible for the balance of the claim. Please notify us of any changes to your insurance coverage prior to service. Insurance denials for termination of coverage will be automatically billed to you.

Co-Payments / Deductibles

All co-payments are due at time of service. Some high dollar deductible plans require a deductible to paid in full prior to them paying any claims. By contractual law your insurance company requires us to charge for services and for you to pay for all required co-payments, co-insurance deductibles and non-covered services.

Claim Submission

We will submit your insurance claim. As a courtesy to our out of network patients, we will file to your insurance company.

Self-Pay

Uninsured and self-pay patients will be given a 10% reduction when pay at time of service.

Missed Appointment / Cancelling of Surgeries

Missed appointment / surgeries represent not only a cost to us, but also an inability for us to provides services to others in that time set aside for you. We require 24-hour notice of cancellation to avoid a $25.00 cancellation fee for office visits, if a surgery is scheduled, we require 72-hour notice for cancellation to avoid a $100.00 cancellation fee.

Form Completion

FMLA and Disability forms require time and medical review therefore there is a $25.00 charge per form. Please allow 48-72 hours for completion.

Request for Medical Records

Copying of records can be time consuming and expensive, if records are needed for continuity of care to another provide or information is needed by your insurance carrier to pay a claim, you can provide a release of records to that provider or insurance carrier and the information will be faxed / sent directly to that entity at no charge. If you would like a copy for your own information, there is a $25.00 fee. Records requested for your behalf by an attorney will be subject to a $75.00 fee. Please allow five (5) business days for the copying of records.

Collection Fees

In the event of your account being placed into collection status, a 33% fee will be added to the outstanding balance, you will be responsible for attorney fees and court costs.

I have read understand and agree to comply with the terms of this Office / Financial Policy.

_____ _____

Patient Signature Date

_____

Printed Name

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information. The Notice contains your Patient Rights that describes your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change, if we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right the revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restricted the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

Please list individuals with whom you allow Surgical Group of Arizona to discuss your patient care (including medical and billing details).

Name	Relationship	Phone Number
1.		
2.		

_____ _____

Patient Signature Date

_____

Printed Name

_____ _____

Witness, Practice Representative Date

Patient Disclosure Form

Our office is committed to providing patient care in accordance with the highest professional and ethical standards. Our organization and medical staff have derived significant benefits by collaborating with the pharmaceutical, medical device / supply, and nutritional industries within the areas of research, education, and patient care. Such a collaboration must occur in a transparent, non-biased environment where conflicts of interest are disclosed appropriately.

Consequently, below we are disclosing to you that the Physician(s) responsible for your care may have a business relationship with one (1) or more of the following pharmaceutical / medical device / surgical facilities / nutritional companies:

1. Abbvie
2. Boston Scientific
3. Fullscript.com
4. Outpatient Surgical Facility
5. Other: _____

The supplies/drugs/devices/facilities may be used for your procedure/care. The Physician(s) business relationship may involve consulting services, product development/ research, or training services.

The selection of supplies, drugs, equipment, or facilities used in your care is based on what is best for you as our patient, not which company makes the product. The Physician(s) are NOT compensated by the use of any medical devices, supplies, or equipment. The Physician(s) may receive payment from the surgical facility/nutritional companies that they associate with.

Please sign below that you have read the *Patient Disclosure Form* and any questions you may have had, have been answered to your satisfaction.

_____ _____

Patient / Guardian Signature Date

Patient Intake Form

Patient Name: _____

Primary Care Physician Name and phone numbers: _____

Pharmacy Name and phone number: _____

Please list all allergies and reaction(s): _____

_____

_____

_____

Please list all medications including prescription, over the counter, and supplements:

Medication	Dose & Frequency

Family History (Please list any major health issue or disease in immediate family:

Family Member	Health Issue / Disease

Past Medical History (please circle all that apply):

Abnormal Paps	**Yes**	**No**		High Cholesterol	**Yes**	**No**
ADHD	**Yes**	**No**		Hypertension	**Yes**	**No**
Anxiety	**Yes**	**No**		Hypothyroidism	**Yes**	**No**
Asthma	**Yes**	**No**		Kidney Stones	**Yes**	**No**
Congestive Heart Failure	**Yes**	**No**		Lipoma	**Yes**	**No**
BV	**Yes**	**No**		Migraine	**Yes**	**No**
Depression	**Yes**	**No**		Ovarian Cysts	**Yes**	**No**
Diabetes	**Yes**	**No**		PCOS	**Yes**	**No**
Endometriosis	**Yes**	**No**		Pilonidal cyst	**Yes**	**No**
Fibroids	**Yes**	**No**				

Please list any additional medical problems (past & ongoing):

_____

_____

_____

_____

Social History:

Occupation: _____ Employer: _____

Alcohol use: ____Never ____Social ____Occasional ____Moderate ____Recovering Alcoholic

Alcohol consumption: _____Beer _____Wine _____Liquor / Spirits

Current tobacco use: Yes / No If yes, how many years have you smoked? _____ Packs per day? _____

If no, did you quit? _____

Recreational drug use: Yes / No

Former drug use: Yes / No

Are you sexually active: Yes / No

Last menstrual cycle: _____ Menstrual flow: ____Light ____Medium ____Heavy

Miscarriage: Yes / No If yes, how many: _____

Abortions: Yes / No If yes, how many: _____

Number of pregnancies: _____ Vaginal: _____ C-Section _____

Please list your surgical history:

Date	Procedure

Review of Systems

Patient Name: _____ Date: _____

In the last two weeks, have you experienced any of the following (please circle):

Constitutional:
Chills Decline in health Fatigue Fever Weakness Weight Gain Weight loss

Respiratory:
Asthma Cough Wheezing Bronchitis Coughing Blood Positive TB Test Short of Breath

Cardiovascular:
Chest Pain Extremity Cool Heart Murmur History of Heart Attack Leg Pain – Walking Palpitations Recent Electrocardiogram Rheumatic Fever Short of Breath – Exertion Short of Breath – Lying flat Short of Breath –Sleeping Swelling of legs

Gastrointestinal:
Abdominal Pain Constipation Diarrhea Heartburn Jaundice Liver Disease Rectal Bleeding Antacid use Black / Tarry Stools Change in BM Change in stool caliber Change in stool color Change in stool consistency Decrease appetite Excessive Hunger Gallbladder Disease Hemorrhoids Hepatitis Infection Laxative Use Nausea Rectal Pain Swallowing Pain Vomiting Vomiting Blood

Psychiatric:
Depression Behavioral Change Disorientation Disturbing Thoughts Excessive Stress Hallucinations Memory Loss Mood Changes Nervousness Psychiatric disorder

Skin:
Eczema Itching Dryness Easy Bruised Hives Lumps Mole Increased Size Rashes Skin Color Change

Neurological:
Loss of consciousness Blackouts Dizziness Fainting Head Injury Headaches Memory loss Numbness Paralysis Speech Disorders Strokes Tremors Unsteady gait

Endocrine:
Weakness Weight gain Weight loss Cold intolerance Excessive Urination Fatigue Goiter Heat Intolerance Increased Thirst Neck Pain Sweats Thyroid trouble

Hematology / Lymph:
Anemia Bleeding easily Blood clots Radiation Exposure Swollen Glands Transfusion reaction

Genitourinary:
Blood in urine Burning Excessive urination Flank pain Frequency Pain on urination Retention Stones Urine discoloration