FLAGSTAFF SURGICAL ASSOCIATES

Date: (MM/DD/YYYY)

PATIENT REGISTRATION FORM

PROVIDER:

===========================

PATIENT NAME: LAST: FIRST: MI:	RESPONSIBLE PARTY NAME: LAST: FIRST: MI:
BILLING ADDRESS:	CITY: STATE: ZIP:
PERMANENT ADDRESS:	CITY: STATE: ZIP:

HOME PHONE:	BUSINESS PHONE:	MOBILE PHONE:
SEX: MALE FEMALE	BIRTHDATE: (MM/DD/YYYY)	AGE:
PATIENT SOC. SEC.#: CHILD OTHER	RESPONSIBLE PARTY SOC. SEC.#:	RELATION TO PATIENT: SELF SPOUSE PARENT

REFERRING DOCTOR:	REFERRING DOCTOR ADDRESS:
PRIMARY CARE DOCTOR:	PRIMARY CARE DOCTOR ADDRESS:

IS INJURY RELATED TO AN ACCIDENT? YES NO	IF YES, WAS ACCIDENT: AUTO RELATED JOB RELATED	DATE OF ACCIDENT:
RACE:	ETHNICITY: LATINO/HISPANIC OTHER	LANGUAGE:

PATIENT MARITAL STATUS: SINGL"E""""""""""O ARRIED""""""""""F KXQTEGF """"""""""Y KFQY GF	PATIENT EMPLOYMENT STATUS: EMPLOYED STUDENT OHER

EMPLOYER NAME:	ADDRESS:	PHONE:
SPOUSE/NEAREST RELATIVE NAME:	ADDRESS:	PHONE:

INSURANCE INFORMATION

PRIMARY INSURANCE:	SECONDARY INSURANCE:
ADDRESS:	ADDRESS:
SUBSCRIBER NAME: / SEX: M F DOB: (MM/DD/YYYY)	SUBSCRIBER NAME: / SEX: M F DOB: (MM/DD/YYYY)
RELATIONSHIP TO PATIENT:	RELATIONSHIP TO PATIENT:
EMPLOYER:	EMPLOYER:
POLICY NUMBER: / GROUP/CLAIM #:	POLICY NUMBER: / GROUP/CLAIM #:
GUARANTOR NAME: DOB: (MM/DD/YYYY) SSN:	GUARANTOR NAME: DOB: (MM/DD/YYYY) SSN:

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of **Flagstaff Surgical Associates** for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (Patient or Parent, if minor):____ **DATE**: ________

Patient History Form

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Date:(MM/DD/YYYY) _______ Name: ____________________ Date of Birth(MM/DD/YYYY): ___________ Age: _____

Describe the main reason for your visit tod ____

____

____

____

Past Medical History
(List any medical conditions that you have such as diabetes, high blood pressure, etc.)

Past Surgical History

(List any prior surgeries)	Date (estimate)

Family History (Other than you)

			Relation
Prostate Cancer	Y	N	_______
Kidney Cancer	Y	N	_______
Bladder Cancer	Y	N	_______
Kidney Stones	Y	N	_______
Diabetes	Y	N	_______
Heart Attack	Y	N	_______
Stroke	Y	N	_______
Cancer	Y	N	_______
Bleeding Disorders	Y	N	_______

Social History

Any history of tobacco use? Y N

Years of active smoking: ____________

Packs per day: ____________________

Quit? Y N Date: _____________

Alcoholic drinks per day: ________

Recreational drug use? Y N

Occupation: _____________________________

Marital Status: Single Married \

Age and sex of children:

Current Medications and Supplements

Allergies: Medication and Reaction

Review of Systems

Do you have any problems now or have you had any related to the follow systems? Please circle Yes or No

Constitutional Symptoms	(Comments)	Genitourinary			(Comments)
Recent weight change ...., ...V		Stream is smaller	Y	N	
Fever ...., ...V		Nocturia (get up at night)	Y	N	
Chills ...., ...V		Urinary frequency	Y	N	
Other ...., ...V		Burning during urination	Y	N	
		Other	Y	N	
Eyes		**Musculoskeletal**			
Blurry vision ...., ...V		Muscle weakness	Y	N	
Other ...., ...V		Joint pain	Y	N	
		Other	Y	N	
Cardiovascular		**Neurologic**			
Chest pain ...., ...V		Tremors	Y	N	
Irregular heartbeat ...., ...V		Dizziness	Y	N	
Swelling in ankles ...., ...V		Numbness	Y	N	
Other ...., ...V		Other	Y	N	

Psychiatric		Respiratory		
Anxiety ...., ...V		Difficulty breathing	Y	N
Depression ...., ...V		Cough	Y	N
Other ...., ...V		Wheezing	Y	N
		Other	Y	N
Endocrine		**Gastrointestinal**		
Excessive thirst ...., ...V		Heartburn	Y	N
Too hot/cold ...., ...V		Nausea	Y	N
Other ...., ...V		Vomiting	Y	N
		Abdominal pain	Y	N
		Constipation	Y	N
		Other	Y	N
Hematologic/Lymphatic		**Allergic/Immunologic**		
Easy bleeding ...., ...V		Seasonal Allergies	Y	N
Easy bruising ...., ...V				
Swollen glands (groin) ...., ...V				
Other ...., ...V				

Form completed by:____________________________ Date:________________________

Flagstaff Surgical Associates

PAYMENT INFORMATION FORM

Welcome to Flagstaff Surgical Associates. We would like to thank you for you confidence and the opportunity to provide your medical treatment and care. Our office is happy to assist you with any questions you may have regarding you appointment. If you are unable to make your appointment, please try to call us at least 24 hours in advance.

As a courtesy to our patients, we will submit your charges to your insurance company. Please bring your insurance card(s) on the day of your appointment. Without insurance information, the patient will be responsible for the bill on the day seen in the office. Any co-pay or deductible is also due on the day of your visit. If you do not have insurance, payment will be required at the time of visit. If you are scheduled for surgery, your portion of that surgery and any deductible will need to be paid before the surgery date.

If you have an insurance that requires a referral or authorization, we must have that before your appointment. Referrals may be brought in or faxed to us. Appointments will need to be rescheduled if the referral or authorization is not received.

I have read the above information and understand the payment requirements

Patient name: ___________________________________

Patient signature: ________________________________ Date:
(or guardian)

77 W. Forest Avenue, Suite 201 • Flagstaff, Arizona 86001-1483
(928) 773-2222 • 1-800-824-7630 • Fax (928) 773-2598

FINANCIAL POLICY
INSURANCE, CO-INSURANCE AND PATIENT PAYMENTS

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, check, Visa, MasterCard, or Discover. We will be happy to process your insurance claim for you. We must, however, receive current insurance information *before* you see the doctor.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Please know however, that:

1) Your insurance is a contract between you, your employer, and the insurance company. *We are not a party to that contract.*
2) Most insurance companies have a co-pay and a deductible that must be met before the insurance company will pay their portion. If you have not met your deductible for the year, you are responsible for any charges until that deductible is met. Most insurance companies hold us contractually responsible for collecting a co-pay at EACH visit.
3) Patient's deductible and out of pocket patient responsibility is due prior to surgery.
4) Not all services are a covered benefit in all contracts. For instance, if your plan does not cover preventive services, you will be responsible for that charge.
5) If payment for medical services rendered has not been received in 120 days, the account will be referred to a collection agency.

We must emphasize that as medical providers, our relationship is with *you*, not your insurance company. We may have an "In-Network" relationship with a particular insurance company; however, your personal benefits still prevail. Insurance companies highly encourage patients to use "In-Network" providers, and consider it a patients' responsibility to find out which providers are "In-Network".

Surgical Procedures

For those patients receiving surgical or diagnostic treatment, please know that we will prior authorize your procedure, this authorization is not a guarantee of benefits; it is merely a statement by your insurance company that they agree with the course of treatment. **You should still call your insurance yourself and notify them of your proposed treatment plan.**

____
Printed Name

____
Patient Signature   Date

Medical Appointment Cancellation Policy

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that assists us in scheduling appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient in need of our services.

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office by noon the day before, it will be considered a missed appointment unless it is an emergency. A fee of $25.00 will be charged for a missed office appointment, a fee of $100.00 will be charged for a missed procedure or surgery appointment. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be asked to find another physician to continue his/her care.

Additionally, if a patient is more than15 minutes late to his/her appointment, he/she will be seen when possible that same day.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage and understanding.

I have read and understand the Medical Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, ____(print name), have received a copy of Flagstaff Surgical Associates Medical Appointment Cancellation Policy.

_________________________________   ___________________________________

Printed Name of the Patient   Relationship to Patient (if patient is a minor)

____ _

Signature of Patient or Responsible Party if a Minor   Date

Flagstaff Surgical Associates
77 W Forest Ave., Ste. 201 Flagstaff, AZ 86001
Patient Consent for Use/Disclosure of
Protected Health Information

Patient's Name: ________________________________ Date of Birth:
Social Security#: _____________________ Previous Name (if applicable): _________________

I understand that my/the patient's health information is private and confidential. I understand that Flagstaff Surgical Associates work hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's health information. I understand that Flagstaff Surgical Associates may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.
Flagstaff Surgical Associates has a detailed document called the "Notice of Privacy Practices". It contains more detailed information about how we may use and disclose patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.
Flagstaff Surgical Associates may update the "Notice of Privacy Practices". If I ask, Flagstaff Surgical Associates will provide me with the most current "Notice of Privacy Practices".
Under the terms of this consent, I can ask Flagstaff Surgical Associates to restrict how my/the patient health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that Flagstaff Surgical Associates does not have to agree to my/the patient's request.
I may cancel this consent at any time by writing, signing and dating a letter to Flagstaff Surgical Associates. If I write a letter, it must say that I want to revoke my/ the patient's consent to authorize the use and disclosure of my/the patient's health information for treatment, payment, and healthcare operations.
If I revoke the consent, Flagstaff Surgical Associates does not have to provide any further healthcare services to me/ the patient.

____
My signature below indicates that I have read and reviewed a current copy of Flagstaff Surgical Associates "Notice of Privacy Practices". My signature means that I agree and consent to allow Flagstaff Surgical Associates to use and disclose my/the patient's protected health information to carry out treatment, payment and healthcare operations.

____
Patient or legally authorized individual signature Date
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