Arizona Institute
of Medicine & Pediatrics

NEW PATIENT – ADULT DEMOGRAPHICS

Primary Care Provider: ❑ Dr. Patel ❑ Dr. Chamberlin ❑ Dr. Daksha ❑ Eric Koenig

How did you hear about us? ❑ Patient _____ ❑ Internet ❑ Insurance ❑ Physician _____

Patient First Name: _____

Patient Middle Name: _____

Patient Last Name: _____

Do you have another name you would like to be called?

_____

Gender: ❑ Male ❑ Female Date of Birth: _____

Race: _____

Ethnicity: _____

Dominant Hand: ❑ Right ❑ Left

Language(s): _____

Social Security Number: _____

Primary Address: _____

City: _____

State: _____ Zip: _____

Secondary Address: _____

City: _____

State: _____ Zip: _____

E-mail Address:

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Which number would you prefer as your primary contact:

❑ Home ❑ Work ❑ Cell

Emergency Contact Name:

_____

Relationship: ❑ Child ❑ Spouse ❑ Other _____

Telephone Number: _____

I do not hold an insurance policy. I am a self-pay patient and recognize that ALL fees are due at time of service. ❑ Yes ❑ No, see below

Primary Insurance: _____ Insurance Company Telephone: _____

Policy Number: _____ Group Number: _____ Co-pay: $ _____

Secondary Insurance: _____ Insurance Company Telephone: _____

Policy Number: _____ Group Number: _____ Co-pay: $ _____

CHECK ONE: ❑ I am the primary policy holder on the above insurance listed.

❑ I am a secondary participant on the above insurance listed (see below).

If you are the secondary, please provide the primary's info below:

Responsible Party: _____

Relationship: ❑ Spouse ❑ Parent/Guardian

❑ Other: _____

City, State, Zip: _____

Date of Birth: _____

Social Security Number: _____

Telephone: _____

Employer: _____

Work Telephone: _____

PATIENT INFORMATION:
Patient information must be updated on an annual basis. Accurate address, phone and insurance information are crucial. If your contact information changes, please let us know as soon as possible to keep your chart up to date. This includes providing us with your most current insurance card.

PAYMENT OF SERVICES:

- **UNINSURED PATIENTS:** Payment for services rendered at Arizona Institute of Medicine and Pediatrics, LLC is the patient's responsibility, and payment is required in full at time of service. Payment will be accepted in the form of cash, check, money order, MasterCard, Visa or American Express. **A $35 fee will be charged for all return checks. A $0.45 fee will be added to process ALL credit card charges.** At the patient's request, arrangements for extended payments will be discussed with the practice manager.
- **INSURED PATIENTS:** IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS, TERMS AND EXCLUSIONS. We deal with hundreds of insurance companies and policies. Although we are happy to assist you in any possible way, it is not possible for us to know every insurance company in detail. Insurance companies DO NOT notify us when your policy changes. If you take issue with a denial of a claim, it is your responsibility to contact your insurance company directly.

All insurance companies require that co-payments be collected at time of service. If you do not have your co-payment at the time of your appointment, your insurance company requires that your appointment be rescheduled. As a courtesy, we will bill your insurance company for you. If your insurance company does not remit payment within 30 (thirty) days, we reserve the right to bill you directly for the charges incurred. Once your insurance company has paid their portion of your bill, the balance is your responsibility.

COURTESY APPOINTMENT CONFIRMATION CALLS:
Reminder calls are made 48-72 hours prior to an appointment as a courtesy only. PLEASE DO NOT RELY ON THEM. Appointments made within 48 hours of the actual appointment time will not receive courtesy confirmation calls.

CANCELLATION OF APPOINTMENTS:
Please notify us at least 8 hours before your appointment time if you need to cancel or reschedule your appointment. We are a busy practice and would like to give your appointment away to another sick patient that needs to be seen.

SPECIAL REQUESTS: PLEASE ALLOW THE FOLLOWING TIMEFRAMES FOR THESE REQUESTS:

PRESCRIPTION REFILLS.....72 HOURS
Please note: The refill requests come from the pharmacy through a fax line or electronically into our system. We cannot control what happens at the pharmacy level.

MESSAGES.....48 HOURS
Please note: We make every effort to answer messages in a timely manner. When leaving your message, please leave as much information as possible. A message that simply asks us to return a call will result in a delay in finding the answer you need.

REFERRALS.....10 DAYS
PRIOR AUTHORIZATIONS.....7-21 DAYS
COMPLETION OF FORMS .....3-7 DAYS

REGULATIONS REGARDING THE RELEASE OF MEDICAL RECORDS:
Messages left requesting records will not be honored. Upon request of a fully completed and signed release authorization form, medical records can be faxed to another provider for continuity of care. In accordance with HIPAA Privacy Act, this office CANNOT FAX OR MAIL RECORDS TO A HOME, BUSINESS, SCHOOL, OR NON-MEDICAL FACILITY. **NO EXCEPTIONS!** This includes immunization records, labs, etc. Please allow 7 days for processing.

SPECIAL FEES:

Form completion	$25 per incident
Returned Check	$35
Copies of Records (Patient Use)	$10 (Please allow 7 days for processing)

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THE ABOVE AND HAVE AGREED TO THE FOLLOWING:
Payment for services and supplies received are ultimately my responsibility. Should my insurance company fail to pay for such services or supplies provided by this office, I assume responsibility for payment in full. Payment of any balance due to this office will be made in full within 14 days of receipt of a statement. Authorization for insurance billing/ receipt of payment/ medical records release: I authorize this office to bill directly any third-party or private insurance company that is, or may be, financially responsible for payment due for services or supplies received through this office. Payment from any third party or private insurance company is to be made directly to this office. I authorize this office to release copies of this patient's medical record to any insurance company, that is, or may be, liable to pay all or part of this patient's charges for services received in this office.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:
To assist in continuity of care, I authorize this office to discuss and/ or release copies of this patient's medical records to any entity, including, but not limited to, hospitals, physicians or other healthcare providers that may contribute to the medical management of this patient.

PATIENT NAME (PLEASE PRINT): _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY: _____ **DATE**: _____