Patient Information

Print Legibly (PLEASE FILL IN ALL BLANKS)

Patient Name (Last, First, Middle)	If patient is a minor: Parent/Guardian, Responsible Party		
Birth Date:	Social Security #:		
Ethnicity: (Required for certain labs)			
Street Address:	City:	State:	Zip:
Best daytime # ( ) [Hm]-[cell]-[wk]	Alternate# ( ) [Hm]-[cell]-[wk]		
Pharmacy Name/ Major Cross streets /City	E-Mail:		Marital status:
Patient's Employer:	Employer's Phone #:		
Primary Care Physician:	Phone#:	Address:	
Emergency Contact: Name:_____ Relationship:_____	Home#:_____ Other#:_____		

Primary Insurance

Insurance Name:	Policyholder's Name:	D.O.B:
Relationship to patient:	Policyholder's Employer:	
Policy ID number:	Group number:	Ins phone #:

Secondary Insurance

Insurance Name:	Policyholder's Name:	D.O.B:
Relationship to patient:	Policyholder's Employer:	
Policy ID number:	Group number:	Ins phone #:

SIGN:_____ **DATE:**_____

Minor Information

A parent or legal guardian must accompany a minor patient on her first visit to our office so that we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian, if we have the written permission. The adult accompanying the minor patient is responsible for payment of the services at the time of the visit.

Authorization To Treat A Minor
I, _____, being the parent or legal guardian of the minor child, _____ do hereby authorize the provider to treat the above mentioned minor.

IN OFFICE ONLY

Eff date:	Co-pay:	Contact/Ref#:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communications
5. The right to report a disclosure of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	Elements of Care March 01,2010
Contact Person	Amy or Jessica
Phone Number	623-544-1000

Acknowledgement of Notice of Privacy Practices

" I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates of this Notice should it be ammended, modified, or changed in any way."

Patient or Representative Name (please print)

Patient or Representative Signature Date

[ ] Patient refused to sign [ ] Patient unable to sign because

Elements of Care
15515 N. Reems Rd. Ste 101
Surprise, AZ 85374
623-544-1000

Disclosing Health Information to Family, Friends and Others

[ ] I authorize disclosures of my medical information to the following person(s)

_____ _____

_____ _____

[ ] DO NOT disclose my medical information to anyone (family members, other relatives, close personal friends or others)

PATIENT NAME(PRINT)_____DATE_____

PATIENT SIGNATURE_____DATE_____

PATIENT FINANCIAL RESPONSIBILITY

Elements of Care accept cash, Visa, Master Card, Discover and American Express as forms of payment. **We DO NOT accept personal checks**. Please remember that it is the patient's responsibility to know exactly what their insurance benefits are and if a referral is required to see any of our providers. If you have concerns regarding your insurance coverage, please call the number on the back of your insurance card for a full explanation of coverage. Our financial policy is as follows:

Insurance Co-Payments: Must be paid at the time services are rendered.

Deductibles/Co-Insurance: If your deductible has not been met, full payment of the deductible will be required at the time of service along with any applicable co-insurance.

Private Pay/Non-Contracted Insurance Companies: If you do not have insurance coverage or have coverage with an insurance we are not contracted with, you will be responsible for payment in full at time services are rendered.

Cosmetic Procedures: All cosmetic procedure payments will be collected at the time of service.

Collection Policy: If you account is placed with a collection agency, all future visits would require payment in full at the time of service. You will be held fully accountable for any collection agency fees and/or attorney fees that are acquired in the recovery of the debt.

Laboratory Service: Laboratory services will be billed by the lab to which they were sent. We bill your insurance for specimen collection only. You may receive a bill from the lab for any uncovered services, co-insurance or deductible that may be due. **Not all laboratory tests are covered by your insurance company. It is the patient's responsibility to see if a test is covered or not.**

No Show Appointments: There will be a $25.00 fee charged to any account for missed appointments.

Disability/FMLA paperwork: We will be happy to fill out your initial paperwork for a $25.00 fee. Any additional sets will be completed for $15.00 per set. Your paperwork will be available for pick up in our office within **7-10 business days** of your request.

It is very important to stay well informed about your insurance coverage. If you have new insurance, it is your responsibility to provide us with an updated card. You will be held responsible for the total amount of any unpaid claims/denials for incorrect insurance information.

Signature of patient/guarantor *Print name of patient/guarantor* *Date*