

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Date: _____

Patient's Full Name: _____

DOB: _____ Age: _____ Sex (M/F): _____ Social Security#: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Home Phone:(_____) _____ Authorized to leave a Voice Message: YES ___ NO ___

Other Address (If Multiple Residences): _____

City: _____ State: _____ Zip: _____

Other Phone:(_____) _____ Authorized to leave Voice Message: YES ___ NO ___

Cell Phone:(_____) _____ Authorized to leave Voice Message: YES ___ NO ___

Employer: _____ Phone:(_____) _____

Hours of work: _____ May we call you at work and/or leave voice message? YES ___ NO ___

Address: _____

Occupation: _____

Marital Status: _____ Spouse's Name: _____ DOB: _____

Spouse's Employer: _____ Phone:(_____) _____

Address: _____

Emergency Contact (other than spouse): _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship: _____ Phone:(_____) _____

Primary Care Physician: _____ Phone:(_____) _____

Referring Physician: _____ Phone:(_____) _____

INSURANCE INFORMATION

Primary Insurance Plan: _____

Address: _____

City: _____ State: _____ Zip: _____

Group#: _____ ID #: _____

Name of Insured: _____ Relationship: _____

Effective Date: _____

Secondary Insurance Plan: _____

Address: _____

City: _____ State: _____ Zip: _____

Group#: _____ ID#: _____

Name of Insured: _____ Relationship: _____

Effective Date: _____

Are you covered by Medicare? Yes ___ No ___ Medicare #: _____ Railroad? _____

We ask all patients to show their insurance cards so that we may make copies of them.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare and submit any necessary claim forms, reports and itemizations to assist in making collections from the insurance companies and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION

I, _____, hereby authorize my physician to furnish information concerning my medical condition to my insurance plan. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due him for services rendered. Although covered by insurance, I am aware that I am personally responsible for all charges. A photo or fax copy of this authorization will be as valid as the original.

Signature of Patient: _____ Date: _____

PATIENT CONSENT

I hereby authorize my physician to furnish information concerning my illness and treatments to the following:

- 1. My insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician’s participation
- 2. My primary care physician, referring physician and other healthcare providers deemed necessary for my care and treatment.
- 3. My family and/or friend, as designated below:

Name of authorized individual(s):

I hereby request that my lab results, X-rays and other medical records be released to:

MARVIN M. CHASSIN, M.D. / JACK R. CAVALCANT, M.D.
 HARRISON J. BACHRACH, M.D./ MICHAEL M. LONG, M.D./AHSAN M. BASHA, M.D.
 CLAYTON R. POLOWY, M.D. /CHRISTOPHER M. MANUS, M.D./ SUMEET K. MENDONCA, M.D.

1432 S. Dobson Rd.#106 Mesa, AZ 85202 (480) 969-3637/FAX (480) 969-6568
 6424 E. Broadway #104 Mesa, AZ 85206 (480) 985-5331/FAX(480) 924-6919

These authorizations and assignments shall remain in effect until revoked by me in writing. A photocopy or fax of this document shall be considered as valid as the original document.

Please note: If you have elected a managed care insurance and require a referral, you are responsible for obtaining the referral prior to scheduling your return appointment. Our office personnel will be available to assist you if you do not understand the managed care process.

PRIVACY NOTICE ACKNOWLEDGE RECEIPT

I, the undersigned, acknowledge that I have received the Notice of Privacy Practices. I will read and seek assistance from the staff if necessary to insure that I understand the notice.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON

TODAY'S DATE

PRINT PATIENT’S NAME

PATIENT'S DATE OF BIRTH