MESA FAMILY PHYSICIANS

Please fill in EVERY section of this form

PATIENT INFORMATION (patient will receive the bill if all areas are not fully completed)

Last Name:_____ **First Name:** _____**MI**_____
Address_____**Apt #**_____ **City, State, Zip:** _____
Home Phone: (___)_____ **Social Security #:** _____
Work Phone: (___)_____ **Date of Birth:** _____
Cell Phone: (___)_____ **Sex: (m/f) [ ]single [ ]married [ ]other**

Employer Name: _____ **Occupation:**_____
Employer Address: _____

Emergency contact: Name: _____ **Number: (___)**_____
(preferably someone who does not live with you)

WINTER VISITORS – PLEASE COMPLETE SUMMER ADDRESS

Address: _____ **Approximate dates at this address:**
City, State, Zip: _____ **From:** _____ **To:** _____

INSURED INFO (RESPONSIBLE PARTY/INSURANCE HOLDER) IF DIFFERENT FROM ABOVE

Last Name:_____ **First Name:** _____
Address: _____ **City, State, Zip:** _____
Home Phone: (___)_____ **Social Security #:** _____
Work Phone: (___)_____ **Date of Birth:** _____
Cell Phone: (___)_____ **Sex: (m/f) [ ]single [ ]married [ ]other**
Relationship to patient: _____ **Employer:**_____

INSURANCE INFORMATION

We are happy to bill your insurance. All balances after your primary insurance pays are the patient's responsibility. The patient understands that we will NOT wait until their secondary pays before sending out statements on past due balances. We expect payment in a timely manner. It is the patient's responsibility to follow-up with insurance company if payment is not received promptly.

Insurance company name:_____
Insurance company address: _____
Insurance company phone #: _____
Policy #/ member ID/ contract #: _____
Group and/or Union #: _____
Group Name: _____
Insured's Name: _____ **Insured's Date of Birth:** _____
Is this a work related injury (on the job)? **[ ] yes [ ] no**
Is this a Motor Vehicle Accident? **[ ] yes [ ] no**
List your PCP (Primary Care Provider): _____ **Co-Pay Amount: $** _____

I request that my chart remain in: Mesa [ ] Gilbert [ ]

I hereby authorize my insurance company to pay Mesa Family Physicians directly for any and all medical or surgical treatments. I authorize release of any pertinent medical information from my chart to secure payment. A photocopy of this assignment is to be considered valid as an original. I understand that I am fully financially responsible for all charges, including, but not limited to co-payments, annual deductibles and unpaid claims. If a past due balance is sent to collections, a 30% fee will be assessed.

Signed:_____ **Date:** _____

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide standards for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time you may request to refuse all of part of your PHI. You may not revoke actions that have already been taken, which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with your HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature: _____ **Date:** _____
Print Name: _____

I give my consent to release any of my Personal Health Information to the following individuals:
Name: _____ **Relationship:** _____
Name: _____ **Relationship:** _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Mesa Family Physicians

MESA FAMILY PHYSICIANS
OFFICE POLICIES AND PROCEDURES

Welcome to MESA FAMILY PHYSICIANS! Our goal is to deliver the best possible medical care to all our patients in a compassionate, professional manner. In order to accomplish this, we would like you to read the following policies and procedures. We hope this information will answer some of your questions and help you understand how our facility operates.

Our office hours: Monday thru Friday 8:00am – 5:00pm
***Lunch from 12:00 – 1:00 (M,T,TH,F)**
***Lunch from 12:00 – 2:00 (W)**

If you are unable to keep a scheduled appointment, we ask for 24 hours notice, otherwise you will be charged a $35.00 fee.

Payment Procedures: We are contracted with numerous insurance companies; and will accept payment from your insurance company if we are contracted with them and you provide us with the correct information. If you fail to provide us with all the correct information, you are responsible for your visit with the physician. We ask you to pay your co-pay at each visit. This is a requirement of your insurance and we do not bill for co-pays. Please do not ask us to do so. If you do not have insurance, you are responsible to pay in full at each visit. We accept cash, check, Visa or MasterCard. We encourage you to know your insurance. Because of the number of different insurance companies and different plans, it is impossible for us to know each individual's coverage. We will try to answer any questions you may have, however, please educate yourself concerning *your* insurance benefits.

Referrals: If a referral is needed, the physicians and assistants are happy to complete referrals and forward them on to the specialist you are seeing. We strongly request that you check with your specialist before going to any appointment to make sure the referral is in place. We try our best to make sure the referrals are done in a timely fashion, however, we need at the **two to three days** notice in order to facilitate the number of referrals we do each day.

Prescription Refills: If you need a refill of your medication, please call the pharmacy where you initially had the prescriptions filled. They will contact us and we will either fill the prescription or notify you that you need an appointment to have this filled. Please call **48 hours** for these requests. We do **NOT** refill prescriptions on Friday after 12:00pm noon. It is impossible for us to handle the volume of requests that come in after 12:00pm on Fridays, please plan ahead!

It is our desire to become a partner with you in caring for your medical needs and hope this information will help you understand some of the important issues that can sometimes deter this goal. Out staff is here to serve you, the patient, and if you have any questions or concerns, please ask.

Sincerely,

MESA FAMILY PHYSICIANS and Staff
I HAVE READ THE ABOVE AND FULLY UNDERSTAND ITS CONTENTS:

_____ _____
Patient or responsible party Date

How did you hear about us? _____ **Phone Book;** _____ **Internet;** _____**Insurance Provider List;**

_____**Friend;** _____**Dr. Referral;** _____**Other**