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
Email address: _____

Employer Name: _____ Occupation: _____
Employer Address: _____

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

RESPONSIBLE PARTY FOR BILLING - 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
Email: _____ Billing Preferences: [ ] text/email [ ] paper
Relationship to patient: _____ Employer: _____
Employer Address: _____

INSURANCE INFORMATION

We are happy to bill your insurance. All balances after your insurance pays are the patient's responsibility. 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 #: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Subscriber's SSN: _____
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

How did you hear about us? ___ Referral / ___ Internet / ___Insurance assignment / ___ Other_____