ARIZONA DESERT
EAR, NOSE & THROAT SPECIALISTS
A Division of Palo Verde Hematology Oncology LTD

Patient Financial Responsibilty Agreement

Patient Name: Date of Birth: Account #:

We at Arizona Desert ENT are committed to providing quality care and service to all of our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand your responsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments and Coinsurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services.

Non-Covered Services: We will do our best to verify coverage before you are seen, but it is ultimately your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: We will do our best to ensure we have a valid referral for services on file. However, if your insurance policy requires a referral, you are responsible for making sure there is a current and valid referral on file prior to being seen.

Self-Pay: If you don't have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services actually provided for which you may receive a bill.

Returned Checks: We charge a $25.00 fee for any returned checks.

No Show Policy: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours before they are to be seen in our office. Failure to cancel an appointment in a timely manner will result In a No Show fee of $25.00. Multiple No Shows may result in the patient being discharged from Arizona Desert ENT.

Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Finance fees of $5 will accrue each time a new statement is generated after the first statement was sent out and partial or no payment have been made. Your account may be sent to a collection agency if the balance is 90 days old and partial or no payment has been made towards the balance.

Contact: If you have any questions regarding your bill, please contact the Arizona Desert ENT billing office at **(602) 633-3838**.

I have read the above financial policies of Arizona Desert ENT and agree to be bound by its terms. I also understand that Arizona Desert ENT has the right to amend these policies at any time.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient: _____

Printed Name of Responsible Party: _____ Relation to Patient: _____

Contact Phone Number of Responsible Party: _____

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Personal Information

Today's Date: _____

Patient First Name: _____ Initial: _____ Last Name: _____

DOB:_____ Age: ____ Social Security #: _____ Email: _____

Address: _____
Street Apt# City/State/Zip

Home Phone: _____Work Phone: _____ Cell Phone: _____

Gender: M F Language: ENG SPAN OTHER: _____ Marital Status: S M W D O

Race/Ethnicity: __ White __ Black/African American __ American Indian __ Alaska Native __ Asian

__ Native Hawaiian/Pacific Islander __ Hispanic/Latino __ Other _____

Occupation: _____ Retired: __ Yes __ No From: _____

Employer Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Financial Responsible Party Information

Responsible Party Name: _____ Relationship to Patient: _____

DOB: _____ Age: _____ Social Security #: _____

Emergency Contact Name: _____ Phone Number: _____

Relationship to Patient: _____

Insurance Information

Primary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB _____Relationship to patient: _____

Secondary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB _____Relationship to patient: _____

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Patient Name: _____ Date: _____

Reason for Visit

Primary Reason for Visit: _____ Date Symptoms Started: _____

Referring Physician: _____

Related to an Auto Accident? YES NO Work Related? YES NO Date of Injury _____

Are you Pregnant? YES NO Has anyone else in your family seen one of our doctors? YES NO

Medical History
Have you been diagnosed with any of the following conditions?

	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	HIV	☐	☐	Migraines	☐	☐
Asthma	☐	☐	Hearing Impaired	☐	☐	Seizures	☐	☐
Bleeding Disorder	☐	☐	Heart Attack	☐	☐	Sleep Apnea	☐	☐
Cancer	☐	☐	Heart Disease	☐	☐	Stroke	☐	☐
COPD	☐	☐	Hepatitis	☐	☐	TB	☐	☐
Diabetes	☐	☐	High Blood Pressure	☐	☐	_____	☐	☐
Epilepsy	☐	☐	Hypothyroidism	☐	☐	_____	☐	☐

Review of Symptoms
Are your currently experiencing any of the following problems?

			Explanation				Explanation
Vision Problem	YES	NO	_____	Musculoskeletal Problem	YES	NO	_____
Lung Problem	YES	NO	_____	-Chronic Pain	YES	NO	_____
Heart Problem	YES	NO	_____	-Musculoskeletal	YES	NO	_____
Kidney Problem	YES	NO	_____	-Back or Neck Pain	YES	NO	_____
Liver Problem	YES	NO	_____	Neurologic Problem	YES	NO	_____
Stomach Problem	YES	NO	_____	Psychiatric Problem	YES	NO	_____
Bleeding Problem	YES	NO	_____	Skin Problem	YES	NO	_____
Endocrine Problem	YES	NO	_____	Weight Loss	YES	NO	_____
				Fever	YES	NO	_____

Family Medical History- Please indicate family member or none

	Mother	Father	Grandparent	Sibling	Child	None
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Seizure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

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Patient Name: _____ Date: _____

Surgical History

What surgical procedures have you had? (Please give dates) _____

_____

Social History

Have you ever used alcohol? _____

If currently using alcohol, how often? _____ If quit using alcohol, when? _____

Have you ever used tobacco? _____

If currently using tobacco, how many packs per day? _____ If quit, when? _____

Allergies

Are you allergic to any foods? (Please indicate reaction) _____

_____

Are you allergic to any medications? (Please indicate reaction) _____

_____

Current Medications – Please list medication, dosage, and frequency.

_____

_____

_____

_____

_____

_____

_____

Preferred Pharmacy Information

Pharmacy Name: _____ Phone #: _____ Fax #: _____

Address: _____ City/State/Zip: _____

Mail-order Pharmacy: _____ Phone #: _____ Fax #: _____

Address: _____ City/State/Zip: _____

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Allergy Questionnaire - Intake Questions

To Be Filled Out by Patient

Patient Name _____ Date _____

Reviewed by _____

1. Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring? ❑ Yes ❑ No
2. Have you ever been diagnosed with asthma or bronchitis? ❑ Yes ❑ No
3. Do you experience symptoms of allergies? ❑ Yes ❑ No

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HIPAA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Arizona Desert ENT is committed to protecting the confidentiality of its patients' health information. This Notice of Privacy Practices describes how we may use and disclose your health information and the rights that you have regarding your health information.

HOW WILL WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use or disclose your health information without your authorization for the following purposes:

Treatment: We will use and disclose your health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we may disclose your health information, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your health information will be used or disclosed, as needed, to obtain payment for your health care services. For example, we may bill your health plan for the cost of the services we provide to you. We may also contact your health plan to determine whether it will authorize payment for services, to determine the amount of your co-payment or to obtain approval for a hospital admission.

Healthcare Operations: We may use or disclose your health information, as needed, in order to support the business activities of your physician's practice. These activities include, but are not limited to, training and education, quality assessment activities, risk management, claims management, legal consultation, physician and employee review activities, licensing, regulatory surveys, and other business planning activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Appointments and Health-Related Services: We may use your health information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. If you do not want us to disclose your medical information to family members or others involved in your care, please contact our Privacy Officer.

Business Associates: We enter into contracts with third-party entities known as business associates. These business associates provide services to or perform functions on our behalf, such as our accountants, consultants and attorneys. We may disclose your relevant health information to our business associates once they have agreed in writing to safeguard your medical information. Business associates are also required by law to protect the privacy of your health information.

Required by Law: We will disclose your health information when we are required to do so by federal, state or local law.

Public Health Activities: We may use your health information for public health activities such as reporting births, deaths, communicable diseases, injuries, or disabilities and ensuring the safety of drugs and medical devices.

Health Oversight Activities: We may disclose your health information to a health oversight agency for activities such as audits; civil, administrative or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

Food and Drug Administration (FDA): We may disclose your health information to a person or company subject to the FDA to report adverse events, product defects or problems or biologic product deviations; to track FDA-regulated products; to enable product recalls; to make repairs or replacements; to conduct post-marketing surveillance information or for other purposes related to the quality, safety or effectiveness of a product or activity regulated by the FDA.

Law Enforcement: We may disclose your health information to law enforcement in limited circumstances, such as to identify or locate suspects, fugitives, witnesses or victims of a crime, to report deaths from a crime, to report crime on our premises or in emergency treatment situations.

Judicial and Administrative Proceedings: We may disclose information about you in response to an order of a court or administrative tribunal as expressly authorized by such order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process not accompanied by an order of a court or administrative tribunal, under certain circumstances as permitted by law.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We may also disclose information about you if it is necessary for law enforcement authorities to identify or apprehend an individual.

Disaster Relief Efforts: We may use or disclose your health information to an authorized public or private entity to assist in disaster relief efforts. You may have the opportunity to object unless it would impede our ability to respond to emergency circumstances.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information consistent with applicable law to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose health information consistent with applicable law to organizations that handle organ, eye or tissue donation or transplantation.

Fundraising: We may use certain information to contact you as part of our fundraising efforts. If you receive such a communication from us, you will be provided an opportunity to opt-out of receiving such communications in the future.

Workers' Compensation: We may disclose your health information as authorized to comply with workers' compensation laws and other similar programs established by law.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your health information as required by military command authorities or to the Department of Veterans Affairs. We may also disclose medical information to authorized federal officials for intelligence and national security purposes.

Correctional Institutions: If you are or become an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose to the institution or law enforcement official information necessary for the provision of health services to you, your health and safety, the health and safety of other individuals and law enforcement on the premises of the institution and the administration and maintenance of the safety, security and good order of the institution.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Research: Under certain circumstances, we may also use and disclose information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information and balances the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. However, we may disclose your PHI to people preparing to conduct a research project, so long as the PHI they review is not removed from us. We may also use or disclose your PHI to contact you (or, under certain circumstances, to allow a research entity with whom we contract to contact you) about the possibility of enrolling in a research study.

If you do not want to be contacted about the possibility of enrolling in a research study (as described above), please initial here: _____

Other Uses and Disclosures: If we wish to use or disclose your health information for a purpose not discussed in this Notice, we will seek your authorization. Specific examples of uses and disclosures of your health information requiring your authorization include: (i) most uses and disclosures of psychotherapy notes (private notes of a mental health professional kept separately from

a medical record); (ii) most uses and disclosures of your health information for marketing purposes; and (iii) disclosures of your health information that constitute the sale of your health information. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

YOUR HEALTH INFORMATION RIGHTS

Although your health information is our property, you have the right to:

Request access to your health information. You may request to inspect and/or obtain a copy of your health information. If we maintain your health information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. If you request a copy (paper or electronic), we may charge you a reasonable, cost-based fee. Any request to access your health information must be in writing and submitted to our Privacy Officer.

Request a restriction on the use or disclosure of your health information. You may ask us not to use or disclose any part of your health information for a particular reason related to treatment, payment or health care operations. We will consider your request, but we are not legally obligated to agree to a requested restriction except for in the following situation: If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We are required to abide by such a request, except where we are required by law to make the disclosure. Any request for a restriction must in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request to receive confidential communications. You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request an amendment to your medical information. If you believe that any information in your medical record is incorrect, or if you believe important information is missing, you may request that we correct the existing information or add the missing information. Such a request must be in writing and submitted to our Privacy Officer. We will notify you if we cannot accommodate your request.

Request an accounting of certain disclosures. You have the right to request a list of certain disclosures we have made of your health information. Any request for an accounting must be in writing and submitted to our Privacy Officer. The first list in any 12-month period will be provided to you for free, but you may be charged for any additional lists requested during the same 12-month period.

Receive a paper copy of this Notice. You have the right to receive a paper copy of this Notice upon request, even if you agreed to accept this Notice electronically.

OUR RESPONSIBILITIES

We are required to (i) maintain the privacy of your health information as required by law; (ii) provide you with notice of our legal duties and privacy practices with respect to your health information, and to abide by the terms of such notice; and (iii) notify you following a breach of your health information that is not secured in accordance with certain security standards.

We reserve the right to change the terms of this Notice and to make the provisions of the new Notice effective for all health information that we maintain. If we change the terms of this Notice, the revised Notice will be made available upon request and posted in our practice locations. Copies of the current Notice may be obtained by contacting our Privacy Officer.

QUESTIONS, CONCERNS OR COMPLAINTS

If you have any questions or want more information about this Notice or how to exercise your privacy rights, please contact our Privacy Officer at 1-888-787-9845 or by mail at 9250 N. 3rd Street, Suite 4010, Phoenix, Arizona 85020

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with us, you may contact our Privacy Officer. To file a complaint with HHS, you may contact the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F HHH Bldg., Washington DC 20201 (OCRComplaint@hhs.gov). **We will not retaliate against you for filing a complaint.**

Effective Date: September 23, 2013

Signature below is acknowledgment that you have read and understand this Notice.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

RELEASE OF INFORMATION

I _____ hereby autorize Arizona Desert ENT to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____ Relationship:_____
Phone Number _____

Name: _____ Relationship:_____
Phone Number _____

Name: _____ Relationship:_____
Phone Number _____

I authorize Arizona Desert ENT to contact me at:

Home Phone _____ Work Phone _____

May we leave a message on machine? __ Yes __ No

Cell Phone _____ Alternate Phone _____

Patient Signature_____ **Date**_____

Witness:_____ Date _____