Integrity Internal Medicine

REGISTRATION FORMS

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First: [First Name]	Middle:	Marital status: Single / Married / Divorced / Separated / Widow

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Complete address (street, city, zip code):

Social Security no:	Home phone no:	Cell phone no:
Pharmacy:	Pharmacy major cross streets:	Pharmacy Phone number:

Email:

INSURANCE INFORMATION

(**Please provide your insurance card to the receptionist.**)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other: [Other insurance]

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: | Other:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: | Other:

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Integrity Internal Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Integrity Internal Medicine

HIPPA AUTHORIZATION FORM

Patient's Full Name _____ Date of Birth _____

I authorize the following person (s):

_____

To call or receive the following health information regarding my care (please select):

- ○ All medical information
- ○ Billing related information
- ○ My health information related to the following treatment or condition only:
  _____
- ○ Other:
  _____

DO YOU ALLOW INFORMATION REGARDING ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH BE DISCLOSED:

- ○ YES, DISCLOSE THIS INFORMATION *
- ○ NO, DO NOT DISCLOSE THIS INFORMATION *

*I understand that the information used or disclosed may be subject to re-disclosure by the person or class of person or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization anytime by notifying Blessings OB/GYN and Women's Health in writing. I understand that any revocation request will not be effective for any action taken prior to the request. Those actions cannot be reversed and this request will not affect those actions.

_____ _____

Patient Signature Date

Integrity Internal Medicine

Financial Agreement

1. **Insurance-** We participate in most major insurance plans; however, please be aware that we may not participate in all of their individual plans. It is your responsibility to know your own insurance benefit, including whether or not we are an **in-network provider** with your plans network. It is also your responsibility to know your covered benefits and any exclusions in your insurance policy.

   **If you choose to receive care prior to verifying this you understand you will be responsible for any out of network benefits which may include but are not limited to higher copays, deductibles and co-insurance.

2. **Non-payment**-If your account is over 90 days past due, your will receive a final notice letter stating that you have 10 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid we refer your account to an outside collection agency. An additional 30% will be added to any outstanding balance. You will be responsible for any collection fees, legal fees, or court costs incurred in the collection process.

3. All copays and deductibles must be paid in full at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. **Non-covered services-** Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You understand you will be responsible for payment of any denied charges. These must be paid in full at the time of your visit.

5. **Proof of insurance**- We must obtain a copy of your driver's license and valid insurance card prior to your visit to provide proof of insurance. If your fail to provide us with the correct insurance information you will be held responsible for the balance of the claim.

6. **Claim submission**- We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information to them directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claims. Your insurance benefit is a contract between your and insurance company for payment of services.

7. **Coverage changes**- If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your claim is not paid within 45 days the balance will be automatically billed to you. It is then your responsibility to work with your insurance company for payment of services.

8. We have an on-site lab for patient convenience. They are not part of Integrity Internal Medicine. Any bill related questions must be discussed with labs billing department.

9. **Release of Information**: I assign benefits of my medical insurance to Blessings OB/GYN and Women's Health and authorize payment directly to Blessings OB/GYN and Women's Health. I authorize Blessings OB/GYN and Women's Health to release medical information to payer as required for payment of claims for medical services.

We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I have read and understand this Patient Financial Agreement. Any questions have been answered to me.

_____ _____

Patient / Guardian Signature Date

Integrity Internal Medicine

Medical Treatment agreement

Patient or the patients' legal representative agree to the following terms of encounter s with Integrity Internal Medicine and its providers.

1. **Medical Treatment**: The patient consents to the treatment, services and procedures which may include but are not limited to laboratory procedures (including routine urine drug screens), X- ray examinations, telemedicine services, medical and surgical treatments or procedures or anesthesia.
2. **Release of Information**: The patient acknowledges and agrees that medical and/or financial records (including information regarding alcohol or drug abuse, HIV/AIDS related and/or to other communicable disease related information) may be release to the following: **A.** Healthcare Providers or their agents who are providing or have provided health care to the patient; any individual or entity responsible for payment. Blessings OB/GYN and women's health care provider or organizations accrediting the facility or conducting utilization review, quality assurance , or peer review and to Blessings OB/GYN and women's health or Integrity Internal Medicine legal representatives and professional liability carriers. **B**. Individuals and organizations engaged in medical education and research, provided that information may only b released for use in medical studies and research without patient identifying information. **C.** Individuals and entities as specified by federal and state law and /or in Integrity Internal Medicine. Notice of Privacy practices. **D.** Patient records of services provided at any facility including, surgecentres, Hospitals, etc. may be exchanged among these facilities to provide appropriate patient care.
3. **Contraband**: Drug, alcohol, weapons and other articles specified as contraband Integrity Internal Medicine may not be brought onto Integrity Internal Medicine premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.
4. **Dismissal from physician services:** Patient may be dismissed from physician care or Integrity Internal Medicine for 1.) Excessive no-shows 2.) Inappropriate or disruptive behavior 3.) Failure to follow treatment recommendations 4.) Medication dishonesty 5.) Failure to meet financial obligations 6.) Providing false or inadequate information 7.) Failing to authorize the release of record to Integrity Internal Medicine or 8.) Being a difficult patient.
5. **Photographs /Taped** Sessions: I understand and agree that a photograph may be take of me for identification purposes or for other treatment purposes. I further agree that therapy sessions may be taped (audio and or videotaping) and that all photographs and tapes will remain the property of Integrity Internal Medicine. I will not audiotape, videotape or take pictures of Integrity Internal Medicine staff without their permission/consent.

6. **Terms of Agreement:** This agreement shall remain in effect as long as I am seeking services Blessings OB/GYN and women's health. I will be asked to sign a new agreement every year. This release shall continue for so long as the medical and /or financial records are needed for payment, treatment or healthcare operations.

_____ _____

Patient signature/Authorized legal guardian Date

Integrity Internal Medicine

Only AHCCCS patients

AHCCCS Non-Covered Services Waiver

Name: _____

Any procedures and/or surgeries ordered by the physician will be verified with AHCCCS in advance and discussed with the patient. Should the procedure not be covered and you decide to follow through, you understand you will be held responsible for all costs. By signing below you are agreeing in advance to accept full responsibility for all costs associates the non-covered medical services.

_____ _____

Patient Signature Date

Integrity Internal Medicine

FOR SHORT TERM DISABILITY AND FAMILY LEAVE OF ABSENCE FORMS

Please be aware there is a $25.00 charge per document (due at time of request) for all FMLA or short-term disability requests forms which typically take 5 – 7 business days to process.

You may have documents rushed (within 48 hours) for a $50.00 charge per document.

By signing below, you acknowledge that you have been notified of our price and turnaround time for processing documents.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copy of medical records. This facility may apply a printing fee of $25.

_____ _____

Patient Signature Date