

SUN CITY WEST INTERNAL MEDICINE
13927 WEST GRAND AVE, #401
SURPRISE, AZ. 85374

Date _____ Home Phone _____

Patient Name: First _____ Middle Initial _____
Last _____

Address: _____ Apt _____

City _____ State _____ Zip _____

Social Sec No (Required for Billing) _____

Birth Date ____ / ____ / ____ **Sex** _____ **Age** _____

Marital Status Single Married Widowed Divorced

Emergency Contact Information (Other than Spouse)

Name _____ Relationship _____

Emergency Contact Phone _____

Employer _____

Employer Address _____

City _____ State _____ Zip _____

Occupation _____

Person Responsible for Account _____

Relationship to Patient _____ D.O.B. _____

Social Security No of person responsible for the account _____

How did you learn of our practice? _____

Do you have Advance Directives (Living Will)? **Yes / No**

Do you have Insurance? Yes No

Primary Insurance _____

ID# _____ Group# _____

Effective Date _____

Secondary Insurance

ID# _____ Group# _____

Effective Date _____

Assignment and Release

I, the undersigned, have insurance with _____
Name of the Insurance Company

And assign directly to Dr. J Bains / Dr. N Rakkar all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment of the benefits. I authorize the use of this signature on all my insurance submissions.

Signature _____ Date _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. J Bains / Dr. N Rakkar (Wabash Medical Associates, PC) for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or the supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ Date _____
Beneficiary of Insured/Guardian

**SUN CITY WEST INTERNAL MEDICINE
13927 W. GRAND AVE #401
SURPRISE, AZ 85374
PHONE: 623-544-6963**

Patient Communication Sheet

Patient Name _____ D.O.B _____

We must call on occasions to discuss confidential protected health information. Below is a list of ways for us to communicate this information with you. Please check how you would like for us to get this information to you, and be sure to check the box for each of the following that apply:

- Do not call my home phone, call only this number _____.
- Okay to call my home phone and leave a message on my answering machine.
- Okay to call my home phone, but do not leave a message.
- Okay to leave a message with my family member.

These are the following individuals who have my permission to receiver protected health information:

1. _____

2. _____

Date: _____

Signature: _____

**SUN CITY WEST INTERNAL MEDICINE
DR. JAGDEEP BAINS & DR. NAVJOT RAKKAR
FINANCIAL / OFFICE POLICIES
EFFERCTIVE: SEPTEMBER 1, 2004**

Dear Patients,

- Welcome! Please take the time to review the following policies and procedures that we at Sun City West Internal Medicine have set in place to better serve you: We look forward to establishing a long and wonderful relationship.

- Payment is expected at each visit, may it be a deductible, co-payment, percentage, or payment in full. If you are waiting for coverage to become effective or have no insurance, payment will be expected at the time of the visit. For your convenience, we accept cash, checks and credit/debit cards.

- There is \$25.00 charge for all returned checks. NSF, checks must be redeemed with certified funds. (Cashier's check, money order, certified check or cash). A \$25.00 Surcharge fee may be applied to your account if not paid in full within 90 days to Offset cost of processing statements, use of collection agency and/or attorneys. A \$10.00 surcharge fee may be applied to your account for co-pays not paid at the time of service.

- Our practice handles all claims and billing questions. You can reach our billing staff by calling our main phone number. Any accounts with outstanding balances greater than 90 days from the date of service will be subject to collections. We realize at times that there may be a financial hardship. Please communicate this with our billing and they will assist you.

- Due to all various insurance plans now in effect in the market place; it has become a very complicated process to become familiar with each plan. We therefore are requiring your cooperation so that we may better serve you and give you the proper health care you deserve without spending an exorbitant amount of time obtaining benefit information from your insurance company. It is your responsibility to know all of the information required by your insurance plan to avoid any confusion or non-payment of services, (Examples being; well/sick visit overage, immunizations, in-house testing, contracted laboratory, & radiology.

- Please be aware that an authorization from your insurance company for treatment is not a guarantee of payment.

- We require that you notify the scheduler when you make an appointment of any of the following; change of insurance, address, telephone number, and emergency contact, by doing so, this will eliminate unnecessary delays in your health care.

- If your unable to arrive for your appointment on time, please call to inform the office. Please be aware that failure to cancel your appointment may hinder another patient's ability to be seen by our physicians. Therefore we request a courtesy call 4 hours prior to your scheduled appointment. Repeated "no-shows" may be subject to discharge from our practice.

- I have read and understand the forgoing financial and office policy and agree to abide by the terms of this policy. I will bear full financial responsibility for the payments of all charges for these services if not covered by my health plan.

PATIENT NAME: _____

PATIENT / P.O.A. SIGNATURE: _____

DATE: _____

SUN CITY WEST INTERNAL MEDICINE
13927 W. GRAND AVE, SUITE 401
SURPRISE, AZ 85374
PHONE: 623-544-6963
FAX: 623-975-5486

Authorization for Release of Confidential Medical Records

Patient name: _____ Date of Birth: ___/___/___

I have been informed of SCW Internal Medicine's privacy practice, and I authorize the doctor or facility listed below to provide a complete copy of my confidential medical records.

From: Name _____
Address _____

The following medical records should be forwarded to the following facility.

To: Name: _____ Sun City West Internal Medicine
Address: _____ 13927 W. Grand Ave, Suite 401, Surprise, AZ 85374
_____ Fax records to: (623) 975-5486

In addition to the general authorization to release records to the person or entities listed above, I authorize the release of records described as the following:

Communication disease related information, including records of testing, diagnosis, or treatment for HIV, HIV related illness, AIDS.	YES	NO
Drug and alcohol treatment	YES	NO
Psychological/psychiatric information including diagnosis and treatment	YES	NO
Pathology slides, x-ray's, etc.	YES	NO

THIS REQUEST COVERS DATES OF SERVICE _____

This authorization is valid from the date of signing and may be revoked at any time by providing written notice of revocation. I understand that I may refuse to sign this authorization and that my refusal to sign, in no way affects my treatment, payment, or enrollment in a health plan.

Patient signature _____ Date _____

Legally authorized representative _____ Date _____

Relationship to patient _____

Witness _____

Notice of Privacy Practices

SUN CITY WEST INTERNAL MEDICINE ASSOCIATES, PC.

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To corrections institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or in a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Sun City West Internal Medicine Associates.
4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to HIPAA Compliance Officer, Sun City West Internal Medicine Associates, PC, 13927 W Grand Ave, Suite 401, Surprise, AZ 85374. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact HIPAA compliance officer at Sun City West Internal Medicine Associates, PC, at 623-544-6963. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Sun City West Internal Medicine Associates, PC, at 623-544-6963.

I hereby acknowledge that I have been presented with a copy of Sun City West Internal Medicine Associates, PC, and Notice of Privacy Practices.

Signature _____

Date _____

Name of Patient _____

