PHOENIX SKIN MEDICAL SURGICAL GROUP

(602) 222-9111

Patient Information
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

E-mail _____

Any restrictions for contacting you? ❒ No ❒ Yes Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Sex Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other:

Responsible Party _____ Relationship to Patient _____

Address _____
Street & Apt # City State Zip

Phone Number _____ Responsible Party Date of Birth _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Patient Pharmacy Info Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address/Cross Streets: _____

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

HOW DID YOU HEAR ABOUT US? _____ **REFERRING PHYSICIAN:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Phoenix Skin Medical Surgical Group to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Phoenix Skin Medical Surgical Group and myself.

Signature _____ **Date** _____

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RESPONSIBILITIES & AUTHORIZATION OF BENEFITS

For services rendered, I hereby assign payment from Medicare/other insurance company to Phoenix Skin Medical Surgical Group. I shall be financially responsible to pay for any non-covered charges, unpaid balance, deductible or co-insurance. **I also understand that it is the office policy of Phoenix Skin Medical Surgical Group to collect monies for any deductible or co-insurance that my insurance states I am responsible for at the time services are rendered.**

Should payment come to me from my insurance for any reason or inadvertency, I understand I am not entitled to keep any monies, but must return money owed to Phoenix Skin Medical Surgical Group.

I authorize release of any and all medical information to help in processing my claims. I also permit a photocopy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Printed Name: _____

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Authorization for Phoenix Skin to Disclose my Health Information

Patient Name: _____ DOB: _____

I. My Authorization/Denial

I agree to allow Phoenix Skin to contact me in the following methods regarding my private health information, evaluation and treatment. I understand that some forms of communication are not secure, such as text messaging, but still give my authorization for these forms of communication.

METHOD	NUMBER/ADDRESS	MESSAGES (YES OR NO)	
___ Home Phone	(___) _____	☐ Yes	☐ No
___ Cell Phone	(___) _____	☐ Yes	☐ No
___ Work Phone	(___) _____	☐ Yes	☐ No
___ Alternate Phone	(___) _____	☐ Yes	☐ No
___ Text Messages	(___) _____		
___ Email	_____@_____	☐ Yes	☐ No
___ Patient Portal			

I authorize Phoenix Skin and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other information) with the contacts listed below. I understand that by leaving spaces blank, I am indicating my choice to be a "No information" and I do not want any information to be released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO

II. My Rights

I understand that I may revoke this authorization in writing at any time.

Once the office discloses health information, the person or organization that receives it may re-disclose it as privacy laws may no longer protect it.

I understand that if this office has requested this authorization, I have a right to receive a copy of it.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, etc)

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NO SHOW/MISSED APPOINTMENT POLICY

We, at Phoenix Skin, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: (602) 222-9111.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at Phoenix Skin and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Phoenix Skin will assist you to reschedule this appointment if needed.

5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $20.00 no show fee.

6. If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $20 no show fee assessment. Dismissal from the practice will be considered.
   ***You will be notified by letter if the dismissal was approved.**

I have read and understand Phoenix Skin's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Phoenix Skin appropriately if I have difficulty keeping my scheduled appointments.

_____	_____	_____
Patient Name	Date of Birth	Date
_____	_____	
Patient Signature or Parent/Guardian if minor	Relationship to Patient	
_____	_____	
Staff Signature	Date	

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NOTICE TO PATIENTS

Although we try our best, due to the constant changes in insurance policies and coverage, it is no longer possible for us to interpret each individual policy or keep up with the many plans each insurance carrier adds. It is YOUR RESPONSIBILITY to know your coverage and to make sure we are contracted with your particular plan. Please check your coverage for anticipated services before your appointment.

Please remember your insurance coverage and related costs are between you and your insurance company and/or employer, NOT the insurance company and the doctor.

Because your policy is a confidential agreement between you and your insurance company, we are rarely privileged to know what procedures are covered or the deductibles for your specific policy.

I have read the above and understand.

_____ _____

Patient Signature **Date**

_____ _____

Staff/Witness Signature **Date**

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NOTICE OF PRIVACY PRACTICES (NPP)

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.
Phoenix Skin Medical Surgical Group respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations:

For treatment:
- Information obtained by a physician, physician assistant or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:
- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:
- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - medical quality review by your health plan;
    - accounting, legal, risk management, and insurance services;
    - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights
The health and billing records we create and store are the property of the practice. The protected health information in it, however, generally belong to you. You have a right to:
- Receive, read, and ask questions about this Notice
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information
- You may make this request in writing.
- Have us review a denial of access to your health information-except in certain circumstances.
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released.
- It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- For help with these rights during normal business hours, please contact: Phoenix Skin Medical Surgical Group, Privacy Officer, 602.604.6900.

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Our Responsibilities

We are required to:
- Keep your protected health information private
- Give you this notice
- Follow the terms of this notice

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer at 602.604.6900.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief efforts.
- You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**. If the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law**:
    - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public
    - to public health or legal authorities
    - to protect public health and safety
    - to prevent or control disease, injury, or disability
    - to report vital statistics such as births or deaths
- **To Report Suspected Abuse or Neglect** to public authorities
- **To Correctional Institutions** if you are in jail or prison, as necessary to your health and the health and safety of others.
- **For Law Enforcement** Purposes such as when we receive a subpoena, court order, or other legal process, or you are a victim of a crime
- **For Health and Safety Oversight Activities**. For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes**. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health**. For example, an employer may ask us to assess health risks on a job site.
- **To The Military Authorities of U.S. and Foreign Military Personnel**. For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions**. For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

We have a website that provides information about us at: www.phxskin.com.

By signing, you acknowledge that we have provided you with this form of our privacy practices.

Patient Name: _____ Birthdate: _____

Signature: _____

Date: _____ Relationship to Patient: _____