Scottsdale Personal OBGYN, PLLC

8414 E Shea Blvd. Suite 103
Scottsdale, AZ 85260

Please complete the entire form and print clearly

Last Name _____ First Name _____

DOB _____ Social Security # _____ Marital Status _____

Mailing Address _____Apt # _____

City _____ State _____Zip_____

Home Phone _____Mobile Phone _____

EMAIL Address: _____
Is it OK to contact you via text? YES NO

Employer _____ Occupation _____

Whom should we contact in case of an emergency?
Name _____ Relationship _____ Phone # _____

Spouse/Significant Other Information:
Name _____DOB _____ Phone # _____

Primary Care Physician:
Name _____Phone # _____

I authorize Scottsdale Personal OBGYN to release medical information to my primary care physician.

Patient Signature **_____** ***Date*** **_____**

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I authorize the release of my medical information necessary.

Patient Signature **_____** ***Date*** **_____**

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Acknowledgement of Receipt of Privacy Notice

By signing below, I acknowledge that I have been offered a copy of Scottsdale Personal OBGYN Notice of Privacy Practices and have therefore been advised of how health information about myself may be used and disclosed by Scottsdale Personal OBGYN and how I may obtain access and control this information.

_____ _____
(Signature of Patient or Guardian) (Date)

_____
(Print Patient name or Guardian)

_____
(Description of Guardian)

Please list family member(s), friends or caretakers whom you would want to have access to your pertinent medial information.

1. _____
2. _____
3. _____

May we leave a message on an answering machine? **YES** **NO**

What is your Preferred method of contact:

Home # _____

Cell # _____

Work # _____

Scottsdale Personal OBGYN Financial Agreement

Insurance: Please bring your current insurance card with you at the time of service. If you are not insured, if we cannot verify your benefits, you do not bring your insurance card or if we do not participate with your insurance plan; payment in ***full*** is expected at the time of service.

Non-covered services: Many insurance plans do not cover ***Preventative Well Woman Exams.*** If services are denied as non-covered by your insurance, we ***will not*** resubmit the claim with another diagnosis.

Claim submission: We will submit your insurance claims and assist you in any way we reasonably can to get your claims paid. Your insurance company may request additional information from you. It is ***your responsibility*** to comply with their requests. Balance of the account becomes payable within 30 days.

Statements are mailed every 28 days with any balance due. If the first statement is not paid, a second statement will be sent with a reminder for payment. If this is still not paid, a ***$20 billing fee*** added. The balance and the fee will be due immediately. If it remains unpaid, we will be required to turn the account over to a collection agency. ***Any fees incurred by our office associated with collection on a past due account, including administrative or legal costs will be the patient's responsibility.*** A fee of 35% will be added to an account turned over to an outside agency. We reserve the right to discontinue services until the balance is paid in full.

Cancellation Policy: For scheduled office visits, there is a ***24-hour cancellation policy. OUR ANSWERING SERVICE DOES NOT CANCEL APPOINTMENTS.*** A $45.00 fee will be charges and cannot be billed to insurance.

If you are being referred by another physician, the medical records are necessary for your visit. It is your responsibility to obtain these records and/or have these records faxed to our office prior to your appointment. ***Our fax number is (480) 8602433***. Without the records your appointment may be delayed or rescheduled.

_____ _____

Patient (please print & sign-if a minor Parent/Legal Guardian) **Date**