AZ Endocrine Institute, P.C.
2971 W Elliot Rd Ste 1
Chandler, AZ 85224
480-733-5483

DATE: _____

APPOINTMENT INSTRUCTIONS

Patient: _____

Dear Ms. / Mrs.:
You have been scheduled for an
Appointment on _____, _____, 20____
at ___:___,
to see Dr. _____.

Enclosed are your pre-registration forms. Please complete these forms and return to the office by mail or bring them in with you at your initial visit. Please bring all documentation pertaining to your visit (i.e., Labs, Ultrasound, X-ray's, etc). This will make your registration quicker upon your arrival.
We ask that our patients arrive 15 to 30 minutes early for pre-registration and insurance verification.
Thank you for choosing our practice to take care of your needs.

Sincerely,

Office Manager

PATIENT RIGHTS AND RESPONSIBILITIES:

We consider you a partner in your medical care. When you are well-informed, participate in treatment decisions, and communicate openly with health professionals, you help make your care as effective as possible. We encourage and respect the personal preferences and values of each individual. Patients have certain rights and responsibilities which should be given consideration during each episode of care. They are as follows:

1. In recognition of your human dignity, you have the right to, considerate and quality care that reflects your personal values and beliefs and is consistent with sound nursing and medical practices. You are responsible for being considerate of the needs of other patients and staff.
2. You have the right to expect your caregiver to make a reasonable response to your request for services. You have the responsibility to keep appointments or make appropriate notifications when this is not possible.
3. You have the right to every consideration concerning the privacy and confidentiality of your medical care and medical records. You have the responsibility to provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, sensitivities or allergies to drugs and agents, and other matters relating to your health when asked by either the staff or physicians.
4. You have the right to expect reasonable continuity of care and assistance in locating alternatives when medically indicated. You have the responsibility to report unexpected changes in your condition to the responsible practitioner as soon as possible. We cannot be held accountable for problems we are unaware exist.
5. You have the right to be informed of your condition and our explanation of your treatment program and to ask for clarification of the course of treatment if it is not understood. You are responsible to actively participate in the decisions regarding your treatment and cooperate in the agreed plan.
6. You have the right to be informed of alternative treatments and to choose among alternatives. You have the right to accept or refuse treatment to the extent permitted by law and to be informed of the medical consequences of your actions. You are responsible for your actions if you do not follow your caregiver's recommendations.
7. You have the right to examine and receive an explanation of charges related to your care and be provided with information available regarding payment methods. You have the responsibility to provide information necessary for claim processing and to assure that the financial obligations of your health care are fulfilled as promptly as possible. You have the responsibility of making sure payment is surrendered at time of service.
8. You have the right to be informed about the patient rights and responsibilities and the procedure for review and resolution of your complaints and concerns. You are responsible for adhering to the patient responsibilities as outlined.

The physicians, the medical staff, and the employees wish to treat our patients with fairness and concern, recognizing their needs and wishes, and satisfying them to the fullest extent possible.

Sincerely,

Management

_____ _____

To our patients.

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 Regulation created as a result of the Heath Insurance Portability and Accountability Act of 1996 (**HIPAA**).

Our Commitment to Your Privacy

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

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us or disclosure health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Proceedings in response to a court or administrative order.
3. If required to do 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 help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the laws appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by the law.
7. To correctional institutions or law enforcement officials if you are in inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

REQUIRED ITEMS FOR YOUR INITIAL VISIT

☐ Current **driver's license** (Must be presented at every visit).

☐ Current medical **insurance card(s)** (Must be presented at every visit).

☐ A copy of your insurance **referral** (**if** you are **required** to have one by your insurance carrier). If unsure please contact your insurance company prior to your visit to confirm provider participation as well as approved procedures. If you do not have your referral or it has not been received by our office you may be asked to reschedule or choose to pay for the visit. Payment for your visit is ultimately your responsibility.
Our office will make every effort to help you in this matter.

☐ **List of all medications** that you are taking including quantity and dosage.

☐ Any **blood test results** (6 months or sooner).

☐ Any **CT scans, ultrasound, or radiology reports** within the last 6 months.

☐ Your primary physician's reports stating **why you were referred.**

☐ Any other type of information that would assist the physician with your initial appointment.

☐ According to our office policy if you have been scheduled for an appointment and you do not keep that appointment, you will be charged a *missed appointment fee up to $100*. You must call to cancel or reschedule at least **24 hours prior** to that appointed time to avoid the fee.

- **ALL COPAY, COINSURANCE AND DEDUCTIBLES ARE DUE AT TIME OF SERVICE.**
- **WE ACCEPT ALL MAJOR DEBIT/CREDIT CARDS, CASH**.

NOTE: Please *bring* all items requested and payments with you *the day* of your appointment, or have them to our office prior to your visit.

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480-733-5483

PATIENT REGISTRATION FORM

Account #: _____Marital Status: Single { } Married { } Divorced { } Widowed { }
(OK to Email): Yes { } No { } Email
Email Address:_____

Name _____ Date of Birth _____
Social Security #_____

Address _____ City _____ State _____ Zip_____

Phone _____ Cell _____ _____Work _____ _____
OK to leave a message Yes { } No{ }

Religion Preference _____ _____
Employer _____Occupation _____Employer Phone _____
Employer Address _____ City _____State_____ Zip _____
Pharmacy _____Pharmacy Phone _____

Primary Care Physician
_____Phone_____FAX_____

Referring Physician
_____Phone_____FAX_____

Emergency Contact _____Relation _____ Phone _____

Insurance Information
Primary Insurance
_____ ID#_____Group#_____
Policy Holders Name _____ Relation _____ Date of Birth _____
SSN_____
Phone _____
Employer_____ Address _____ Phone _____
Secondary Insurance *_____ ID# _____Group #_____*
Policy Holders Name _____ Relation _____ Date of Birth _____
SSN _____
Phone _____
Employer_____Address _____ Phone_____

PLEASE Carefully READ THE following

___If I have no medical coverage, I am aware that payment is due at the time of service for services rendered.
___I am aware that I am to pay my co-pay and or deductible at the time of service. If not paid at the time of service, I am aware that I will be billed a **$15.00** *re-billing fee.*
___I hereby authorize to release any MEDICAL information which might be needed in connection with payment for medical services rendered. I request that all amounts payable under my medical insurance policies be made directly to the provider rendering services to me. When a non-contracted health insurance company rejects a claim, the total amount of the fee is due from me. I understand that I am responsible for charges related to any service deemed non-covered by my insurance company.
___I am aware that if I fail to pay my account and if it is deemed necessary to turn any past due balance over to collections, I have been informed that there will be additional costs of up to 33.3% accessed in addition to my account balance.
___I am aware that I will give the office at least 24 hours in advance for a cancellation and if I choose not to show for my appointment, I will be billed up to **$100.00** *for a no show.*

By completing this form, I acknowledge that I have read and understand the above statement