

ARIZONA ASSOCIATED SURGEONS, PLLC

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|--|---|--|--|
| <input type="checkbox"/> Charles E. Castillo, MD | <input type="checkbox"/> Richard J. Harding, MD | <input type="checkbox"/> Brett I. Siegrist, MD | |
| <input type="checkbox"/> William R. Friese, MD | <input type="checkbox"/> David C. Johnson, MD | <input type="checkbox"/> Edward H. Charles, MD | <input type="checkbox"/> Douglas J. Carlon, MD |
| <input type="checkbox"/> Ravia B. Bokhari, MD | <input type="checkbox"/> Sandra B. Gladding, MD | <input type="checkbox"/> Jon A. King, MD | |
| <input type="checkbox"/> Adrienne W. Forstner-Barthell, M.D. | <input type="checkbox"/> Keith G. Zacher, MD | <input type="checkbox"/> Jeromy S. Brink, MD | |

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #
HOME ADDRESS			CITY	STATE	ZIP
HOME PHONE #	EMAIL	CELL PHONE #		MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER	
REFERRING PHYSICIAN NAME AND PHONE NUMBER				PCP NAME & PHONE#	

HOW DID YOU HEAR ABOUT US: PROVIDER REFERRAL INTERNET WORD OF MOUTH PREVIOUS PATIENT CURRENT PATIENT
 BROCHURE INSURANCE OTHER

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> RUSSIAN <input type="checkbox"/> CREOLE <input type="checkbox"/> OTHER _____	ETHNICITY <input type="checkbox"/> LATINO/HISPANIC <input type="checkbox"/> NON LATINO/NON HISPANIC	RACE <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> REFUSE TO REPORT
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RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE
ADDRESS	CITY	STATE	ZIP
EMPLOYER	OCCUPATION	WORK PHONE	
EMPLOYER ADDRESS	CITY	STATE	ZIP
RELATIONSHIP TO RESPONSIBLE PARTY			<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO – OTHER THAN SPOUSE/RELATIONSHIP	PHONE
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PHARMACY

NAME AND LOCATION	PHONE
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INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	SUBSCRIBER NAME AND SOCIAL SECURITY	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE
	ZIP	PHONE
SECONDARY INSURANCE	SUBSCRIBER NAME AND SOCIAL SECURITY	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER	
ADDRESS	CITY	STATE
	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS
 I understand I am financially responsible for services rendered regardless of insurance or other third party payer. Unpaid balance subject to collection fees of 30%, as well as legal fees if applicable. Also, I understand that I may be financially responsible for a surgery cancellation fee of up to \$150 should I fail to cancel/reschedule at least **24 hours in advance**.

I hereby authorize direct payment to Arizona Associated Surgeons PLLC of any medical benefits payable to me for the services provided at Arizona Associated Surgeons. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.

X _____
 Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE
 I hereby authorize Arizona Associated Surgeons PLLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X _____
 Patient Signature or Signature of Guardian or Parent Date