□ **NEW REGISTRATION** □ **UPDATED** □ **EIN 20-1505116**

ARIZONA ASSOCIATED SURGEONS, PLLC

□ **Allen Agapay, MD** □ **Ravia Bokhari, MD** □ **Jeromy S. Brink, MD** □ **Charles Castillo, MD** □ **Adrienne Forstner-Barthell, MD**
□ **Tracy Freeborn, DO** □ **William Friese, MD** □ **Jordan Glenn, DO** □ **Richard Harding, MD** □ **David Johnson, MD** □ **Jon King, MD**
□ **Tafadzwa Makarawo, MD** □ **Jennifer O'Neill, MD** □ **Brett Siegrist, MD** □ **David Smith, MD** □ **Neeraj Singh, MD**

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX □ MALE □ FEMALE

HOME PHONE # «PHTele»	EMAIL	CELL PHONE # «PCTele»	MARITAL STATUS: □ MARRIED □ SINGLE □ WIDOWED □ DIVORCED □ 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	**ETHNICITY**	**RACE**
□ ENGLISH □ SPANISH □ RUSSIAN □ CREOLE □ OTHER _____	□ LATINO/HISPANIC □ NON LATINO/NON HISPANIC	□ ASIAN □ NATIVE HAWAIIAN □ OTHER PACIFIC ISLANDER □ BLACK/AFRICAN AMERICAN □ AMERICAN INDIAN/ALASKA NATIVE □ WHITE □ REFUSE TO REPORT

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY □ SELF □ SPOUSE □ CHILD □ OTHER

EMERGENCY INFORMATION

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

PHARMACY

NAME AND LOCATION	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	**SUBSCRIBERNAME 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 have read, agree to and signed the Arizona Associated Surgeons Financial Policy. I agree I will be responsible for any unpaid balances for any reasons.

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.

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

Date_____ Patient Name: _____ Patient DOB: _____

Medical and Surgical History

1. When was your last Colonoscopy/Endoscopy

2. Medical History:
   COPD
   AFIB
   Kidney Disease
   Heart Disease or Heart Attack
   HIV
   Hepatitis
   Bleeding Disorder or Abnormal Clotting
   Stroke

3. Medications:
   Name Strength/Dose

   _____

   _____

   _____

   _____

   _____

   _____

   _____

4. Blood thinners use if any (like but not limited to Coumadin, Xarelto, Plavix , Aspirin – Please specify and for how long)

   _____

   _____

   _____

   _____

5. Allergic reaction to anything or any medication – Please specify clearly

_____

_____

_____

_____

6. Social History -

Smoking YES / NO How much and for how long? _____
Alcohol YES / NO How much and for how long? _____
Drugs YES / NO

7. Family history (please specify the family member relation)

Colon/Rectal cancer or polyps –

Breast, Ovarian other cancer –

History of Colitis (Please specify)

8. Previous Surgeries (Please specify the reason and date)

Operations Date and Reason

_____

_____

_____

_____

_____

_____

Date: _____ Patient Name: _____ Date of Birth: _____

Review of Systems- Please circle items that relate to your health

General
Weight loss Fatigue Fever
Skin
Rash/sores Lesions Itching
Burning
HEENT
Ringing in ears Vertigo Hearing loss
Glasses/Contacts Eye Pain Double Vision
Glaucoma Cataracts Hay Fever
Hives/Eczema HIV/AIDS
Respiratory
Shortness of Breath Coughing Blood Wheezing
Asthma Chills
Cardiovascular
Chest Pain Palpitations Hypertension
Fainting Spells Swelling ankles/other_____
Gastrointestinal
Heartburn Nausea/Vomiting Difficulty Swallowing
Jaundice
Genitourinary
Pain Urinating Burning Frequency
Difficulty Urinating Blood in Urine Abnormal Discharge
Sexually transmitted diseases
Female: Vaginal discharge #Pregnancies _____
#Living births _____ #Miscarriages _____
#Vaginal Deliveries _____ #C-Sections _____
Last PAP Smear_____
Musculoskeletal
Arthritis Claudication
Neurological
Seizures Weak/Paralysis Numbness
Memory Loss
Psychiatric
Difficulty Sleeping Anxiety Depression
Mood Swings
Endocrine
Loss of Hair Heat/Cold Intolerance Change in Nails
Diabetes Thyroid Problems
Hematology
Easy Bruising Gums Bleed Easily Enlarged Glands
Prolonged Bleeding

COLON & RECTAL CARE CENTER OF PHOENIX

PATIENT NAME: **DATE OF BIRTH:**

I acknowledge that I have been provided the Arizona Associated Surgeons PLLC's Notice of Privacy Practices:

- It tells me how the Practice will use my health information for the purpose of my treatment, payment for my treatment and Practice's Health care operations
- The Notice explains in more detail how the practice may use and share my health information for purposes other than treatment, payment and healthcare operations.
- The practice will also use and share my health information as required/permitted by law

I consent to receive calls from AAS providers/staff for my protected healthcare and other services at the phone numbers provided by myself, including my wireless number I provided. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please List ALL:

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at anytime. My revocation must be in writing, signed by me or my legal representative, and delivered to Arizona Associated Surgeons., Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Arizona Associated Surgeons actually receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

«PName»	**«PDOB»**
Printed Patient Name	Patient's Date of Birth
Signature of Patient	Date
Signature of Client/Personal Representative	Relationship to Patient

To access our complete Notice of Privacy Practices, please visit our website at www.PhoenixColonRectal.com. Or call the office to have a copy sent to you.

Please note this form expires one year after signed. You will be asked to complete this form annually.

Date printed: 4/20/2018

Financial Policy Acknowledgment:

Patient Name: **Date of Birth:**

Please initial below to acknowledge that you have read our financial policy, which reflects that you the patient are ultimately responsible for the charges associated with your care.

Initial: _____

Please initial below to acknowledge that you are aware of our appointment cancelation/no-show policy which states:

If 48-hour notice is not given prior to an office appointment, you will be charged a $25 fee.

Initial: _____

If 72 hour notice is not given prior to a scheduled surgery, you will be charged a $250 fee.

Initial: _____

To access our financial policy, please visit our website at www.PhoenixColonRectal.com
Or call the office to have a copy sent to you.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Credit Card Authorization Form

Patient Name: _____ DOB:_____

The purpose of this form is to authorize Arizona Associated Surgeons to retain a valid credit card number on file for you. This information will be kept secure and can only be accessed by authorized staff. Your credit card will ONLY be charged under the following circumstances:

Copays/Coinsurance/Deductible: AAS reserves the right to charge the credit card on file for all patient balances including copays, coinsurance, deductibles and any patient responsibility as directed from your insurance company. A receipt will be sent to you for all transactions. This notice serves as your consent to being charged for all current patient balances on your account.

No Show Appointment Fee: If a patient misses a scheduled appointment in the office without a 48 hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $25.00 fee. If a patient misses a scheduled surgery appointment without a 72 hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $250.00 fee.

Returned Payment Fee: If we receive notice that a payment is returned to us for any reason, AAS reserves the right to charge the card on file a $40 returned payment fee.

Self-Pay Patients: If you are a self-pay patient without insurance, AAS reserves the right to charge the credit card on file for services performed.

Refusal to sign: In the event you opt not the sign the credit card authorization form you will be required to pre pay for all services according to your benefit plan. You will receive **ONE** statement for any remaining balances. If the balance is not paid within 14 days, you will incur a $25.00 service fee for each additional statement.

Other than the conditions mentioned above, under NO circumstances will AAS charge your credit card for anything not discussed with you personally. In conjunction with HIPAA regulations, all credit card information will be confidential and securely kept within our PCI compliant merchant service system. Only authorized staff will be able to access this information.

By signing the credit card authorization form, you understand that as soon as your EOB (explanation of benefits) is received by our office from your insurance company your credit card will be charged for the balance due on your account. As a courtesy we will text you prior to running the card on file. If you would like your balance charged to a different card or need to set up a payment plan you will have 2 days to contact us before the card on file is ran.

Acknowledged, Agreed, & Accepted. Having read this form, my signature below acknowledges that I give my authorization and consent for my credit card to be charged for the conditions listed above.

_____ _____

Patient Signature Date Staff Signature Date

COLON & RECTAL CARE CENTER OF PHOENIX

Credit Card Refusal Form

Patient Name: _____ DOB:_____

By signing this form, I understand that by opting out of credit card on file I will be required to pre-pay for all services according to my benefit plan. I also understand that any remaining balances must be paid within 14 days of receiving the first statement or I will be charged a fee of $25 service fee for each additional statement generated.

_____ _____

Patient Signature Date Staff Signature Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

1. Patient Information

Name:_____ Date of Birth: _____

Address: _____ Phone: _____

City/State/Zip Code: _____

2. Release of Information

Information to be released from:

Name: _____

Address: _____

City/State/Zip: _____

Phone:_____ Fax: _____

Information to be released to:
Name: Dr. Neeraj Singh
Address: 19646 N 27th Ave Ste 201
City/State/Zip: Phoenix, AZ 85027
Phone: 623-226-4025 Fax: 623-226-4229

Information to be released:
☐ All medical records
☐ Medical Records for the following dates:
☐ Medical records relating to the following treatment/condition

☐ Other: (e.g. X-ray, bills)

Reason for the release:
☐ Personal ☐ Doctor ☐ Attorney ☐ Insurance ☐ Other:

3. Patient Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing, if I do, it will not affect any actions already taken by Arizona Associated Surgeons based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must write a letter to Arizona Associated Surgeons. This information may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

Signature of Patient/
Authorized Representative _____

This Authorization expires:
(If left undated it will expire 365 days from the date printed below.)