**Sex:** \_\_\_ Male \_\_\_ Female

**Marital Status:** S D M W O

**Social Security #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMAIL:**

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zipcode:

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Race:** \_\_\_AM Indian \_\_\_AK Native \_\_\_Asian \_\_\_African Am/Black \_\_\_White

**Preferred Language:**

**Ethnicity** (please check one): \_\_\_Hispanic/Latino \_\_\_Non-Hispanic/Latino

**Can we leave detailed or confidential messages on your phone?** \_\_\_YES \_\_\_NO

**Can we can we send text messages to your cell phone?** \_\_\_YES \_\_\_NO

**Can we speak to anyone other than you regarding your lab/radiology results or anything concerning your health?**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have a Living Will?** \_\_\_\_**YES** \_\_\_\_\_**NO Do you have a power of Attorney?** \_\_\_\_**YES** \_\_\_\_\_**NO**

**Emergency Contact Name:**   **Relationship to patient:**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do we have permission to release your medical information to your emergency contact?** \_\_\_\_**YES** \_\_\_\_\_**NO**

**Is Your Spouse/Parent the Policy Holder of your Primary Insurance?** \_\_\_\_**YES** \_\_\_\_\_**NO**

Policy Holder Name: Policy Holder Date of Birth:

Policy Holder Employer: Policy Holder Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance: Policy Holder Name:

Relationship to Patient: Policy Holder Date of Birth:

Policy ID # Group #

Claims Address:

Secondary Insurance: Policy Holder Name:

Relationship to Patient: Policy Holder Date of Birth:

Policy ID # Group #

Claims Address:

Assignment and Release

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the provided to release any information necessary to process this claim. I authorize the office to release all Medical Information Necessary to any hospital, specialist office and any insurance company acting on my behalf concerning advise, care, treatment, services including drug, alcohol or mental and nervous treatment unless specifically excluded by me below, for purposes of medical treatment and evaluating and administering claims.

Signature: Date:

**FINANCIAL POLICY OF THUNDERBIRD FAMILY MEDICINE, LTD.**

**INSURANCE:** You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. **IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE.** Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. **NEW PATIENT VISITS ARE NEVER BILLED AS A WELLNESS EXAM.**

The patient is responsible for obtaining all necessary information regarding referrals or authorizations to another physician. Failure to do so may result in denial or delay of payments. Referral will be done at appointment only. Please be sure to bring your insurance card and valid picture ID to EVERY visit to ensure we have the most up to date information.

**NO SHOW/LATE CANCELLATION FEE:** If you need to cancel your appointment, please contact our office **at least 24 hours before** your appointment time. Because of the high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A $25.00 fee will be assessed for all missed appointments not cancelled with us **at least 24 hours** in advance. Should you no show or late cancel repetitively, we may discharge you from our practice.

We respect your time and every attempt is made to run on schedule. Therefore, we ask you to arrive 15 minutes prior to your appointment time for the check in process. If you are late for your appointment, you may be asked to reschedule. If your doctor is running behind due to emergencies and you need to reschedule, please notify the office staff. If you choose to stay, your visit will be given the same consideration.

**BILLING:** As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification and your insurance card. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.

In order to keep billing costs to a minimum, all co-pays, co-insurance and deductibles are to be paid on the day of the visit without exception. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in. For your convenience, we accept credit and debit cards as well as cash and check.

In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an “out of network provider” for your insurance, the deductibles and co-insurance amounts may be higher. Your insurance policy, not our office, determines the amounts. After your insurance company processes your claims, you will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you. Patient balances are due and payable in full upon receipt of your statement. Delinquent accounts will be transferred to a collection agency or our attorney after 90 days.

In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for as long as the law provides.

Please understand maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enable us to deliver the quality healthcare you deserve and expect.

There will be a $40.00 service fee for all returned checks. Any checks returned for any reason must be paid with certified funds (cashier check, money order or cash).

**MEDICARE AND MEDICARE ADVANTAGE PLANS:** If Medicare or Medicare advantage plans do not fully cover any services, procedures or tests provided you may have a balance to pay. Medicare and Medicare advantage plans do NOT pay for everything, even some care that you or your health care provider have good reason to think you need.

**PRESCRIPTION REFILLS: Please plan ahead for prescription refills**. We encourage you to address refills at the time of your office visit. Any changes in medication, new prescription, or mail in prescription problems require an office visit. No prescription refills will be granted on weekends, after hours or during routine well visits.

**FORM/LETTERS:** ANY form or letters you request the doctor to complete are not included with your medical care. The doctor will complete your forms if you qualify. An appointment may be required to determine eligibility. There is a minimum fee of $25.00 for each form or letter due and payable prior to the provider completing the form or letter. This is NOT a covered benefit by your insurance company. **A $15 extra fee will be applied to any express forms and letters needed.**

**NO FMLA OR LEAVE OF ABSENCE FORMS OF ANY KIND WILL BE COMPLETED AT A NEW PATIENT VISIT. THERE WILL NEED TO BE A SEPARATE VISIT SCHEDULED TO GO OVER THESE TYPES OF FORMS.**

**Have you ever smoked tobacco? \_\_\_\_YES \_\_\_\_NO**

**Do you currently smoke tobacco? \_\_\_\_YES \_\_\_\_NO**

**If NO: Year quit smoking \_\_\_\_\_\_\_**

**If YES: How many years? \_\_\_\_\_\_\_ How much per day? \_\_\_\_\_\_**

**Do you currently use any form of smokeless tobacco? \_\_\_\_YES \_\_\_\_NO**

**eSig\_\_\_\_ Vape\_\_\_\_ Chewing tobacco\_\_\_\_**

***Must Sign Below for all information given:*** My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Thunderbird Family Medicine, LTD. Notice of Privacy Practices, Financial Policies and have agreed to the above terms and policies.

Signature of patient or authorized person Relationship to patient

Print name of authorized signer

\*\*\*FOR OFFICE USE ONLY\*\*\* We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

\_\_\_\_\_ Individual Refused to Sign \_\_\_\_\_ Communication Barrier \_\_\_\_\_ Care Provided was Emergent \_\_\_\_\_ Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_   
Employee Name Date