2024 Update

First Name: _____ Last Name: _____

Date of Birth: _____

Address: _____ Apt #_____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ Home phone: _____

Primary Insurance: _____

ID # _____ Group # _____

Secondary Insurance: _____

ID # _____ Group # _____

I understand and acknowledge that:

1. It is my responsibility to contact my insurance company and verify that Dr. James Nichols (Ahwatukee Family Medical Center) is contracted and in network with my insurance plan.
2. All deductibles, co-pays, co-insurance or past due balances will be collected at time of service. If insurance information given at time of service is incorrect and/or payment is not received within 30 days, patient will be responsible for paying any outstanding amount.

Signature: _____ Date: _____

AHWATUKEE FAMILY MEDICAL CENTER FINANCIAL POLICY

YOUR RESPONSIBILITY- You are financially responsible for the services provided. As a courtesy to you we will file insurance claims on your behalf, when supplied with current and precise insurance information. If you present without this information, please be prepared to either pay cash or reschedule your visit. It is your sole responsibility to know the individual coverage and benefits of your insurance plan. It is your responsibility to ensure our practice is a contracted provider with your plan.

PATIENTS WITHOUT INSURANCE - It is our pleasure to provide services to patients that do not have insurance. However, you will be expected to pay for your services at the time of the visit. We do not bill self pay accounts.

MEDICARE PATIENTS - AFMC accepts Medicare assignment. We will bill secondary insurance if you provide us with the proper insurance information. You are, however, solely responsible for any coinsurance, deductibles or any charges for non-covered services.

PRIVATE INSURANCE PATIENTS - AFMC accepts assignment for most major insurances. You will be required to pay any applicable copayments, coinsurance, deductibles and/or any non-covered services rendered at the time of service.

HMO PATIENTS - It is the patient's responsibility to ensure our practice is a contracted provider and that Dr. Nichols is designated as your Primary Care Physician with your plan. If your plan requires referrals to a specialty physician, you must adhere to our office referral policy. If you seek care without prior authorization, you will be financially responsible for the specialist visit(s).

WE DO NOT FILE THIRD PARTY LIABILITY INSURANCE CLAIMS - We will provide medical care for you in accident cases, but we will only file with your medical insurance or accept cash at the time of the visit.

METHODS OF PAYMENT- We accept cash, checks, and all major credit cards. A $35.00 charge will be assessed for any returned (NSF) checks.

BILLING STATEMENTS - Patient statements are sent out monthly via email and text.

PRIOR BALANCES - Patients with a prior balance will be asked to pay in full before being seen. If the balance cannot be paid in full, you may be asked to reschedule your appointment.

NO SHOW/NO CALL - Please notify our office at 480-759-5151 twenty-four hours in advance if you must cancel or reschedule your appointment. This allows us time to serve another patient. No show/no call appointments will be billed $50 and $100 for each subsequent no show appointment.

FORM CHARGES - There will be a charge assessed for the completion of any forms. These charges are not covered by insurance and are due at the time of service, in addition to any applicable office visit fees. FEE SCHEDULE - FMLA form - $125, Temporary Disability form -$125, Wellness Exam Forms - $25 per page, Custom Letters - $450 per hour.

INFORMATION CHANGE - Please advise us of any address, phone number, email, and/or insurance change promptly. You will be asked annually to verify your demographic information.

COLLECTION PROCEDURES - Prompt payment for services rendered is expected in full. Failure to reply to communications from our office may result in the account being turned over to a collection agency and discharge from our practice. If your insurance company has not paid your account in full within 120 days, you will be billed

the balance. Balances that are not paid after three billing cycles (90 days) will be sent a final notice letter. If still not satisfied within 30 days, the account will be turned over to collections and a 25% surcharge will be added to your account.

I HAVE READ AND AGREE TO THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY AHWATUKEE FAMILY MEDICAL CENTER.

I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO AHWATUKEE FAMILY MEDICAL CENTER. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

SIGNATURE _____

DATE _____

PARENT SIGNATURE (IF MINOR)

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

I acknowledge that a copy of the NOTICE OF PRIVACY PRACTICES for Ahwatukee Family Medical Center have been made available to me.

Please list the names and phone number of the individuals involved in your care or with whom you will allow us to share your health and treatment information.

Name:_____ (____)_____

_____ Relationship

Name:_____ (____)_____

_____ Relationship

Name:_____ (____)_____

_____ Relationship

Patient Name:_____ Date of Birth:_____

Signature:_____ Date signed: _____

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Signature:_____ Date:_____