Established Patient Update

First Name:_____ Last Name:_____

Date of Birth:_____

Address:_____

_____

Cell Phone #_____

Email:_____

Primary Insurance:_____

ID #_____ Group #_____

Secondary Insurance_____

ID #_____ Group #_____

I understand and acknowledge that:

1. It is my responsibility to contact my insurance company to 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 amounts outstanding.

SIGNATURE:_____ DATE:_____

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:_____