Scottsdale Gastroenterology Specialists
8761 E. Bell Road #105, Scottsdale, AZ 85260
P: 480.219.6662 x205 / F: 480.219.6596

Patient's Name_____ DOB_____ Last 4 SSN_____
First Middle Last
__ Male __ Female

Marital Status __ Single __ Married __ Widowed __ Divorced __ Separated Occupation_____

Street Address_____

City/State/Zip Code_____

Phone (primary)_____ Phone (alternate)_____

Email_____ Access to Patient Portal: Y N

Preferred Method of Contact: Primary phone Alternate phone Email Please leave message: Y N

Race: American Indian or Alaska Native Asian Black/African American Hispanic/Latino
Native Hawaiian/Other Pacific Islander White/Caucasian Other Unknown Decline to provide information

Patient's Employer_____

Check One FT PT Not Employed Disabled Retired Student

In case of emergency ONLY, contact name_____

Phone_____ Relationship to Patient_____

Referring Physician's Name_____ Phone_____

Primary Care Physician Name_____ Phone_____

Primary Insurance Name_____

Subscriber's Name_____ OR ____Self Employer_____

Date of Birth_____

Relationship_____ Policy #_____ Group #_____

Secondary Insurance Name_____

Subscriber's Name_____ OR ____Self Employer_____

Date of Birth_____

Relationship_____ Policy #_____ Group #_____

Pharmacy_____ Address/Cross St_____

Phone_____

I assign all medical/surgical benefits to Scottsdale Gastroenterology Specialists, PLC and understand that I am financially responsible for all charges regardless of payment or non-payment from my insurance company. I authorize payment be made to the provider. In the event that payment is made to the policyholder or patient, I agree to submit payment in full, to the provider's office upon receipt of such payment.

I hereby authorize the provider to release or procure all information necessary to secure the payments of benefits, for treatment purposes and any other destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters, I further agree that a photocopy of this agreement shall be valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and Privacy Policies are available online and in the office at my request.

_____ _____ _____

Patient/Guardian Signature **Guardian's Name** **Date**

Scottsdale Gastroenterology Specialists
S. Jaffrey Kazi, MD
8761 E. Bell Road #105
Scottsdale, AZ 85260
P: 480.219.6662 x205 F: 480.219.6596

Financial Policy

Thank you for choosing Scottsdale Gastroenterology Specialists as your healthcare provider. The following is an explanation of our financial policy which we require you to read and sign prior to receiving services. Due to Scottsdale Gastroenterology Specialists office policies, refusal to sign the Financial Policy will result in a cancelled appointment.

- If you have provided us with insurance information, we will submit claims to your insurance plan(s) and will assist you in any way we reasonably can to facilitate getting your claims paid. However, your insurance plan(s) may need you to supply certain information directly and it is your responsibility to comply with this request.
- Once your insurance claims have been processed by your insurance plan(s), a statement will be sent to you for any deductible, co-insurance, co-payment or other remaining balance not paid by your insurance plan(s).
- Verification of Eligibility and benefit information obtained from your insurance company is not a guarantee of payment. Should any portion of our claim be denied by your insurance carrier, you are responsible for all unpaid and/or non-covered charges.
- If your insurance policy requires a referral for your office visit, procedure, anesthesia or for the facility where services are rendered, you are responsible for verifying that a valid referral is on file at our office for the service(s) prior to the date of service.
- Your medical records can be copied upon your written authorization. Please allow up to 2 weeks to copy your records. The Arizona Legislature (A.R.S. 12-2295) states that a reasonable fee for copying your records can be charged. SGS may charge $0.50 (fifty cents) per page. If charged, this fee is due upon patient authorization prior to the release of the records. Postage may also be incurred in addition to the copying fee. To avoid postage fees, the patient or guardian may pick up records in the office of choice. There will be no charge for records sent to another physician's office involved with your continuity of care.

Payment: Patient copays are collected at check-in on the day of your appointment.

Payment in full is due upon receipt of your first statement. We accept payment by cash, credit card (Visa, MasterCard, Discover and American Express), personal check or money order. If you wish to make a payment online, please visit, azgastrohealth.com and complete the required fields. There will be a service charge of $35.00 added to a return check from your financial institution for any reason.

If you are unable to pay your balance in full, it is your responsibility to contact our Billing Office to establish a mutually agreeable, interest-free payment plan as soon as possible and to discuss other financial resources which may be available.

Cancelled Appointments: We understand that things come up beyond your control. We do ask that you give us proper notice if you are unable to keep your appointment so that another patient can be seen. Cancellations of less than 24 hours-notice may be charged a $50 fee.

No Show Appointments: If you are unable to keep your scheduled appointment, we request that you call our office to notify us. Leaving a message on our main voice mail box or with our answering service after hours would be appreciated.

No show patient office visit appointments will be charged a $50 fee.

No show procedure appointments cancelled less than 48 hours of the procedure date, will be charged a $200 fee.

I,_____ (patient/responsible party name), agree that I have read and fully understand the financial policies of Scottsdale Gastroenterology Specialists, a division of Arizona Gastrointestinal Associates. I also acknowledge that all questions I may have regarding these policies were answered adequately by SGS staff and I am satisfied with the explanation provided.

_____ _____ _____

Patient/Guardian Signature **Guardian's Name** **Date**

Scottsdale Gastroenterology Specialists

HIPAA Privacy Acknowledgement

_____ I have received or read the HIPAA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

_____I hereby authorize Scottsdale Gastroenterology Specialists to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved in my care.

_____I also authorize the release of information that may be necessary in the processing of any insurance claims.

_____I also authorize the release of any medical records, including pharmacy records, to Scottsdale Gastroenterology Specialists upon request.

PERSONAL REPRESENTATIVES

(Family members, attorneys, etc.): I hereby authorize Scottsdale Gastroenterology Specialists, and its employees permission to discuss, send and/or receive medical information to/with the following individuals:

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

Name_____ Relationship to patient_____

_____ **Decline** (I do not authorize permission to discuss, send and/or receive medical information to/with others)

FAXES When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, by its very nature, is not confidential. YES NO

MESSAGES

It is OK to leave a message on my primary phone voice mail #: YES NO

It is OK to leave a message on my alternate phone voice mail #: YES NO

Patient Name (Print)_____ Date of Birth_____

Patient Signature_____ Date_____

Scottsdale Gastroenterology Specialists

8761 E. Bell Road #105, Scottsdale, AZ 85260

P: 480.219.6662 x205 / F: 480.219.6596

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____ DOB_____ Phone_____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone **Fax**

PLEASE SEND INFORMATION TO:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone **Fax**

I AUTHORIZE the following information to be disclosed (check mark all that apply)

_____Entire GASTROENTEROLOGY Record
_____Immunization Record
_____Lab Tests
_____TB Test
_____Billing Record
_____HIV Record
_____STD Record
_____Psychiatric/Mental Health Record
_____Alcohol/Substance Abuse Record
_____Other:_____

REASON for disclosure of health information (Initial only ONE option):

_____At my request
_____Continuing Care
_____Insurance
_____Other (please specify)_____

I authorize the use and disclose the medical records indicated above in the possession of Scottsdale Gastroenterology Specialists. Any further disclosure of medical record information by the office is not authorized without specific written consent of the person to whom it pertains. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or Health Care Professional, it may no longer be protected by the federal and state privacy regulations. This authorization may be revoked in writing by the undersigned at any time prior to the release of the information from the disclosing part. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received. I am aware that this authorization shall become effective immediately and shall remain in effect for one (1) year from the date of signature. A copy of this signed authorization is valid as an original.

Patient Signature_____ Date_____

NOTICE TO PATIENTS

State law requires a physician to notify a patient that the physician has a financial interest in a separate diagnostic facility to which the physician is referring the patient for non-routine services prescribed by the physician, and whether these services are available elsewhere on a competitive basis.

We support this law because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, this form advises you that our Medical Providers have a financial interest in Arizona Digestive Center, the licensed ambulatory surgery center where we have recommended you have the endoscopic procedure we have prescribed for you. Further, the endoscopic procedure that we have prescribed for you is available elsewhere on a competitive basis.

The law requires us to obtain your written acknowledgement that you have read and understand the disclosures made in this form. Accordingly, please sign and date this form in the space provided below. Your executed form will be kept in your patient file.

ACKNOWLEDGEMENT

I have read this Notice to Patients, and I understand the disclosures that it contains.

_____	_____	_____
Signature of Patient or Guardian	Date of Birth	Today's Date

S. Jaffrey Kazi MD NPI 1164440293

Scottsdale Gastroenterology Specialists

Colonoscopy Notification Statement

Types of Colonoscopy:

Diagnostic/therapeutic colonoscopy:

Patient has past and/or present gastrointestinal symptoms, polyps or gastrointestinal disease.

Surveillance/High Risk colonoscopy:

Patient has no gastrointestinal symptoms (either past or present) BUT has a personal history of gastrointestinal disease, colon polyps and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at shortened intervals (e.g. every 2-5 years).

Preventative Screening Colonoscopy

Patient has no gastrointestinal symptoms (either past or present), is over age 50 AND has no personal or family history of gastrointestinal disease, colon polyps and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

Who will bill me? You may receive bills from separate entities associated with your procedure as

1. Physician
2. Facility (Arizona Digestive Center or Hospital)
3. Anesthesia (Scottsdale Anesthesia Group or hospital associated anesthesia group)
4. Pathologist (or hospital pathologists)
5. Laboratory if blood work is required

How will I know what I will owe? Call your insurance carrier and verify the benefits and coverage by asking the following questions:

1. Is the procedure and diagnosis covered under my policy?
2. Will the diagnosis code be processed as preventive, surveillance or diagnostic and what are my benefits for that service? (Benefits vary based on how the insurance company recognizes the diagnosis).
3. Will I owe any coinsurance and/or deductible amounts?
4. Is the facility in-network?
5. Are there age and/or frequency limits on my colonoscopy? (e.g. one every ten years over age 50, one every two years for a personal history of polyps beginning at age 45, etc.)
6. If the physician removes a polyp, will this change my out-of-pocket responsibility? (Insurance carriers vary on this policy)
7. Representative name_____ Call reference #_____ Date_____

Possible codes for your procedure are listed above. You will need to give the insurance representative your preoperative CPT code and reason for the procedure

Can the physician change, add or delete my diagnosis so that it can be considered a preventative screening colonoscopy? No! The patient encounter is documented as a medical record from information you have provided as well as an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage.

If your insurance plan has a high deductible, you may be asked to make a deposit prior to your procedure.

Patient Name (Print)_____

Patient Signature_____ Date_____

Arizona Digestive Center

Scottsdale Anesthesia Group

Patient Name_____

Account #_____

Financial Policy for Out-of-Network Insurance

Please be advised that our anesthesia services for sedation may possibly be out-of-network with your insurance company. We will gladly check your out-of-network benefits and our insurance benefits specialist will go over them with you should you have any questions. You are also more than welcome to contact your insurance company to verify if you are in-network or out-of-network by utilizing our Tax ID #32-0229237. We still bill all your services to your insurance company. It is, however, our expectation that you, the member, will receive all payments and correspondence directly from your insurance company.

Please understand that once you receive payment for the anesthesia service from your insurance company you should endorse and mail the check with the copy of explanation of benefits to our office address: Dept. 993, PO Box 29901, Phoenix, AZ 85038-0901. Otherwise, you will be liable for the full fee for anesthesia.

If your insurance is your secondary insurance, we will bill them for you after the primary insurance payment is received. At that time, we will send you a bill for the secondary balance and ask that you pay us that amount. Your insurance company should reimburse you directly.

Our goal is to make this billing process efficient and convenient for all parties involved. If you have any quetions regarding this process, please contact our benefits specialist at (480) 219-6662 ext. 216. We will always be here to help make sure that you get your appropriate reimbursement.

By signing below, I acknowledge that I agree to the terms above and I am accepting treatment by a provider who has informed me that they are out-of-network with my insurance.

_____ _____

Patient/Guarantor Signature **Date**