Phoenix Medical Group, PC
PATIENT CONSENT AGREEMENT

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Phoenix Medical Group, PC and all entities operated and owned by Phoenix Medical Group, PC for the purpose of diagnosing or providing treatment to me, evaluating treatment through research, obtaining payment for my healthcare bills and laboratory bills, referring my care to outside specialists when necessary, or to conduct healthcare operations. I understand that diagnoses or treatment of me by Phoenix Medical Group, PC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Phoenix Medical Group, PC is not required to agree to the restrictions that I may request. However, if Phoenix Medical Group, PC agrees to a restriction that I request, the restriction is binding on the practice and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Phoenix Medical Group, PC has taken action in reliance on this consent.

My "protected health information" (PHI) means health information including my demographic information, collected from me and created or received by my dentist, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Phoenix Medical Group, PC Notice of Privacy Practices prior to signing this document. Phoenix Medical Group, PC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performances of dental care operations by Phoenix Medical Group. The Notice of Privacy Practices for Phoenix Medical Group is also posted in the waiting room of the office. This Notice of Privacy Practices also includes and describes my rights and Phoenix Medical Groups, PC's duties with respect to my protected health information.

Per the HIPPA Privacy Rule, my signature on this consent form authorizes the use of my Personal Health Information between Phoenix Medical Group and all other practices, for the continuity of my care.

_____If the patient has initialed on this line, patient is **declining** the release of behavioral health information including, but not limited to: psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501), drug abuse, alcoholism, or other substance abuse, sickle cell anemia, and records which may indicate the presence of a communicable or venereal disease which may include but are not limited to diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS testing or results.

Phoenix Medical Group, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Printed Name of Patient or Personal Representative | Personal Representative's Authority

_____ _____
Witness | Date

Phoenix Medical Group

Financial Responsibility

- All patients must provide accurate and complete personal and insurance information prior to being seen by Phoenix Medical Group (herein referred to as “Practice”)

- Payment is required at the time of service and may be in the form of cash, check or credit card.

- Practice may disclose all or part of a patient's medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided.

- We will gladly file a courtesy claim with your health insurance company. It is your responsibility to comply with any pre-determination or notification requirements of your insurance plan. Many of the services provided may be covered and paid for by your insurance company. Unfortunately, insurance companies do not pay for all services that the provider may deem appropriate.

- In all cases we require the guarantor, the person who is financially responsible, to be personally liable for all balances.

- We believe the fees we charge to be reasonable and customary fees. If your insurance company uses a different fee schedule, you may be responsible for any balance remaining.

- Practice may charge reasonable fees for services related to your account including, but not limited to, returned check fees, interest on unpaid accounts, and medical record copies.

- Individuals who do not show up for their scheduled appointment or do not give at least 24 hours cancellation notice may be subject to a $25 no-show fee.

- Should it become necessary to forward an account balance to a collection agency, the guarantor, the person who is financially responsible, will be responsible for reasonable collection costs.

- You are responsible for informing the Practice of any change in demographic information, including telephone number, address, and health insurance coverage.

- We may collect a deposit on the charges you incur today toward your balance (e.g. copay, deductible, self pay) and bill you for any remaining balance. All bills are due upon receipt.

- Federal laws require that we submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. We are not allowed to change information just so the insurance company can pay a claim.

I have read and understand the financial policy and agree to abide by it. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am authorized to act on behalf of the patient and sign this agreement.

_____	_____	_____
Signature	Relationship to Patient	Date
_____	_____	
Patient First last Name Printed	Witness	

Phoenix Medical Group - Cancellation/No Show Policy

Our goal is to provide quality medical care in a timely manner.

If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. To cancel or reschedule an appointment, please call 623.815.7800.

Late Cancellation and/or No-Show Policy:

Late cancellations will be considered as a "no-show". "No-shows" inconvenience those individuals who need access to medical care in a timely manner. Any "no-show" will be subject to a $25.00 fee.

I have read and understand the Cancellation/No Show Policy.

Patient Signature_____ **Date**_____

Phoenix Medical Group – Patient Permission Form

Patient Name:_____ Date of Birth_____

Home Phone:_____ Work Phone_____ Cell/Other_____ Email_____

X_____I give permission for_____ to accompany me in the examination room during the physician visit.

X_____I give permission to call _____ Home _____ Work _____ Cell _____ Email

X_____I give permission to contact me regarding research opportunities ____Phone _____Email

X_____I give permission to leave a message at my _____ Home _____ Work _____ Cell

X_____ Message may include _____ Normal Test Results _____ All Test Results

X_____I give permission for_____ to speak with Phoenix Medical Group regarding my _____ Test Results _____ Billing Issues

X_____ I give permission to have normal results mailed to my home address.

Patient Signature_____ **Date**_____

Witness Signature_____ **Date**_____