Phoenix Medical Group, PC
PATIENT CONSENT AGREEMENT

PMG
PHOENIX MEDICAL GROUP, P.C.

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 including my provider's participation in The Network, the statewide Health Information Exchange (HIE). 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 HIPAA 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, PC
FINANCIAL POLICY

PMG
PHOENIX MEDICAL GROUP, P.C.

- 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 $75 no-show fee. Upon the third no show, our professional relationship may be terminated.
- 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.

DONALD BOND
Patient First & Last Name (printed)

Witness

Signature

Relationship to Patient

Date

Phoenix Medical Group, PC
NO SHOW POLICY / PATIENT PERMISSION FORM

PHOENIX MEDICAL GROUP, P.C.

Patient Name: _____ Date of Birth _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

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 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 $75.00 fee.

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

Patient Signature X _____ **Date**_____

Initial

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**_____

Phoenix Medical Group, PC
PATIENT CODE OF CONDUCT

PHOENIX MEDICAL GROUP, P.C.

At Phoenix Medical we are always striving to provide the best and timely care to our patients. In order to provide the best and timely care to all of our patients, we ask for your understanding and cooperation on the following matters:

1. If you need a new referral, we are going to ask you to schedule an appointment. For purposes of medical necessity, referrals need to be documented on your medical record. If your referral is urgent and your provider has no openings available, we will accommodate you with another provider who can help you on that particular matter.
2. When scheduling appointments, please let our scheduling team know the reason for your visit. Follow-ups to ER visits, Urgent Cares, and hospitalizations take more time.
3. Our patient population includes several members of the same family. It is a common occurrence that during a patient's visit, he/she request something for his/her family member who is also our patient. If you have such a request, we ask that you please call and speak with his/her medical assistant or schedule an appointment.
4. If you need any kind of forms to be filled out or completed (FMLA, MVD, doctor's letter, VA forms, etc.), please allow 10 to 14 days for completion.

Unfortunate circumstances that may result in the ending of the physician-patient relationship may include:

- Noncompliance with treatment recommended by the provider
- Failure to pay, or be consistent with our payment policy
- Threatening or abusive behavior directed at office staff, physicians, or patients
- Consistent failure to keep appointments. Our goal is to provide the best possible care and physician availability to each patient. You have the responsibility to keep appointments and be on time.
- The patient decides to leave the practice.

The code of conduct also applies to chaperones and caregivers who may bring the patient into the office for their appointments.

Signature: _____ Date: _____

Print Name: _____ DOB: _____

Phoenix Medical Group, PC
MEDICATION NOTIFICATION

PHOENIX MEDICAL GROUP, P.C.

Dear Patient;

Phoenix Medical Group does not provide continual chronic pain management through the use of opioids or other controlled substances. Patients in need of these services will be referred to the appropriate health care provider.

Because opioids cause physical dependence when taken regularly, you may experience withdrawal symptoms when you decrease or stop taking the medications. We may provide non-opioid medications to minimize withdrawal symptoms. Please follow the directions provided to taper off the medications. We do not provide opioid medications to bridge gaps in care or if you have been released from a pain management facility.

Our goal at Phoenix Medical Group is to provide the best care to our patients.

I have read and understand the medication notification above. 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.

Patient First & Last Name (printed) _____ Witness _____

Signature _____ Relationship to Patient _____ Date _____

Phoenix Medical Group, PC
ACKNOWLEDGEMENT OF RECEIPT OF NOPP

PHOENIX MEDICAL GROUP, P.C.

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Phoenix Medical Group's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Phoenix Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Phoenix Medical Group Patient Privacy Officer as indicated on your Notice.

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

Patient Name (Printed): _____

If Patient Representative, Name (Printed): _____

Relationship to Patient (Printed): _____

Account # or Medical Record #: _____

Signature: _____ Date received: _____