Results you can see.
Care you can feel.

4425 E. Agave Road, Bldg 9, Suite 148
Phoenix, AZ 85044
P: 480-704-7546
F: 480-704-7549

www.ahwatukeeskincare.com
info@ahwatukeeskincare.com

Patient Information Forms

Name……Date Of Birth……..

Address……

City…….....State……..…Zip……..……..…

Home Phone……..……Cell……..……..Work……..……..….

Email Address…….....

Employer……..Occupation……..…….

Age……..Gender……..Marital Status…….....

Race*……Ethnicity*……
*Optional. For Federal Reporting Purposes Only. *

Would you like access to our Patient Portal via email? ☐ Yes ☐ No Newsletter via email? ☐ Yes ☐ No

How were you referred to our office: ☐Patient ☐ Doctor ☐ Insurance ☐ Internet ☐ Friend ☐ Other

In case of Emergency, whom should we call? .....

Relation……..Phone……

Release of Information: I, the undersigned, hereby authorize the release and/or discussion of my medical information to:

Name:……Relation to Patient: ……

Phone Number……..should I not be available.

Test Results and Messages: I agree to allow Ahwatukee Skin to leave detailed messages and test results on my voice mail at the following numbers: ☐Home…….. ☐Cell…… ☐Work……
.
☐ I do not wish for Ahwatukee Skin to leave detailed messages / test results on my voice mail.

By Signing below, I agree that all of the above information is correct.

Signature of Patient / Guardian……..Date……..

Patient Name:……Date of Birth:……

Primary Care Physician…… Phone……

Pharmacy Name…….Cross Streets……Phone……..

Insurance Information:

1) Primary Insurance Company:…….Plan Type: ☐ HMO ☐ PPO

ID #.....Group #.…….

Insurance Address……..City……State……..…..Zip……..

Do you need a referral letter from your insurance to be seen by a Specialist? ☐ Yes ☐ No

Primary Policy Holder Name……..Date of Birth……

Phone.……. Relation to Patient……....

Same Address as Patient.……If not, Address.……..……

2) Secondary Insurance Company…… Plan Type: ☐ HMO ☐ PPO

ID #.....Group #.…….

Insurance Address.……..City……State……..…..Zip……

Do you need a referral letter from your insurance to be seen by a Specialist? ☐ Yes ☐ No

Primary Policy Holder Name.……..Date of Birth……

Phone.……. Relation to Patient……....

Same Address as Patient?.…… If not, Address.……..……

Responsible Party If Patient Is A Minor

Name……..Relationship……..

Address……City……State…….Zip……

Phone Number……..Alternate Phone Number……

If patient is under the age of 18 and needs to be seen without a Parent/Guardian, do you consent? _____

Consent Signature of Parent/Guardian……...

Patient Name:……Date of Birth:……

Release and Assignment (Please Initial Each Line):

I UNDERSTAND I WILL BE CHARGED $50.00 IF I DO NOT CANCEL 24HOURS PROIR TO MY SCHEDULED APPOINMENTMENT TIME, NO EXCEPTIONS OR WAIVERS GRANTED.

I understand that I am responsible to pay my co-payment in full at the time of my scheduled appointment.

I, the undersigned, have insurance coverage and assign directly to Ahwatukee Skin & Laser, LLC and all medical benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan.

I understand that if such an agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance.

I understand that I am financially liable in the event of non-payment.

I understand that all balances due are due in full within 90 days of each date of service. If my bill is not paid in full within 90 days of each date of service, a 10% interest charge will be added for each month thereafter. We also reserve the right to send your account to collections after 90 days.
I agree to pay the collection agency's cost and / or court costs and reasonable attorney fees.

I understand that it is my responsibility to provide a referral letter prior to being seen if my insurance requires it.

I request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to Ahwatukee Skin and laser, LLC for any services furnished me by that party who accepts assignments/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information needed for this or a related Medicare claim/other Insurance Company claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.

I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information.

By signing below, I am consenting to all of the above:

SIGNATURE OF PATIENT……..……...…….Date……..

PLEASE READ AND SIGN:

I have read the 'Notice of Privacy Practices' form and was provided a copy for my records (see next page). This Notice describes how Ahwatukee Skin & Laser may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. I also understand that the 'Notice of Privacy Practices' form is available online at www.ahwatukeeskincare.com.

SIGNATURE OF PATIENT……..……....Date……..

Ahwatukee Skin
4425 E Agave Rd, Ste #148
Phoenix, AZ 85044
P: (480) 704-7546 F: (480) 704-7549

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

WE ARE REQUIRED BY LAW to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, health care operations, and any other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information that we also describe in this health notice.

WAYS IN WHICH WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Treatments: We will use and disclose your protected health information to provide treatment. For example, information obtained by a nurse, physician, or other member of our staff will be recorded in your records and used to manage your health care. Laboratory tests may be ordered and results may be used to help us reach a diagnosis. Prescriptions may be written for you or we may call, fax, or electronically send a prescription to a pharmacy on your behalf. We may also disclose your information to other physicians involved in your care including the referring physician or a specialist we have referred you to see.

Payment: We will use and disclose your protected health information to obtain payment for services we provide. For example, we may contact your health insurer to verify coverage and we may provide your insurer with details of your treatment including diagnosis and procedures. We may also provide your information to the laboratories from which we have ordered tests on your behalf. We also may contact a third party who may be responsible for payment such as a spouse, parent, or family member. We may also use the information to bill you directly for services.

Health care operations: We may use and disclose your protected health information to operate our business. For example, we may disclose your health information to third party business associates who perform billing and consulting services.

Appointment reminders: We may contact you to remind you of an appointment or to make appointments for periodic check-ups.

Others involved in your care: We may discuss your protected health information with a family member, friend, or any other person identify that is involved in your medical care.

As required by law: We may disclose your information when we are required to do so by federal, state or local law. For example, we may release information to the state cancer registry when requested.

To advert a serious threat to public health or safety: We will use and disclose your information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease or injury.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A paper copy of this notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by printing a copy from our website.

Inspect and copy: You have the right to inspect and copy protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we may use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection by copying law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to:

Ahwatukee Skin & Laser, LLC
4425 E Agave Rd, Ste #148
Phoenix, AZ 85044

You may mail your request or bring it directly to our office. We will have 30 days to respond to your request and are allowed up to 60 days to respond but must inform you of this delay.

Request amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our privacy officer stating exactly what information is incomplete or inaccurate, and your reasoning that supports your request. We are permitted to deny your request if the information was not created by us or the person who created it is no longer employed by the facility.