Patient Payment Policy

1. Co-Payments, Co-Insurance and Deductibles: ***All co-payments, co-insurance and deductibles must be paid prior to the time of service***. The amount collected at the time of service is ***only an estimate*** and the final amount due will be determined by your insurance company when the claim is processed. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, deductibles and co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your co-payment and/or deductible and co-insurance at each visit.

(Initial Here)_____

2. Proof of Insurance: All patients must complete all patient forms prior to seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you are responsible for the balance of the claim.

(Initial Here)_____

3. Claims Submission: We will submit your claims and assist you in any way we reasonably can to process your claim(s). Your insurance may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

(Initial Here)_____

4. Coverage Changes: If your insurance changes, please notify us immediately so that we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

(Initial Here)_____

5. Nonpayment: If your account is over 30 days past due after your insurance has paid their portion and a statement has been sent out and you have failed to pay the remaining balance you owe, an *18% finance charge will be charged to your account as of the 30 days from the date the statement was mailed to you. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collections agency and you and your immediate family members may be discharged from the practice. In the event of finding it necessary to turn your unpaid balance over to a collections agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this is to occur, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

(Initial Here)_____

6. In Case of Divorce/Custody Issues: We cannot become involved with double billing in divorce settlements. Our policy is to hold the parent who brings in the child for medical treatment responsible for payment at the time of service.

(Initial Here)_____

7. No-Show & Cancellation Policy: Failure to show up to your appointment within 15 minutes of your scheduled appointment time or failure to cancel your appointment at least one business day in advance will result in a $50 fee for New Patients or a $25 fee for Established Patients automatically charged to your account. Thank You.

(Initial Here)_____

New Policy: You will be asked for a credit card at the time of booking your Initial Evaluation as a new patient. The information will be held securely until your insurance(s) have paid their portion. You will be responsible for payment of all services performed at the time of service (this will be an estimate based on information provided by your insurance company). If you do not check out and pay for these services we will charge your card on the date of service. If a patient balance remains, a statement will then be sent to you. Any balance remaining after 30 days will be charged to your card unless other payment arrangements have been made. Failure to show up to your appointment within 15 minutes of your scheduled appointment time or failure to cancel your appointment at least one business day in advance will result in a fee ($50 for New Patients & $25 for Established Patients) automatically charged to your account. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Credit Card Information:

Type of Card (Please Circle): Visa MasterCard Discover American Express

Card #:_____ Expiration Date:_____/_____ Security Code:_____

Billing Address:_____ City:_____

State:_____ Zip Code:_____

Phone #_____

***Finance Charge: All patients have a responsibility to keep their accounts current. A finance charge of 18% per month will be charged to all accounts 30 days delinquent.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
I have read and understand the payment policy of Dr. Erik Dean and Dr. Amit Sahasrabudhe and agree to abide by its guidelines:

Patient Name:_____

Signature:_____ Date:_____

AZ SPORTS MEDICINE

Amit Sahasrabudhe, MD • Erik Dean, DO

Patient Name: _____ DOB_____ Height_____ Weight_____
What are you seeing the doctor for today:_____ Affected side: Left Right
Date of injury or onset of problem:_____ Dominant Hand: Left Right
Work Related? Yes No Auto Accident? Yes No Attorney Involved? Yes No
Have you had x-rays taken? Yes No If yes, where?_____
Have you had an MRI? Yes No If yes, where? _____
Pharmacy:_____ Pharmacy Cross streets or address:_____
Pharmacy Phone Number: _____
Drug Allergies: Yes No Please list drug and reaction_____

Daily Medications: (please include pain meds, herbs, vitamins & OTC)

Name Dosage/Strength Times/day

_____
_____
_____
_____

Past Surgical History (list type and date)

_____
_____
_____

Past Medical/Hospital History (Illness/Conditions):

_____
_____
_____

Do you smoke? Yes No Packs per day:_____
For how many years?_____
Do you exercise? Yes No How Often?_____
What type? (Running, biking, etc.) _____
Do you drink alcohol? Yes No
If yes, average consumption a week?_____
What is your occupation?_____

Do you now or have you ever had:

Anemia	Yes	No
Diabetes	Yes	No
Cancer/Type	Yes	No
Kidney Trouble	Yes	No
Bladder Issues	Yes	No
High Blood Pressure	Yes	No
Heart Trouble	Yes	No
High Cholesterol	Yes	No
Asthma	Yes	No
Neurological Disorder/Seizures	Yes	No
Depression	Yes	No
Stroke	Yes	No
Thyroid Disorder	Yes	No
Ulcer/Stomach Problems	Yes	No
Hepatitis (Type)	Yes	No
Arthritis	Yes	No
Gout	Yes	No
Phlebitis/Blood Clots	Yes	No
AIDS/HIV	Yes	No
Substance Abuse	Yes	No
Fibromyalgia	Yes	No
Sleep Apnea	Yes	No

Family History:
Please list any major medical conditions & if they are deceased or alive:
Father:_____
_____
_____
Mother:_____
_____
_____
Siblings:_____
_____
_____

Is there any possibility you could be pregnant? Yes No

Has any blood relative younger than 50 ever had unusual bleeding tendencies? Yes No

If yes, who and what is their age:_____

Have you or any blood relative, younger than 50, ever had a serious reaction to anesthesia? Yes No

If yes, who and what is their age?_____

The above information is, to the best of my knowledge, a true statement of my current condition.

Patient Signature:_____ Date:_____

AZ Sports Medicine

PHYSICIAN: **Dr. Erik Dean** **Dr. Amit Sahasrabudhe**

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home Phone #: _____ Work Phone #: _____

Email: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Other: _____ Phone: _____

Date of Birth: _____ Gender: Male Female Marital Status: _____

Social Security #: _____ Employer/School: _____

Employment Status: ☐FT ☐PT ☐Not employed ☐Self-employed ☐Retired ☐Student ☐Active Duty

Emergency Contact: _____ Relationship: _____ Phone: _____

Federal Privacy Standards require the following information:

Race: _____ (i.e. Caucasian/Hispanic/Asian) Ethnicity: _____ (i.e. American/ Mexican/German) Primary Language: _____

How did you hear about us?

☐ Home ☐ Family Member ☐ Friend ☐ Internet ☐ School Athletic Trainer

☐ Another Physician (Name of Physician): _____ ☐ Other: _____

Responsible Party/Insured Party Information: (Please fill out completely **if other than self**)

Name: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell #: _____ Work #: _____

E-Mail: _____ Responsible/Insured Party's Employer: _____

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Policy ID#: _____ Policy ID#: _____

Group #: _____ Group #: _____

Insurer's Address: _____ Insurer's Address: _____

If the primary policy holder is anyone other than you, please fill out Responsible Party/Insured Party Information above.

Signature: _____ Date: _____

AZ Sports Medicine
Dr. Erik Dean & Dr. Amit Sahasrabudhe
Consents Form

Patient Name: _____ **Birth Date:** _____

Would you like a copy of the Notice of Privacy Practices? Declined ☐ Accepted ☐

Acknowledgement of Notice of Privacy Practices:
I have been offered a copy of the Notice of Privacy Practices. I understand that AZ Sports Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact AZ Sports Medicine at any time to obtain a current copy.

**Signature:_____ Date:_____

I may be contacted in the following manner (circle all that apply):

Ok to leave message with detailed information: Home Work Cell No

Ok to leave call back number only: Home Work Cell No

Ok to email to: _____

Authorization of Release of Health Information:
I authorize the following individual(s) to have access to my personal health information.
Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

Name:_____ Relationship:_____ Phone: _____

** Signature:_____ Date: _____

Workman's Compensation, if applicable
Insurance Carrier: _____ Claim #:_____ Date of Injury: _____

Address: _____ City:_____ State:_____ Zip:_____

Adjuster: _____ Phone:_____ Fax:_____

Nurse Case Manager: _____ Phone:_____ Fax:_____
