ARIZONA TRANSPLANT ASSOCIATES, PC
James L. Cashman, MD, FACS
Jeffrey A. Brink, MD, FACS
Willem J. Van der Werf, MD, FACS
Thomas Chaly, Jr., MD, FACS

2218 North Third Street
Phoenix, Arizona 85004-1401
Ph (602) 252-2543
Fax (602) 252-3861

(Office use only)

PATIENT ACKNOWLEDGEMENT OF POLICIES & PROCEDURES

PATIENT NAME:_____ DOB:_____

INITIAL EACH STATEMENT AND SIGN BELOW (**BLACK** INK ONLY)

1. _____ A photocopy of this acknowledgement shall be considered as effective and valid as the original.
2. _____ I hereby acknowledge that I have been presented with a copy of Arizona Transplant Associates, PC's **Notice of Privacy Practice** *(attached to clipboard)* and am entitled to receive a copy of the notice from the receptionist.
3. _____ I understand that if I do not have my insurance card, referral and/or co-payments that my appointment may be rescheduled until such time that I can provide the required documents or payments. **NOT APPLICABLE FOR ORGAN DONORS.**
4. _____ I understand this office requires all requests for confidential communication to be in writing; including medical record requests and disclosing information to family members or others. I can revoke these authorizations in writing at any time.
5. _____ I authorize the use of this signature on all claim submissions.
6. _____ I authorize Arizona Transplant Associates, PC to release any information necessary for the purpose of processing my insurance claims and securing payment of benefits to the insurance company.
7. _____ I authorize direct payment of medical benefits to Arizona Transplant Associates, PC for services rendered. **NOT APPLICABLE FOR ORGAN DONORS.**
8. _____ I understand that I am financially responsible for any services not covered by my insurance carrier, including co-pay(s), co-insurance, deductible(s), and/or non-covered services. **NOT APPLICABLE FOR ORGAN DONORS.**
9. _____ I authorize Arizona Transplant Associates, PC to initiate a complaint on my behalf to the Insurance Commissioner for any issues/problems with the insurance company. **NOT APPLICABLE FOR ORGAN DONORS.**
10. _____ If failure to pay co-pay(s), co-insurance, deductible(s), and/or non-covered services imposed by my insurance or other carrier, I agree to pay all collection costs (up to 50% of balance due), attorney fees, or any other collection fees that may be incurred to enforce collection of outstanding amount. **NOT APPLICABLE FOR ORGAN DONORS.**
11. _____ I understand that a $25 service fee will be added for any check(s) returned for any reason. I will be liable for payment of this fee plus the original amount of the returned check; payable by cash, credit card or money order. **NOT APPLICABLE FOR ORGAN DONORS.**

☆_____ _____ _____

PATIENT SIGNATURE (If patient is a minor, must have responsible party/guarantor sign) Relationship to patient if minor **Date**

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