ARIZONA TRANSPLANT ASSOCIATES, PC

SCANNED

(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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