NEW PATIENT REGISTRATION FORM

Today's Date: [Date]		**PCP:**	
Patient's Last Name:	**First:**	**Middle:**	**Marital status:**
Maiden Name:	**Date of Birth:**	**Age:**	**Select: Male ☐ Female ☐**
Address: [Address/ P.O Box, City, ST ZIP Code]		**Email:**	
Social Security No.:	**Home Phone No.:**		**Cell Phone No.:**
Occupation:	**Employer:**		**Employer Phone No.:**

Ethnicity & Race:

☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ American Indian/Alaska Native

☐ Native Hawaiian or Other Pacific Islander ☐ Non-Hispanic/Latino

PREFERRED PHARMACY: **PHONE:**

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth Date:**	**Group No.:**	**Policy No.:**

Patient's relationship to subscriber:

Name of Secondary Insurance (if applicable):	**Subscriber's Name:**	**Group No.:**	**Policy No.:**

Patient's Relationship to Subscriber:

IN CASE OF EMERGENCY

Emergency Contact #1:	**Relationship to Patient:**	**Home Phone No.:**	**Work Phone No.:**
Emergency Contact #2:	**Relationship to Patient:**	**Home Phone No.:**	**Work phone no.:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ARIZONA LIVER HEALTH or insurance company to release any information required to process my claims.

Patient/Guardian signature **Date**

Patient's name:

ARIZONA LIVER HEALTH™

Allergies
Medical Conditions
Prior Surgeries & Hospitalizations

Medications	For	Dose	Frequency

Patient's name: _____

Notice of Health Information Practices

Arizona Liver Health participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information.

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

_____ ____/____/____

Signature of Patient or Personal Representative *Date:*

_____ ____/____/____

Printed Name of Patient or Personal Representative *Date:*

Notice of Research Database Practices

***Arizona Liver Health** participates in a research database in a service as a software (saas) named CRIO managed by the Institute for Liver Health (ILH). It will not cost you anything and will be utilized to find possible clinical trials that may benefit the participant by securely sharing their health information.*

I acknowledge that I received information regarding the research database functionality. I understand that my health information may be securely shared to the research database and will be utilized to find potential clinical trials that I may participate in. I acknowledge that health information may be updated in the research database until I decide to opt out of participation in it (previous health information gathered in the research database prior to opt out will be kept).

_____ ____/____/____

Signature of Patient or Personal Representative *Date:*

_____ ____/____/____

Printed Name of Patient or Personal Representative *Date:*

Patient's name: _____

ARIZONA LIVER HEALTH™

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____ Contact Number _____

Patient Mailing Address: _____ City _____ State _____ Zip code _____

I hereby authorize: _____ _____
(Provider, Hospital, Urgent Care, etc.) Fax

Address _____ City, State & Zip Code _____ Phone _____

To release information to:

Arizona Liver Health
2201 W Fairview Street, Ste
Chandler, AZ 85224
Phone: 480-470-4000| **Fax: 480-686-8875**

☐ For the following purpose: _____

OR

☐ All Records

Medical Records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

☐ **I DO** authorize the release of this type of information.

☐ **I DO NOT** authorize the release of this type of information.

I understand that:

- I may revoke this authorization, except to the extent that it has already been acted upon.
- Treatment will not be conditioned on my providing this authorization unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization for my personal records.

Patients: This form allows our office to request medical records on your behalf from other physicians, hospitals, and care providers to better coordinate your care. Please fill out the form to the best of your ability. Please make sure to sign and date form.

_____ _____

Patient Signature or Personal Representative of Patient Signature Date

Patient's name:

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arizona Liver Health (ALH) is committed to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our Practice and outlines your rights regarding your health information. Please sign this form below to acknowledge that you have received our Notice of Privacy Practices. A copy of our Notice of Privacy Practices can be found on our website at www.azliver.com under Privacy Policy or displayed inside the Clinic.

I acknowledge that I have received/reviewed a copy of the Notice of Privacy Practices of Arizona Liver Health.

Printed Name of Patient or Personal Representative	Date
Signature of Patient or Personal Representative	Date

Patient's name: _____

ARIZONA LIVER HEALTH™

HIPAA Protected Health Information Form

Name:_____ DOB:_____

I_____authorize Arizona Liver Health to release and/or discuss protected health information pertaining to my care to the below listed individuals. I realize that if I've listed an emergency contact on my registration paperwork, and I want them to have access to my protected health information, I must list them below. I also understand I may revoke access to the listed individuals at any time. I also understand the withdrawal must be in writing.

Name/ Relationship/ Telephone Number

1. _____
2. _____
3. _____
4. _____

☐ I **do not** authorize my medical records to be released or discussed with anyone.

_____ _____

Signature of Patient or Legal Representative Date

ARIZONA LIVER HEALTH™

APPEALS AND PRIOR AUTHORIZATIONS

I authorize Arizona Liver Health to file a prior authorization on my behalf for any medications, labs, procedures, etc. I also authorize Arizona Liver Health to make an appeal on my behalf due to a denied determination from my insurance company. I realize that this authorization is good for one year from signature date. If at any time I have questions, I will contact Arizona Liver Health to discuss.

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Patient Financial Responsibilities: We will bill your primary insurance company and any secondary insurance as a courtesy to you. To properly bill your insurance company, you must timely and accurately disclose all insurance information, including primary and secondary insurance plans, as well as any change of insurance information. Failure to provide timely, accurate and/or complete insurance information may result in you being responsible for the entire bill.

Copayments, Coinsurance, and Outstanding Balances: Copayments, coinsurance, deductibles and balances not covered by insurance are due prior to or at the time services are rendered. Inability to pay at the time of service may result in having to reschedule your appointment. Payment can be made by check, cash, MasterCard, VISA, and Discover.

Account Balances: Our billing office will notify you of any outstanding balances through the following communication formats (email, text, and/or US Postal Service). This will contain all account activity including our charges, payments and contractual adjustments from your insurance carrier along with payments made by you. Please be aware that you will be charged a returned check fee for all payments, made by a personal check, that have been returned by your banking institution for any reason. Please note that failure to pay outstanding balances that are your responsibility may result in having to reschedule future appointments until the balances are paid in full. In addition, any unpaid delinquent balance may: (a) delay scheduling of future appointments; (b) result in your account being forwarded to a collection agency or collection attorney of our choice; (c) reporting you to one or more third-party credit reporting agencies.

Referrals: Certain insurance plans require referrals to see a Specialist. It is your responsibility to obtain a referral from your primary care physician. Referrals must be presented at the time services are rendered, if applicable. As a courtesy, we will make efforts to obtain referrals and prior authorizations on your behalf. If you need to have a referral faxed to us, our office will provide you with our fax number. If your insurance plan requires you to have a referral or other authorization, and you fail to provide that to us, your appointment will be rescheduled or your claim for that date of service will be processed via optout benefits, if applicable.

For self-pay patients, payment is due at check-in. The account balance is expected to be paid in full.

Patient Authorizations: By my signature below:

- I hereby authorize ALH and the physicians, staff, labs and facilities associated with ALH to release necessary medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and/or other physicians or healthcare entities required to participate in my care.
- I hereby assign my financial benefits directly to ALH for all items and services rendered by or on behalf of ALH, to the maximum extent permitted by law. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Agreement:

X_____ X_____

Printed Name of Patient Date of Birth

X_____ X_____

Signature of Patient or Guardian Date