ARIZONA PERFORMANCE
SPORTS MEDICINE & ORTHOPAEDICS

Patient Information Form

PATIENT INFORMATION

Patient's Full Legal Name (Last, First, MI)	Date of Birth	Sex M / F	Social Security Number

Home Street Address	City, State, Zip Code

Home Phone ( )	Mobile Phone ( )	Work Phone ( )

Primary Contact Number: Circle One Home / Work / Mobile	Email Address (If Minor, indicate Guardian's)

Patient's Marital Status: Circle One   Married / Single / Other

May we leave medical information on your primary contact voicemail? YES / NO

RESPONSIBLE PARTY INFORMATION

Garantor's Full Legal Name (Last, First, MI)	Date of Birth	Sex M / F	Social Security Number

Home Street Address, City State, Zip Code	Phone Number

EMERGENCY CONTACT

Name	Relationship	Phone Number ( )

EMPLOYMENT

Employment Status: Circle One Full Time / Part Time / Unemployed / Disabled / Retired / Student	Occupation

Employer (Name, Address, Phone)

PHARMACY

Name of Pharmacy	Phone Number ( )

Address or Cross-Streets

PRIMARY CARE PHYSICIAN OR PEDIATRICIAN

Name of Primary Care Physician / Practice Name	Phone Number ( )

City, State, Zip

May we speak to someone other than yourself regarding your treatment? YES / NO

Name	Relationship

Are you the primary policy holder? YES / NO If you are not the subscriber, please fill out the following information.

Subscriber's Full Name	Sex M / F	Date of Birth	Relationship to Insured: Circle One Spouse / Child / Other

Subscriber's Employer	Subscriber's Social Security Number

William M. Meszaros, M.D., P.C.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

William M. Meszaros, M.D., P.C. is dedicated to maintaining the privacy of your personal health information. Each time a patient visits this office, a record is made that describes the treatments and services provided. Federal law outlines specific privacy protections and individual rights related to the information we maintain that identifies you as a patient. Protected information includes demographic data and facts about your past, present, or future physical or mental health. Our office has put in place policies and procedures to help protect your health information. We are required to provide this notice outlining our legal duties and responsibilities related to the use and disclosure of patient identifiable health information, Privacy Practices, and examples of how your information may be used or disclosed.

Practice will abide by the terms of this notice. We may revise this notice at any time. The new notice will be posted in our office in a prominent location. You can request a copy of our most current notice at any time. Revisions to the notice will be effective for all health care information this office maintains: past, present, or future.

Practice may use your individually identifiable health information for the following purposes without your authorization:

1. **Treatment**: We may use and disclose your identifiable health information to treat you and assist others in your treatment. For instance, we may send a copy of your records to another doctor so that you can be evaluated for a specific condition, or we may disclose information to others who take part in your care, such as your spouse, children, or parents.
2. **Payment**: We may use your health information to bill and collect payment for services provided. This may include providing your insurance company with the details of your treatment, sharing your payment information with other treatment providers, contacting you over the phone or through the mail about balances, or sending unpaid balances to a collection agency.
3. **Health Care Operations**: We may use and disclose health information to operate our business. For example, your health information may be used to evaluate the quality of care we provide, for state licensing, or to identify you by name when you visit the office.
4. **Appointment Reminders**: We may use and disclose your information to remind you of appointments. We may also mail you a reminder for follow-up visits.
5. **Treatment Options**: We may use your health information to inform you of treatment options or other health-related services we offer that may be of interest to you.
6. **Business Associates**: We may share your health information with other individuals or companies that perform various activities for, or on behalf of, our office such as after-hours telephone answering, billing, or quality assurance. Our Business Associates agree to protect the privacy of your information.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect, or domestic violence.
- To health oversight agencies.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner, or funeral director.
- For the facilitation of organ, eye, or tissue donation if you are an organ donor.
- For research purposes under strictly limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

YOUR HEALTH RECORD IS THE PHYSICAL PROPERTY OF PRACTICE. THE INFORMATION CONTAINED IN IT BELONGS TO YOU. BELOW IS A LIST OF YOUR RIGHTS REGARDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. ALL REQUESTS RELATED TO THESE ITEMS MUST BE MADE IN WRITING TO OUR PRIVACY OFFICER AT THE ADDRESS LISTED BELOW. WE WILL PROVIDE YOU WITH APPROPRIATE FORMS TO EXERCISE THESE RIGHTS. WE WILL NOTIFY YOU, IN WRITING, IF YOUR REQUESTS CANNOT BE GRANTED.

1. **Restrictions on Use and Disclosure**: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of your health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. **Confidential Communications**: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. **Access**: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy your records. You may request a review of this denial.
4. **Record Amendment**: You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement.
5. **Accounting of Disclosures**: You have the right to receive an accounting of disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. **Copy of Notice**: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have questions about this notice, please contact Practice's Privacy Officer at William M. Meszaros, M.D., P.C.; or PRACTICE PHONE. If you feel your privacy rights have been violated, you have the right to file a written complaint with our office. You may also file a complaint with the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint.

I have received a copy of this office's Notice of Privacy Practices that outlines how patient confidential information will be used, disclosed, and protected.

______________________________	______________________________
Printed Patient Name	Name/Relationship if Signed by Individual Other than Patient
______________________________	______________________________
Signature	Date

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of this Notice of Privacy Practices but could not because:

_____ Individual Refused to Sign _____ Communication Barrier _____ Care Provided was Emergent

_____ Other: ____

Employee Name Date

Financial Policy

IT IS YOUR RESPONSIBILITY AS A PATIENT TO KNOW AND UNDERSTAND YOUR INSURANCE COVERAGE.

All co-payment or co-insurance amounts are due in full at the time of your visit

A fee of $50 will be assessed for any missed appointment without notifying our office beforehand. This is so we may be able to schedule another patient in need of care.

Procedures performed during the visit, such as injections and fracture care, are typically not covered by your office visit co-pay . Any additional deductible or co-insurance amounts for these services will be estimated and are due at checkout. Any overpayment/underpayment will be refunded/billed once billing to your insurance has been completed.

We require a deposit for all braces provided in the office.

If surgery is scheduled, any deductible or co-insurance will be estimated and due before the procedure is performed. **This amount is an estimate and may change depending on the findings during surgery.** Any overpayment/underpayment will be refunded/billed once billing to your insurance has been completed.

Self-pay patients are required to pay a $200 deposit ($350 deposit for fractures) before the office visit. We will then reconcile the difference at checkout.

A fee between $10 and $50 will be charged for copies of medical records and completion of any/each disability, FMLA, or outside work status forms. A work restriction form generated by the office system will be provided free of charge.

Most fractures are billed as a procedure/surgery and include any initial casting/splinting (excluding cast supplies) and follow-up care for 90 days. Any additional casting/splinting or visits for other reasons are billed separately and may involve another co-payment or co-insurance amount.

A $35 service fee will be added to all returned checks.

Any unpaid balances over 90 days past due are subject to being sent to a collection agency.

If you have any questions regarding the above policy, please ask our staff. We can make financial arrangements if necessary.

I have read and understand this office policy:

Printed Name: ______________________________________

Signature: ____ Date: _______________