ARIZONA HEMORRHOID & ANORECTAL CENTER
AT SONORAN SURGICAL

Patient Information

****Please write your name EXACTLY how it is shown on your insurance card****

Last Name_____ First Name_____MI_____ Date of Birth _____

Gender ☐Male ☐Female Marital Status: ☐Married ☐ Single ☐Divorced ☐Separated ☐Domestic Partnership

Address_____ City_____State_____Zip_____

Primary Phone:_____**Circle** (Home, Mobile, Work) Secondary Phone_____**Circle** (Home, Mobile, Work)

Email Address_____

Occupation_____ Employer_____ Phone _____

MEDICAL PROVIDERS:

Primary Care Provider: _____ Phone:_____

Referring Physician: _____ Phone: _____

PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Phone: _____

Pharmacy Address (Cross Streets) _____

PRIMARY INSURANCE

Primary Insurance_____Phone_____

ID #_____ Group #_____

Guarantor(Policy Holder) _____ Relationship to Patient_____ Date of Birth_____

SECONDARY INSURANCE (IF APPLICABLE)

Primary Insurance_____Phone_____

ID #_____ Group #_____

Guarantor(Policy Holder) _____ Relationship to Patient_____ Date of Birth_____

EMERGENCY CONTACT

Name _____ Phone_____ Relationship _____

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Date_____

Name_____

Date of Birth _____

Referring Physician_____

Chief Complaint

_____

_____

_____

Medication Allergies	Reaction

Social/ Personal History	
Tobacco	Never____Former____Current____
If Current, how often?	
Alcohol	Never____Former____Current____
Drug Use	Never____Former____Current____
Pregnant	Yes_____ No_____

Past Medical History	Yes	No
Heart Disease		
Hypertension		
High Cholesterol		
Diabetes Type: _____		
Stroke/ TIA		
COPD		
Cancer: _____		
Bleeding Disorder		

Family Medical History	Illness
Father Living_____Deceased_____	
Mother Living_____Deceased_____	
Siblings How Many_____	

Surgical History	Date

Please check any of the following that has occurred in the past ye

	Yes	No		Yes	No
Headaches			Incontinence		
Vision Changes			Depression		
Hearing Loss			Chest Pain		
Shortness of Breath			Anxiety		
Cough			Bleeding Problems		
Stomach Ulcer			Chills		
Blood in Stool			Fever		
Diarrhea			Loss of Appetite		
Constipation			Night Sweats		
Bladder/ Kidney Infection			Skin Rash		
Joint Pain					
Stiffness					
Swelling					
Dizziness					
Thyroid Disease					
Anemia					

Date of Last Colonoscopy: _____

Current Medication	Dose
Blood thinners (aspirin, Plavix, Eliquis, Xarelto, etc):	

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Office Policies and Patient Consent Form

_____ **Insurance**
Initial

Proof of Insurance: You must provide a copy of your driver's license and current valid insurance card to provide proof of insurance. If you are covered by a participating plan, but you are either missing an updated insurance card or you cannot provide the policy and group numbers, you will be required to pay for your visit in full until our office is able to confirm your coverage. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If you are not insured by a participating plan, payment in full is expected at each visit (i.e., self pay).

Non-Covered Services: Knowing your insurance benefits is your responsibility. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by your insurers. You will be billed for these services. Please contact your insurance company with any questions you may have regarding your coverage.

Change in Insurance Plans: You are expected to notify our office if your insurance coverage changes. We will ask you to update your record at each visit to our office. It is also your responsibility to notify the office immediately of these changes.

_____ **Co-Payments, Co-insurance, Deductibles and Account Balances**
Initial

Co-payments, co-insurance, deductibles, balances, and services not covered by your insurance are due at the time services are rendered. If you are on a high deductible plan, we will collect **$160 for new patients**, **$100 for established patients,** and possibly additional fees (for other in-office procedures) that will go towards your deductible.

Please be aware that if a balance remains unpaid after 3 notices, we will refer your account to a collection agency or our attorney. The patient or guarantor will be responsible for all costs of collection including legal fees, and collection fees.

_____ **No-Shows, Cancellations and Rescheduled Appointments**
Initial

Our office requires a **24-hour notice** for any cancellations/re-scheduled office appointments and a **5-business day notice** for procedures/operations (including colonoscopy). **Failure to provide the 5-business day notice for procedures/operations will be subject to a $100 fee.**

_____ **Disability and FMLA Paperwork**
Initial

The office charges **$35** to complete medical forms. Payment is due at the time that you pick up these forms. If you would like the forms mailed or faxed, payment will be due first.

_____ **Dismissal Policy and Process:**
Initial

If you are "dismissed" from the practice, it means you are no longer our patient. We will send a letter to your last known address, via certified mail, notifying you of your dismissed status. If you have a medical emergency within 30 days of the date on the dismissal letter, you may still see our providers. After that, you must find another doctor and we can help provide a list of other similar doctors in the area. We will forward a copy of your medical record to your new doctor upon receipt of a signed release form.

_____ **AUTHORIZATION FOR CELLULAR DEVICE SMS TEXT MESSAGES, EMAILS, and PATIENT PORTAL .**
Initial

Our practice uses text message, email, and the patient portal to communicate with patients for a variety of purposes including confirmations, appointment reminders, treatment information, billing information, and request for feedback about your experience. No transmission system is perfect, and we will do our best to maintain electronic security. By initialing above and signing below, I certify I am the owner of this cellular device and its contract and give permission to the office to do the above. I understand that this information is confidential and that it is my responsibility to maintain this privacy on my device. I can revoke consent at any time.

Acknowledgement: I acknowledge that I have read and agree to the office policies.

_____ _____
Patient/Guarantor Name (please print) Relationship (if applicable)

_____ _____
Signature of Patient/Guarantor Date

Thank you for understanding our office policies. Our goal is to provide you with excellent care! We are excited you chose AZ Hemorrhoid & Anorectal Center!

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it has been cancelled.

If there are any changes to your payment card preference, please notify us to fill out a new form.

Credit Card Information
Card Type: ☐VISA ☐Mastercard ☐Discover ☐AMEX ☐Other _____
Card Holder Name (as shown on card): _____
Card Number: _____
Expiration Date: _____/_____
Billing ZIP Code: _____
CVC: _____

I authorize **Sonoran Surgical Specialists** to charge my credit card above for agreed upon amount towards my account balance. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(Please Print Name)

Signature: _____ Date: _____

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AALOK K. SAHAI, M.D.
ROHIT K. SAHAI, M.D.
PAUL TENDER, M.D.
963 N McQueen Road
Chandler, Arizona 85225
Office: 480-646-8440 Fax: 480-646-8441

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that Sahai Surgical Specialists release my medical records to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I hereby authorize and request my medical records to be released to Sahai Surgical Specialists from:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax:** _____

I authorize to release the following information:

☐ History & Physical ☐ Lab Reports ☐ XR/MRI/CT Scan/EMG ☐ Discharge Summaries
☐ Operation/Pathology Reports ☐ Medication Profile ☐ All Available Records

Patient Name: _____ DOB: _____
Print Name Please

Patient Signature: _____ Date: _____

When requesting release of records, please allow us 7-10 days for processing – Thank you