Arizona Community Physicians

Patient Information

FIRST NAME | MIDDLE | LAST NAME | ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE # | EMERGENCY CONTACT NAME / RELATION

DOB (/ /) | SEX | MARITAL STATUS | PAGER | RACE (optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | PREVIOUS NAME

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE #

Billing Information
(If Different Than Patient)

FIRST NAME | MI | LAST NAME | ADDRESS | CITY | STATE | ZIP | PHONE #

Primary Insurance Information

INSURANCE NAME | **EFFECTIVE DATE** | **MEDICAL CLAIMS ADDRESS**

GROUP I.D. # | **POLICY I.D. #** | **RELATIONSHIP OF PATIENT TO SUBSCRIBER** (SELF SPOUSE CHILD OTHER)

SUBSCRIBER NAME (POLICY HOLDER) | **SUBSCRIBER ADDRESS (if different than patient)** | **SUBSCRIBER PHONE (if different than patient)**

SUBSCRIBER DATE OF BIRTH | **SUBSCRIBER SEX** | **SUBSCRIBER SSN #** | **CO-PAY AMOUNT**

SUBSCRIBER EMPLOYER | **EMPLOYMENT ADDRESS** | **EMPLOYER PHONE #**

Secondary Insurance Information

INSURANCE NAME | **EFFECTIVE DATE** | **MEDICAL CLAIMS ADDRESS**

GROUP I.D. # | **POLICY I.D. #** | **RELATIONSHIP OF PATIENT TO SUBSCRIBER** (SELF SPOUSE CHILD OTHER)

SUBSCRIBER NAME (POLICY HOLDER) | **SUBSCRIBER ADDRESS (if different than patient)** | **SUBSCRIBER PHONE (if different than patient)**

SUBSCRIBER DATE OF BIRTH | **SUBSCRIBER SEX** | **SUBSCRIBER SSN #** | **CO-PAY AMOUNT**

SUBSCRIBER EMPLOYER | **EMPLOYMENT ADDRESS** | **EMPLOYER PHONE #**

I consent Arizona Community Physicians (ACP) to use and disclose my protected health information for psychiatric care, substance abuse, and HIV/AIDS for carrying out treatment, payment, and healthcare operations. ACP has offered me a copy of their privacy policies.

I assign all medical/surgical benefits to ACP for services rendered. I confirm all demographic and insurance information is current and correct. If not, I understand I will be responsible for all charges incurred today.

Effective Sept. 1, 2009 personal balances over sixty (60) days will be assessed a 1% per month finance charge. Balances written off to bad debt or to a collection agency will be assessed a one-time 30% finance charge.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Person giving consent | Relationship if not the patient | Date

AZCO-107 REV. 6/16