arizona gastrointestinal associates

Michael S. Shapiro, MD FACG, AGAF
Lina Kay, PA-C
10181 N 92nd Street, Suite 101 Scottsdale, AZ 85258
P (480) 657-3400 F (480) 657-3550

Last Name: _____ First: _____ M: _____

Date of Birth: _____ Sex: F M SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____

Cell: _____ Fax: _____

Email: _____

Contact preference where we may leave personal and health information: Home Cell Email Fax

Employer Name: _____

Race: _____ Ethnicity: _____ Language: _____

Marital status: Single Married Divorced Separated Widowed Civil Union Declined

Referring: _____ Primary : _____ Cardio: _____

Pharmacy (name, #, cross streets): _____

Emergency contacts or who may receive information regarding your Protected Health Information:

Name: _____ DOB: _____ Phone: _____

Name: _____ DOB: _____ Phone: _____

Information sharing: Please initial/sign

HIPPA privacy policy received/reviewed
YES NO _____

I consent to having my medical and demographic information shared with other health care entities

YES NO _____

I consent to obtaining a history of my medications purchased at pharmacies

YES NO _____

Date: _____ Signature: _____

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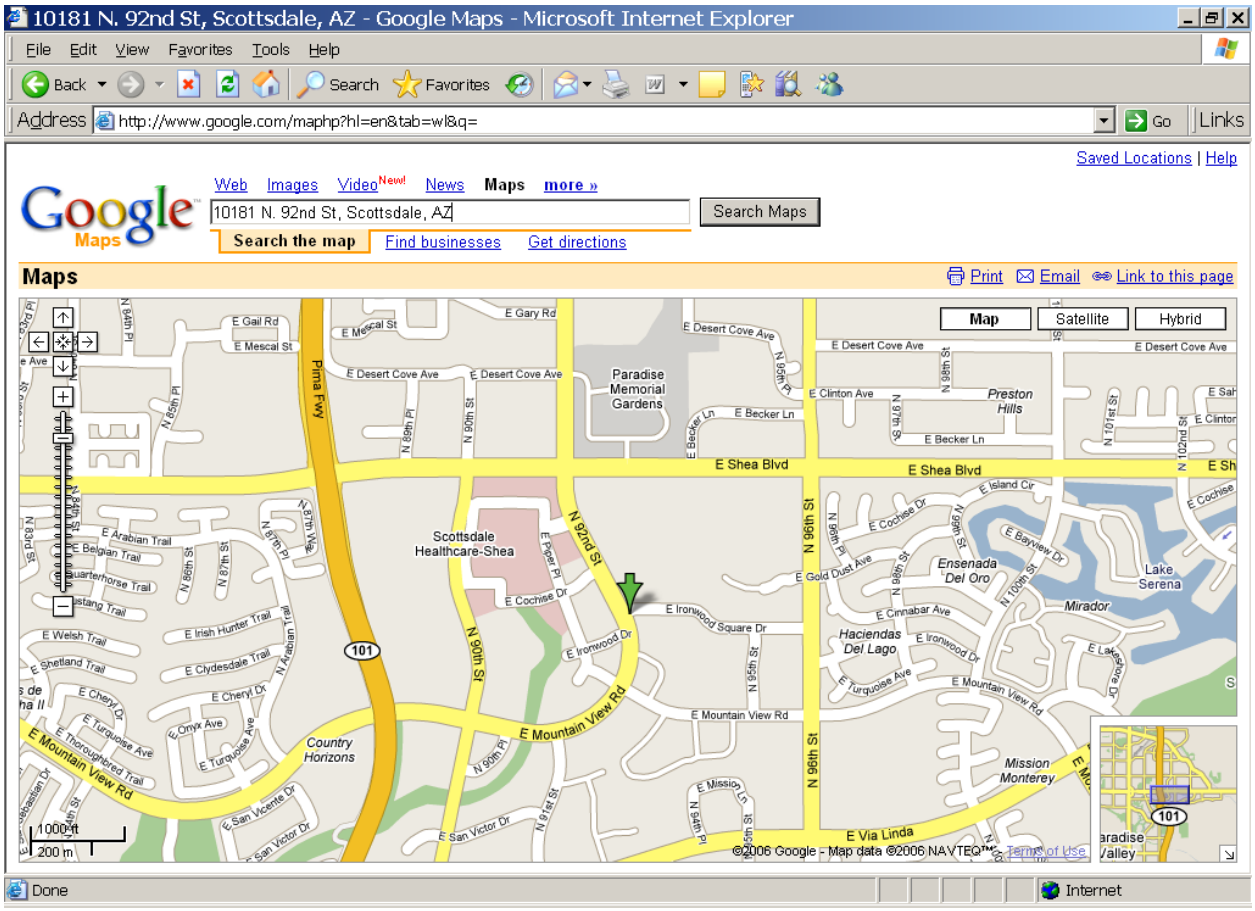

From Shea Blvd:

Go south on 92nd Street

Take the 3rd Left from 92nd Street into the Ironwood Square Parking lot.

Once you turn into our parking lot, you will see the Caremark bldg on the right and the Ironwood Office Complex on your left, bear left into our parking lot and we are the 4th bldg in from 92nd St on your left.

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FINANCIAL POLICY

Please bring your insurance card to every visit. Without proof of insurance coverage, we are unable to bill your insurance carrier, and you will be responsible for the charges. Payment will be due at the time of service.

Patients will not be seen if co-pays are not paid at the time of the visit. We do not bill co-pays. If your insurance deductible has not been met, full payment will be collected at the time of service for office visits and deposits will be required before procedure scheduling. If you have no insurance or an insurance that we do not participate with, full payment is expected at the time of service.

Once an account is placed in collection status, Dr. Shapiro will no longer participate in your GI care. All financial correspondence must go through the collection agency.

Any office appointment cancellations must be done no later than one business day prior to your appointment. If you cancel on the day of your appointment, or if you do not show for an appointment, you will be charged $25.00 as a late-cancellation or no-show fee; $100 fee for procedures; $25 fee for medical records; $10 fee for misc paperwork to be filled out (i.e. work notes, FMLA, disability, etc…)

I agree to pay for any and all medical services I receive from the doctors/providers of Michael S. Shapiro, MD PLLC and division of Arizona Gastrointestinal Associates. This office will file a claim on my behalf; however, if my insurance company denies payment for any reason (i.e., non-covered preventative medicine visits, pre-existing conditions), I will be responsible for payment.

I hereby authorize payment of medical benefits billed to my insurance to Dr. Michael S. Shapiro and hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

I understand that this office can only code for my visit(s) with a diagnosis that was encountered and documented in my medical record. To ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

I agree to and understand all above stated policies, charges and fees.

Date: _____ Signature: _____

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (HIPPA)

I, _____, hereby authorize Dr. Michael S. Shapiro and mid-level providers to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Michael S. Shapiro can refuse to treat me.

I have been informed that Dr. Michael S. Shapiro has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Dr. Michael S. Shapiro, in writing, but if I revoke my consent, such revocation will not affect any actions that Dr. Michael S. Shapiro took before receiving my revocation.

I understand that Dr. Michael S. Shapiro has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Dr. Michael S. Shapiro restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Dr. Michael S. Shapiro does not have to agree to such restrictions, but that once such restrictions are agreed to, Dr. Michael S. Shapiro must adhere to such restrictions.

Date: _____

Signature of patient: _____

Date revoked: _____

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT: _____D.O.B:_____

I AUTHORIZE THE OFFICE OF DR. MICHAEL SHAPIRO AND LINA KAY, PA-C TO:

_____ Obtain medical information **FROM**… (Below)

AND/OR

_____ Release information **TO**… (Below)

ORGANIZATION/AGENCY: _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

DATES OF SERVICE REQUESTED: _____TO_____

I HEREBY CONSENT THE RELEASE OF MY MEDICAL INFORMATION:

_____ALL RECORDS

_____X-RAY REPORTS

_____LABORATORY/PATHOLOGY REPORTS

_____PROCEDURES/SURGERIES

I understand that this authorization shall not expire without my express revocation in writing. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

SIGNATURE OF PATIENT: _____

RELATIONSHIP (IF NOT PATIENT: _____

DATE:_____