

Name		Date of Birth	Gender (circle one) Male · Female
Address	City	State	Zip Code
Home Phone	Cell Phone	Social Security No.	
Marital Status (circle one) Single · Married · Divorced · Widow · Legally separated · Partner		E-mail Address*	
Employer	Work Phone		
Emergency Contact	Relationship	Emergency Contact Phone	
Referral Source (circle one) Family/Friend · Web Site · Insurance Company · Radio/TV · Physician · Newspaper/Magazine · Electronic Newsletter · Search Engine			
Responsibility Party Name (if patient is under 18 OR other than patient)			
Address/City/State/Zip		Social Security No.	
Phone	Date of Birth	Employer Name & Phone No.	
Who may we thank for referring you?			
Pharmacy	Location	Phone	
Persons/Relatives who may receive information regarding my medical records and / or test results 1. 2.		Phone	
Messages may be left at: (circle one or more) HOME WORK CELL			
Primary Insurance Carrier			
Policyholder Name (if other than patient)		Social Security no	
		Date of Birth (of policy holder)	
ID/Policy No	Group No	Primary carrier Phone	
Secondary Insurance		Phone	
Policy holder name(if other than patient)		Social security no	
ID/Policy No	Group #		

Please allow us to copy your insurance cards

I authorize my insurance company to pay directly any and all claims submitted from Thompson Peak Internal Medicine, Gary A. Betz, II, MD. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

Signature** _____ Date _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

* My signature on this document allows Thompson Peak Internal Medicine, LLC to communicate to me via my e-mail address.

** My signature on this document allows Thompson Peak Internal Medicine, LLC to request copies of any and all medical records from any source pertinent to my medical care.

I acknowledge that the office's Notice of Privacy Practices has been made available to me

Signature _____ Date _____



Patient Insurance-Financial Responsibilities Notification

To all patients:

Thompson Peak Internal Medicine, LLC the office of Dr. Gary Betz, commonly requests blood work or consultation with other specialists regarding your care. For those of you who have limitations in terms of managed care programs, or insurance contracts with laboratories or imaging facilities, it is your responsibility to make sure that the laboratory or imaging facility which is used is proper for your coverage, or make sure that necessary insurance authorization is obtained before your consultation, lab work or diagnostic testing.

Although we make an effort to try to make sure our referrals and orders are in accordance with the individual patient's health plan, we cannot take responsibility for this.

For those who have Medicare and other insurances, we attempt to provide the coding necessary for Medicare and insurances to cover your blood work, but it is not always possible that blood work ordered is covered by Medicare or insurance. We make no representation that we can guarantee insurance coverage, and will not accept any responsibility for payment of laboratory or diagnostic imaging charges. If you decide that you do not wish to have diagnostic studies or laboratory tests performed which are recommended by our physicians, because of insurance coverage, that responsibility is yours, including responsibility for failure to diagnose a disease which otherwise would have been found.

It is regrettable that we have to issue this letter, but "circumstances" with today's complex insurance / Medicare rules and regulations require this. Please contact the office if you have any questions.

Sincerely,

The office staff of Thompson Peak Internal Medicine

I have read and understand the above.

Patient: _____

Date: ____/____/____



FINANCIAL AGREEMENT
Gary A. Betz, II, MD

We're dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with our office manager.

Our office understands the value of insurance benefits, as a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. Your insurance policy is an agreement between you and your insurance carrier; therefore, all patients are directly responsible for all charges. It is a patient's responsibility to be aware of their benefits. If you are unclear of your insurance benefits you will need to contact your insurance carrier for clarification of coverage. Exclusions, pre-existing conditions and terminated benefits nullify insurance coverage and transfer full responsibility to the patient.

In the event of default, legal interest on the indebtedness, collection costs (which could be as much as an additional 50%) and related attorney fees will be added. All returned checks are subject to a \$50.00 fee plus the original amount of the check. Failure to notify this office of the need to cancel or reschedule an appointment 24 hours in advance of the appointment is subject to a \$50 no show fee. These fees are not reimbursable by insurance.

Any and each office visit, including but not limited to: appointments with physicians, nurse/medical assistant visits, blood draws in the office, vaccinations, and blood pressure checks- will require a co-pay charge if your insurance has co-pays.

Due to tardiness by insurance carriers to service claims submitted by physicians, please read the following information.

In order to promote/sell an insurance product to Arizona residents, your insurance carrier is regulated by Arizona State Statutes. We agree to bill your insurance carrier, under our contract obligation and in a timely fashion. (Dependent on patient supplying correct/current insurance coverage information.)

"Per Arizona State Statutes, Title 20-462...payment or formal denial must be received within 30 days of the stated claim..."

If your insurance company does not respond in a timely fashion a "Statement" will be released to you. Upon receipt of this "Statement" we suggest that you contact your insurance carrier and request that they process your claim.

Should you receive any correspondence from your insurance company in regards to services in this office you must respond to that correspondence immediately, in order to have the claim processed and paid. Any balance outstanding at sixty (60) days is the patients responsibility.

It is necessary that you understand, as physicians, the doctors must remain primarily interested in furthering "Your Good Health." Your responsibility is providing correct billing information, including all changes and updates that take place, with either your insurance carrier or your personal billing information. The primary insurance contract is between yourself and/or your spouse, and/or an employer group coverage carrier. In signing this agreement you accept financial responsibility for your treatment.

Patient Signature

Date

Patient Name (Print clearly)