AZ GOOD HEALTH CENTER
INTEGRATIVE MEDICAL CARE

First Appointment:

Date:		at	Time:	☐ AM ☐ PM

Deborah M Murphy, PA-C
$300 Intermediate Initial Evaluation

We accept cash, checks, Master Card, Visa, and Discover Card

We reserve large segments of time for your initial evaluation. **If, for any reason, you need to cancel your appointment, we request to be notified at least three business days (Monday through Friday) prior to the date of your appointment.** If you cancel earlier than three business days prior to the appointment, and choose not to re-book, you will not be charged. If you choose to cancel *AFTER* the cancellation date, we will charge 50% of the initial evaluation fee. When you reschedule, this charge is applied to your future appointment. If you neither call to cancel nor show up at your appointment, half the cost of the initial appointment is charged, and you are welcome to re-book for a future date.

I understand the cancellation policy, I am aware of the charges for initial evaluation, and I accept this policy.

X_____

Patient (or Guardian) Signature

2055 E Southern Ave Suite B Tempe Arizona 85282 Phone 480-704-7446 Fax 480-699-4775

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PAYMENT IS REQUESTED THE DAY OF FIRST VISIT.

Financial Policy

Our main concern is that you and your family receive the proper and optimal treatment needed to restore you to health.

- Your insurance policy is a contract between you, your employer and the insurance company. All charges are ultimately your responsibility.
- Not all services are a "covered benefit" in all contracts. Some insurance carriers arbitrarily select certain services which they will not cover – among them often the majority of complementary and preventive medical treatments.
- Payment for goods and services rendered is expected at the time of service. **Refunds are not issued**, however a credit may be applied on a case-by-case basis.
- For those scheduling multiple treatments per week, payment is expected at the beginning of the week for which the treatments are planned.
- IV Appointments must be cancelled 24 hours prior to the appointment. Monday appointments must be cancelled by phone the Thursday of the previous week. There is a 50% fee if the IV has already been prepared at the time of cancellation.

Cancellation/no-show policy: **a 24-hour cancellation policy is in effect**. If you miss an appointment **without calling ("no-show"), or fail to call 24 hours in advance, the full amount of the visit is charged.** Please call the office at (480) 240-2600 if you need to reschedule an appointment. Please note that these fees are payable before your next appointment is scheduled.

Emergency medical phone consultations are charged at the same rate as office visits.

E-mails and phone calls: We are happy to answer brief e-mail questions or phone calls. **More extensive questions, or questions which require a change in treatment, will be considered an office visit or phone consultation, and will be charged accordingly.** Any calls relating to a visit within the previous 2 days, or scheduled within the next 24 hours, are not charged. Please keep emails to a minimum**, Emails are charged as an office visit.**

Prescription refills:. An office visit will be required if a change in dosage or frequency is required. All patients requesting refills must have an office visit at least once per year.

We understand that temporary financial issues may affect timely payment of your balance. We encourage you to communicate any such issues to the staff, so that we may assist you in the management of your account. I have read the above financial policy, and I accept financial responsibility for my medical treatment.

I recognize that some of the services rendered to me may not be covered by insurance, and I accept full responsibility for making such payments.

X _____

Patient (responsible party) signature

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Insurance Policy

AZ Good Health does not accept payment from insurance companies. We prefer to have a direct relationship with our patients and give you (and not your insurance company) the chance to make the final decision as to what treatments you or your child is "allowed" to have.

Once services have been rendered; we provide a detailed invoice for testing services. This detailed invoice may aid in seeking reimbursement from your healthcare insurance carrier (Please note that we do not participate with the US Medicare nor Medicaid programs, and they will NOT reimburse you for our services). Although we can neither guarantee nor predict coverage of services by your health insurance carrier, all invoices accepted by insurance companies require current procedural terminology (CPT) codes as well as diagnosis (ICD-9 or ICD-10) codes; we highly recommend using a third party biller, to help you with insurance forms and to deal directly with your insurance carrier – a third party biller will probably be able to get you better reimbursement than if you try to do it yourself. We do not bill insurance nor accept insurance assignment, ***nor do we respond to insurance inquiries regarding clinical notes, patient history, evaluation, or other such information****. We will pass these inquiries on to you, if we receive them. Thank you*

Please note that we frequently receive letters from insurance companies requesting records or different diagnosis codes, different CPT codes and additional information. We will give this additional information to you to submit to your insurance company; however, we will not send the information directly to the insurance company. You may wish to use a third party biller for your dealings with your insurance company. We are happy to make a recommendation.

I understand and accept the above insurance policy and terms of payment for services rendered.

X _____

Patient or Guardian Signature Date

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Medical Records Release

Patient's Name: _____

Patient's Address: _____

Date of Birth: _____

Release of records to: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Arizona State Board of Medical Examiners.

X _____

Patient or Guardian Signature Date

(if signed by person other than patient, state relationship and authorization to do so)

Patient is: ○ Minor ○ Incompetent ○ Disabled ○ Deceased

Legal authority: ○ Legal ○ Legal guardian ○ Next of kin deceased

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Other Parties Privy to Medical Records

Patient's Name _____ DOB_____

Name of Contact(s) _____

Relationship to Patient _____ Phone Number_____

I also authorize you to communicate with **Deborah Murphy and associates** with regards to my (or my child's) health condition.

X _____

Patient or Guardian Signature