ARROWHEAD SURGERY CENTER

(480) 427-3800

Patient Information as of

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ☐ No ☐ Yes E-mail _____

Contact Restrictions: _____ Drivers License # (include State) _____

Age _____ Birthdate _____ SS# _____ Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. and myself.

Signature _____ **Date** _____

Surgeon: Dr.
Patient's MR#: -25

Patient Label

CONDITION OF ADMISSION TO
ARROWHEAD SURGERY CENTER

PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE AGREES TO THE FOLLOWING TERMS:

1. MEDICAL AND SURGICAL CONSENT: The patient is under the control of his/her attending physician and the facility is not liable for following the instructions of such physicians. The patient recognizes that independent contractors, i.e., surgeon, pathologist, anesthesiologist, or laboratory will be submitting separate bills for services rendered to the patient.
2. TEACHING PROGRAMS: Some services may be provided to the patient by persons in training under the supervision and instruction of your physician or facility nursing staff if he participates in a residency program. These persons may also observe care under the directions of your physician or facility nursing staff.
3. MEDICAL RESEARCH: Information may be released for use in medical studies and medical research.
4. WORKER'S COMPENSATION: The facility recognizes that worker's compensation cases are the sole responsibility of the employer's insurance carrier and that the patient is not financially responsible. In the event that the injury is found to be non-work related or otherwise not covered by worker's compensation insurance upon notification of such denial, the patient will be found to be financially responsible. The patient is responsible for initiating form 102 to qualify claim for industrial injury.
5. FINANCIAL AGREEMENT: In consideration of the services rendered to me, I hereby obligate myself to pay any charges not covered by my insurance company. Should the account be referred to an attorney or license collection service, I shall pay reasonable attorney fees and collection expenses of 30%. I further acknowledge that I have provided all medical insurance plans at the time of admission and further understand that if I failed to disclose all requested information, I will be held responsible for any expenses incurred at this facility.
6. REIMBURSEMENT UNDER MANAGED CARE CONTRACTS: The facility has special contracts with some insurance companies and other payors to which the reimbursement may or may not have any relationship to charges. The patient or insurance is not required to pay any balance over the contracted rate nor is the patient or insured entitled to a refund in the event of overpayment by the carrier according to the allowable rate.
7. MEDICARE ASSIGNMENT: Arrowhead Surgery Center is a participating provider of Medicare. We will accept Medicare assignment. The patient will be responsible for payment of any annual deductible and twenty percent co-insurance not paid by Medicare or secondary insurance carrier.
8. I understand that, as a courtesy, the Center will file my primary and secondary insurance only. After 60 days from the date of service, the total balance will be considered due and payable by the patient.

ASSIGNMENT & RELEASE:

I authorize the release of that part of the record, which is required to submit claims to and collect fees from medical services companies, insurance companies, worker's compensation carriers, welfare funds, or employers. I further authorize any hospital to release pertinent discharge summary/operative report of a transfer/admit to a local hospital as a result of a procedure performed at this facility. I also request payment of government benefits either to myself or to the provider who accepts assignment of benefits. A photostatic copy of this assignment shall be valid as the original. The patient or his/her authorized representative certifies that he/she has read and understands the foregoing, received a copy thereof, and is authorized to execute the above and accept its terms.

Signature _____ Date _____ Witness Signature _____

Check one: □ Patient □ Insured □ Parent of Minor Child □ Court Appointed Guardian

RECEIPT OF INFORMATION & UNDERSTANDING. THE PATIENT CERTIFIES THAT HE/SHE:

1. Has received a copy of Patient's Rights and understand facility's advance directive policy.
2. Has been informed of the facility's grievance process.
3. Has been made aware of financial responsibilities.

Patient Signature: _____ Date: _____

Arrowhead Surgery Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ARROWHEAD
Surgery Center

Patient Label

Communication Preference Form

Patient Name (please print): _____

Please indicate which of the following numbers you would like for us to use:

□ Home: (_____) _____-_____ □ Cell: (_____) _____-_____ □ Work : (_____) _____-_____

E-mail: _____

Mail Communication Preferences

May we send mail to your home address? **(If no, please provide an alternative mailing address below):**

_____

_____

What is your preferred communication method? □ Email □ Phone □ Text □ Mail

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree Arrowhead Surgery Center or one of its legal agents may use the telephone numbers to send me a test notification call using a prerecorded/artificial voice message through the use of an automated dialing service or leave a voice massage on an answering device. If an email address has been provided, Arrowhead Surgery Center or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply, provide name, and phone number)

	Name	**Telephone**
□ Spouse :	_____	_____
□ Caretaker :	_____	_____
□ Child :	_____	_____
□ Parent :	_____	_____
□ Other :	_____	_____

I acknowledge that I have been given the opportunity to request restriction on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

****Patient was informed that by being present in a healthcare facility the risk of acquiring COVID19 increases****

_____ _____ _____

Printed Name **Patient/Representative Signature** **Date**

Relationship to Patient: □ Self □ Parent/Guardian □ Power of Attorney □ Other: _____

ARROWHEAD
Surgery Center

Patient Label

Patient Transportation and Monitoring Policy

Patient Name: _____

I, as the driver listed and signing below, acknowledge that I will be providing transportation after discharge from Arrowhead Surgery Center, I have been advised to remain on premises at the Surgery Center. I will remain on the premises until the patient I am providing transportation has been discharged.

_____ _____ _____

Driver Signature | Driver Printed Name | Date

Driver's Phone Number: (_____) _____ - _____

Please provide the name and number of the person that will be monitoring you for the 24 hours after discharge.

☐ Same as Above

☐ Other: _____ _____

Name | Phone Number

ARROWHEAD SURGERY CENTER, LLC
Patient Satisfaction Survey

Dear Patient,

We read every survey returned to us. We take your suggestions very seriously. We need your comments to make our center better. Please complete the questions below and please contact us if you would like to discuss anything that we could have done to improve your visit.

Physician_____(optional) Your Name_____(optional)

Date of Procedure_____(optional)

PLEASE CHECK *YES* OR *NO*

1. Were you treated in a courteous, pleasant and professional manner?
   By the front office staff ☐ Yes ☐ No
   By the nursing staff ☐ Yes ☐ No
   On the telephone ☐ Yes ☐ No ☐ N/A
2. Was your procedure fully explained to you by your physician? ☐ Yes ☐ No
3. Did you feel your pre-op call and the admitting process were welcoming, informative, and helpful? ☐ Yes ☐ No
4. Did you receive adequate information about your financial responsibilities? ☐ Yes ☐ No
5. Were the general surroundings comfortable for you? ☐ Yes ☐ No
6. Were written instructions given to and reviewed with you and/ or your caregiver before leaving the facility? ☐ Yes ☐ No
7. If given the choice, would you choose to come to this facility again? ☐ Yes ☐ No

If not, why? _____

_____

How would you rate your overall experience?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

How could we have improved your experience the day of surgery?_____

_____

_____

Please list two suggestions for how we can improve: _____

_____

_____

Would you like someone to contact you? If so, please provide us with your name and contact phone number. _____

Please return in person, fax to 480-427-2384 or email Manager@arrowheadsurgerycenter.com