10115 E Bell Rd #107-234
Scottsdale AZ 85260
Phone/Fax: (888) 709-8721
www.mobileonedocs.com

PATIENT REGISTRATION

Last Name ____________________________ First______________________ M.I. _________

Gender: M ___ F____ DOB _____- ______- ______ SS# _______ - _______ - _______

Marital Status: M __ D__ S__ W__ Spouse Name _____________________________

Street Address ___________________________ City_______________ ST_____ Zip_______

Home Phone _____________________________ Other Phone _______________________

Patient's Legal Representative _________________________ Phone ________________

Representative Address _____________________ City ___________ ST ____ Zip_______

Representative's legal authority to act on behalf of patient ____________________

Who referred you to us? _____________________________ Phone __________________

HEALTHCARE INSURANCE INFORMATION

Primary Insurance Company ____

Identification # ________________________________ Group # ___________________

Effective Date ____________________________

Policyholder SS# _______ - _______- _______ Policyholder DOB _____-_____-_____

Relationship to Patient ____

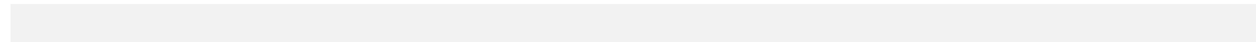
Secondary Insurance Company ____

Identification # ________________________________ Group # ___________________

Effective Date ____________________________

Policyholder SS# _______ - _______- _______ Policyholder DOB _____-_____-_____

Relationship to Patient ____



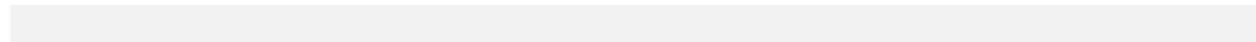
ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the medical provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and my signature below will bind me as though I personally signed the claim. I understand that I am responsible for all charges not covered by my healthcare insurance. If this account should be referred to a collection agency, I will be responsible for all collection and legal fees. I authorize the release of any medical or other information necessary to process my medical claims. I have read and understand the Mobile One Docs medical practice policy and procedures.

____________________________	__________________________	________________
Patient Name/Representative	Patient/Rep Signature	Date

If you are the patient's representative, in the space below please state your relationship to patient and legal authority to act on behalf of the patient:

____



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Mobile Once Docs, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this document.

______________________________	______________________________	________________
Patient Name/Representative	Patient/Rep Signature	Date

If you are the patient's representative, in the space below please state your relationship to patient and legal authority to act on behalf of the patient:

____

FINANCIAL POLICY

I understand that:

- If I do not have my insurance care, referral/or copayment that my appointment may be rescheduled until such time that I provide the required documents or payments.
- I am financially responsible for any copayments, coinsurance, and all charges that are not covered by my health insurance.
- Verification of coverage is not a guarantee of payment of benefits. My insurance company determines benefits; I understand that I will be responsible for the portion not covered by my insurance.
- There is a $25 charge for insufficient funds checks.
- There may be a $25 charge for all forms completed by my medical provider and that I need to allow 7 days for form completion.
- If my account is not paid in full within 90 days that I may be turned over to a collection agency for further processing and that I will not be allowed to make appointments until my delinquent account/s is/are brought current.

I have read and understand the above financial policy and agree to abide by its tenets.

______________________________	______________________________	________________
Patient Name/Representative	Patient/Rep Signature	Date

If you are the patient's representative, in the space below please state your relationship to patient and legal authority to act on behalf of the patient:

____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO MOBILE ONE DOCS

Patient whose Protected Health Information is requested ______________________

Gender: M ___ F____ DOB _____- ______- ______

Street Address __________________________ City_______________ ST_____ Zip_______

Home Phone ____________________________ Other Phone _______________________

Person/Entity from which Protected Health Information should be disclosed:

Name ______________________________Street Address _______________________

City______________________ ST_______ Zip______

Entity to which Protected Health Information should be disclosed:

Mobile One Docs 10115 E Bell Rd #107-234 Scottsdale AZ 85260

Description of Protected Health Information to be disclosed:

☐ Complete Medical Record ☐ Radiology Reports ☐ Laboratory Tests
☐ History/Physical Examination ☐ Operative Reports ☐ Other ________________

Purpose of the disclosures:
☐ Supplemental Care ☐ Transfer of Care ☐ Personal Use
☐ Second Opinion ☐ Worker's Compensation ☐ Legal
☐ Insurance coverage or payment for care ☐ Other_________________________

I hereby authorize to release Protected Health Information ("Information") to Mobile One Docs. I understand that this authorization may cover Information related to: (i) AIDS, HIV, and other communicable disease; (ii) genetic testing; (iii) psychiatric, behavioral, and mental health treatment; and (iv)alcohol, drug, and substance abuse treatment.
I understand that:

- I may revoke this Authorization at any time by notifying provider in writing;
- Any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality;
- This Authorization shall expire one hundred eighty (180) days following the date of execution;
- A photocopy or facsimile of this Authorization is valid in lieu of the original;
- I may refuse to sign this Authorization and that Provider will not condition or deny treatment because of this decision.

____________________________	__________________________	_______________
Patient Name/Representative	Patient/Rep Signature	Date

If you are the patient's representative, in the space below please state your relationship to patient and legal authority to act on behalf of the patient:

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