



# SAGUARO SURGICAL, P.C.

Vascular and General Surgery

## SAGUARO SURGICAL COPAY POLICY

**Thank you** for choosing Saguaro Surgical for your surgical needs; the physicians and staff are committed to providing you with the highest quality of care. In order to serve you today, your insurance policy requires our office to collect your assigned copay at the time of your appointment. As your condition requires continued medical attention, our office will assist as best we can to accommodate your needs and ensure your health care requirements are met. If you do not have or are unable to pay your copay at the time of your appointment, please work with our staff in rescheduling your appointment at a time that is convenient for you. As our office will no longer provide statements for assigned copays; we request your assistance in following the compliance measures mandated by your health insurance policy. For patients with a high deductible health insurance policy, this amount will be collected at the time your surgery is scheduled. In consideration of your time and your physician's, our office requests 24 hour notice to cancel or reschedule your scheduled appointment. Any cancellations or rescheduled appointments that do not provide 24 hour notice will be assessed a \$25.00 fee. We appreciate your consideration and are available to answer any questions.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# Saguaro Surgical, P.C.

## PATIENT REGISTRATION FORM

Account # \_\_\_\_\_ Date \_\_\_\_\_  
Patient Name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
Last First Legal Nickname MI  
Is this your legal name? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, what is your legal name? \_\_\_\_\_  
Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorce \_\_\_\_\_ Widow \_\_\_\_\_ Spouse's Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ PO Box: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone # \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Religion: \_\_\_\_\_ Race: \_\_\_\_\_ Language: \_\_\_\_\_  
Your Employer: \_\_\_\_\_ Phone# \_\_\_\_\_ Occupation: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Referring Physician (if different) \_\_\_\_\_ Phone #: \_\_\_\_\_  
Pharmacy Name and Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

## INSURANCE INFORMATION

**Are you covered by health insurance?** Yes \_\_\_\_\_ No \_\_\_\_\_ **If No, please make payment arrangements with our business office.**  
Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Copay \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Copay \_\_\_\_\_  
If this visit related to an at work injury? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, Employer at time of injury \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Insurance Info \_\_\_\_\_ Claim # \_\_\_\_\_

## EMERGENCY CONTACT

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Date of Birth \_\_\_\_\_

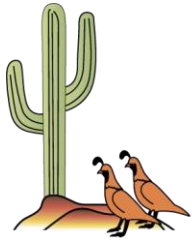
### ALL PATIENTS

#### PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

"I hereby authorize Saguaro Surgical, P.C. to release to or to request from any insurance company, other physician or hospital, any information including the diagnosis and records of any treatment or examination rendered to me during surgical care, including any financial information. This information may be faxed or sent electronically. I also authorize and request my insurance companies to pay directly to the above named corporation the amount due on any pending insurance claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account to collections, I will be liable for the reasonable collection fees and court costs expended therein." I understand that there is a \$35 pre-paid fee for all disability forms filled out by the physician. The organization reserves the right to charge interest on unpaid accounts.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Or parent/guardian if patient is a minor)



# Saguaro Surgical

General, Robotic, Endocrine, Breast & Vascular Surgery



SONORAN  
FOOT & ANKLE INSTITUTE

## NEW PATIENT MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Age/DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_ Weight one year ago \_\_\_\_\_

### Current and Past Medical Problems: (please circle Yes or No)

- Yes No \* Diabetes - If Yes, What Type? \_\_\_\_\_ When were you diagnosed? \_\_\_\_\_
- Yes No \* Angina (chest pain) \_\_\_\_\_
- Yes No \* High Blood Pressure \_\_\_\_\_
- Yes No \* Stroke- If Yes, when? \_\_\_\_\_ Any paralysis or deficit? \_\_\_\_\_
- Yes No \* Heart Disease If Yes, What Type? \_\_\_\_\_
- Yes No \* Epilepsy or Seizures? If Yes, What Type? \_\_\_\_\_
- Yes No \* Cancer? If Yes, What Type? \_\_\_\_\_
- Yes No \* Lung Disease? If Yes, What Type? \_\_\_\_\_
- Yes No \* Kidney Problems? If Yes, What Type? \_\_\_\_\_
- Yes No \* GI Disorders? If Yes, What Type? \_\_\_\_\_
- Yes No \* Hepatitis? If Yes, What Type? \_\_\_\_\_
- Yes No \* Anemia or Blood Disorders? If Yes, What Type? \_\_\_\_\_
- Yes No \* Phlebitis or Blood Clots? If Yes, What Type? \_\_\_\_\_
- Yes No \* Thyroid Disease? If Yes, What Type? \_\_\_\_\_
- Yes No \* Arthritis? If Yes, What Type? \_\_\_\_\_
- Yes No \* Visual Impairment? If Yes, What Type? \_\_\_\_\_
- Yes No \* Mental Health Condition If Yes, What Type? \_\_\_\_\_
- Yes No \* Do you have a Pace Maker? \_\_\_\_\_

Other: \_\_\_\_\_

Past Surgical History (please include dates): \_\_\_\_\_

Have you ever had a blood transfusion? Yes No If Yes, Any Reactions? \_\_\_\_\_

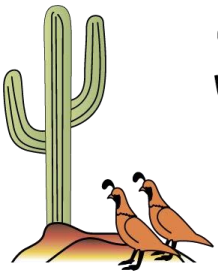
Have you ever had general anesthesia? Yes No If Yes, Any Reactions? \_\_\_\_\_

### PLEASE LIST ALL MEDICATIONS AND DOSAGES: \_\_\_\_\_

Please circle if you are taking any of the following: Coumadin Daily Aspirin Diabetes Medication  
Are you allergic to any medications? Yes No If Yes, Any Reactions? \_\_\_\_\_

**Social History:** Alcohol Use: Yes No How many / How often? \_\_\_\_\_  
Do you smoke? Yes No If Yes, packs per day? \_\_\_\_\_ How many years \_\_\_\_\_ If quit, when \_\_\_\_\_

Date of Last Chest X-Ray \_\_\_\_\_ Last EKG \_\_\_\_\_ Last Mammogram \_\_\_\_\_



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## PODIATRY REVIEW OF SYSTEMS

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? (PLEASE CIRCLE)

### GENERAL:

Fever Sweats Chills Weight Gain or Loss Fatigue Skin Rash Lymph node swelling  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### HEAD, EYES, EARS, NOSE and THROAT:

Headache Congestion Runny Nose Vision Changes Difficulty Swallowing Sore Throat  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### RESPIRATORY/CARDIOVASCULAR

Coughing/Wheezing Difficulty Breathing Shortness of Breath Chest tightness/pain Palpitations  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### GASTROINTESTINAL:

Changes in appetite Constipation Diarrhea Nausea/vomiting Indigestion/heartburn  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### KIDNEY, URINATION:

Frequent urination Pain with urination Blood in urine Urgency Kidney Disease  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### MUSCULOSKELETAL:

Cramping in the calves, Thighs or Buttock Joint Pain Joint Stiffness Foot Deformity  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### NEUROLOGIC:

Numbness Weakness History of Stroke  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### ENDOCRINE:

Hypothyroid Hyperthyroid Type 1 Diabetes Type 2 Diabetes  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### FUNCTIONAL:

Depression Anxiety Difficulty sleeping Under Psychiatric care  
Other: \_\_\_\_\_ or NONE OF THE ABOVE

### PODIATRY HISTORY:

Foot Pain	Fracture	Plantar Fasciitis	Nail Fungus	Foot Ulcer
Joint Pain	Ingrown Toenail	Low Arches	Athletes' Foot	Neuropathy
Bunion	Shin Splints	High Arches	Gout	Charcot
Hammertoe	Heel Pain	Callus	Warts	Clubfoot

PRIOR SURGERY \_\_\_\_\_

Other: \_\_\_\_\_ or NONE OF THE ABOVE

### FAMILY HISTORY:

Mother	Age _____	Alive	Deceased	Cause of Death _____
Father	Age _____	Alive	Deceased	Cause of Death _____
Brother(s)	Ages _____	Alive	Deceased	Cause of Death _____
Sister(s)	Ages _____	Alive	Deceased	Cause of Death _____
Children	Ages _____	Alive	Deceased	Cause of Death _____



# SAGUARO SURGICAL, P.C.

Vascular and General Surgery

## Authorization for Use and Disclosure of Protected Health Information

### Patient Identification

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Information To Be Released – Covering the Periods of Health Care

From (date) \_\_\_\_\_ To (date) \_\_\_\_\_

*Please check type of information to be released:*

<input type="checkbox"/> Entire medical record	<input type="checkbox"/> Pathology report	<input type="checkbox"/> Discharge summary
<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Consultation reports	<input type="checkbox"/> Progress notes
<input type="checkbox"/> Laboratory test results/reports	<input type="checkbox"/> X-ray reports	<input type="checkbox"/> X-ray films / images
<input type="checkbox"/> Operative report	<input type="checkbox"/> Emergency room record	<input type="checkbox"/> Itemized bill

Other (specify): \_\_\_\_\_

I authorize the individuals listed below to receive my medical information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

### Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B & C testing, and/or other sensitive information, I agree to its release.

<i>Check one and initial</i>	
<input type="checkbox"/> Yes	Initials
<input type="checkbox"/> No	

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

<i>Check one and initial</i>	
<input type="checkbox"/> Yes	Initials
<input type="checkbox"/> No	

### Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time, I can revoke this authorization by submitting a notice in writing to the Privacy Officer at Saguaro Surgical, P.C. 6422 E Speedway Blvd – Suite, 150 – Tucson, AZ 85710. This authorization is valid for a period of six months from date of signature.

### Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

### Signature of Patient or Personal Representative Who May Request Disclosure

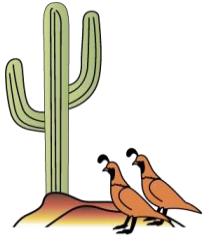
I understand that I do not have to sign this authorization. However, authorization to release my medical records will be denied if I do not sign this form as specified.

I authorize Saguaro Surgical, P.C. to release the protected health information specified above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authority to Sign if not patient: \_\_\_\_\_ Verified By: \_\_\_\_\_

Identity of Requestor Verified via:  Photo ID  Matching Signature  Other (specify): \_\_\_\_\_



# Saguaro Surgical

*General, Robotic, Endocrine, Breast & Vascular Surgery*



**SONORAN**  
FOOT & ANKLE INSTITUTE

## SAGUARO SURGICAL FINANCIAL POLICY

**Thank you** for choosing Saguaro Surgical, P.C. for your surgical needs. The physicians and staff are committed to providing you with the highest quality of care. This following financial policy is in place to assist you with any questions you may have regarding your financial obligation to this practice. We ask that you please review and confirm with your signature below. All billing is completed as a courtesy to our patients on behalf of their health insurance provider. Patients are financial responsible for all medical services.

### INSURANCE

Although we are participants of many insurance companies, it is ultimately your responsibility to confirm that Saguaro Surgical, P.C., or your individual doctor, is in fact a provider for your insurance. We will submit a claim for payment for your services to your insurance as a courtesy, but you are responsible for any copays or deductibles not covered by your insurance. These are collected at time of service. If you are billed for any balance, payment is required within 30 days of receipt of a bill. Secondary insurance claims are filed as a courtesy and become the responsibility of the patient if payment is not received within 60 days of filing a claim. It is your responsibility to be aware of your benefits with your insurance. If your insurance information, copay, or coverage has changed at any time during your treatment, it is your responsibility to notify the office with the most current and up-to-date information.

### PATIENT RESPONSIBILITY

Copays and deductibles are due prior to being seen. If you require a bill sent to you for your copay, a \$10.00 processing fee will be added to your balance. It is your responsibility to provide us with any referral required from your insurance. Any service deemed "non-covered" by your insurance will be your responsibility. If you do not have insurance, or we are not contracted with your particular insurance, you will be required to pay for services prior to receiving them. "Self-pay" accounts are given a 30% discount, which is due prior to any services. NO payment arrangements are made for these accounts. If a circumstance arises where payment arrangements are made, the discount will be taken after all payments are received. If you fail to adhere to your payment agreement, your full balance will be assigned to a collection agency. If your account is referred to a collection agency, you will be responsible for all costs.

### PAYMENT METHODS

For your convenience, acceptable forms of payments are; cash, check, money order, VISA, MasterCard, American Express, or Debit cards. Please note: if a personal check is returned for insufficient funds, there will be a \$25.00 fee added to your account.

### BILLING INQUIRIES

If you have any questions regarding a bill you received from our office, please feel free to contact our Business Office at (520) 318-3004. Our office hours are 8:00am - 5:00pm.

Thank you for allowing Saguaro Surgical, P.C. to be an important part of your medical care. For any further questions or concerns our staff is available to assist you.

### ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, and understand, and agree to the above financial policy. Regardless of my insurance status, I am ultimately responsible for payment for any professional services rendered. I authorize the release of any medical information necessary to process a claim for benefits under my policy and assign payment to Saguaro Surgical, P.C.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Saguaro Surgical Pain Management Policy & Consent

1. Your Saguaro Surgical physician will not prescribe any narcotics, pain pills, etc. other than over the counter medications prior to your scheduled operation.
2. After your operation, hospital inpatients will receive pain medications as determined by their daily inpatient assessment.
3. As a Saguaro Surgical patient, one refill for pain medications may be prescribed upon your discharge from hospital.
4. At the physician's discretion, one refill for pain medication may be prescribed at your post operative appointment.
5. In consideration of continued follow-up care, unless a surgical complication exists, there will be no further pain medications prescribed.
6. At their discretion, the covering physician may prescribe a small quantity of pain medication determined adequate until your surgeon returns.
7. There will be no pain medications prescribed after 3pm Friday, please contact the office after 8am Monday for any pain medication request.

### **I understand and agree to the following:**

- I will candidly provide my physician with a complete and accurate treatment and medication history, including past medical records, past pain treatment, psychiatric history, and alcohol and other drug addiction history.
- I will take my medication as directed by my physician and will not hoard, sell or share my medication.
- Because alcohol and other recreational drugs should not be mixed with narcotics, I will not take them while receiving treatment.
- I will inform my physician before taking naturopathic products or over-the-counter medications.
- I will **not** obtain narcotics from any other physician, including associates of my physician who may be taking his/her calls.
- I will obtain narcotics from one pharmacy and notify my physician of any changes in the pharmacy.
- I understand that if my narcotic medication should be lost, destroyed, stolen, etc., my physician will **not** refill it until time for the next regular refill.
- I understand that my physician may share information regarding my care and treatment with other providers as necessary for my continued care.
- I understand that no guarantee or assurance has been made as to the results of the treatment.
- **Female Patients:** I affirm that I am not pregnant and that I will immediately notify my physician if I plan to or do become pregnant.

**I have read and fully understand this form. I understand I should not sign if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this form. I have no further questions.**

**Do not sign unless you have read and thoroughly understand this form.**

**By refusing to sign this consent, I understand no further prescriptions will be issued.**

By signing this form, I am stating that I have read, understand, consent and agree to the above.

\_\_\_\_\_  
PATIENT | LEGAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS'S SIGNATURE

\_\_\_\_\_  
DATE