NORTH
SCOTTSDALE
FAMILY MEDICINE

6501 East Greenway Parkway • Building 6, Suite 160
Scottsdale, AZ 85254
480.948.9903 Office • 480.998.5887 Fax

Authorization Responsibility Agreement

PATIENT LAST NAME	FIRST NAME & MIDDLE INITIAL		SEX ☐ Male ☐ Female	MARITAL STATUS S M D W Sep	PATIENT BIRTHDATE ___/___/___
PATIENT MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER ( )	
PATIENT SOCIAL SECURITY NUMBER ___-___-___	EMPLOYER			CELLULAR PHONE NUMBER ( )	
EMAIL ADDRESS	WORK ADDRESS			WORK PHONE NUMBER & EXTENSION ( )	

EMERGENCY CONTACT	RELATIONSHIP TO PATIENT		HOME PHONE NUMBER ( )
ADDRESS	CITY & STATE	ZIP CODE	CELL OR WORK PHONE NUMBER & EXT ( )

INSURANCE POLICY HOLDER'S FULL NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER ___-___-___	RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE ___/___/___
POLICY HOLDER'S EMPLOYER	INSURANCE COMPANY NAME		

SECONDARY INS. POLICY HOLDER'S FULL NAME	SECONDARY POLICY HOLDER'S SOC. SEC. NUMBER ___-___-___	RELATIONSHIP TO PATIENT	SECONDARY POLICY HOLDER'S DOB ___/___/___
SECONDARY POLICY HOLDER'S EMPLOYER	INSURANCE COMPANY NAME		

Authorization Responsibility Agreement

Payment is due at the time of service. If we are providers for your insurance, we will bill your insurance and collect only your co-pay portion at the time of service. Many insurance plans have **"timely filling deadlines."** Accurate information to bill your claim must be provided on the date of your visit or you may be responsible for payment in full for services rendered to you. Insurance can vary in coverage of preventative care, physicals and immunizations. **Please verify all coverage options with your plan *before* scheduling any of these services. Patient will be billed for the balance of any non-covered services.**

I authorize medical care and accept the financial responsibility for myself and my minor children. I am responsible for all fees regarding my health care, and will make sure the charges are paid in a reasonable time.

I authorize the release of any medical or other information necessary to process any claims.

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE — TODAYS DATE

Whom can we thank for referring you to our office?

☐ Friend ☐ Doctor ☐ Health Plan ☐ Emergency Room ☐ Website ☐ Newspaper Ad ☐ Other? _____

Name _____