Physician Group
OF ARIZONA, INC.

REFERRAL SOURCE (How did you hear about us?)

? Physician (name): ______________________ ? Family/Friend ? Newspaper ? Radio/TV

****REQUIRED** RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I authorize the release of medical information necessary to process my claim. As a courtesy to our patients we will file the claim with their insurance carrier with the understanding that the patient/guarantor, not his/her insurance company is responsible for payment of this account.

Signature of Patient (or Responsible Party):______________________ Date Signed______________

Printed Name______________________

PERSONAL PAY PATIENTS

As a courtesy to our personal pay patients we extend a 25% discount to all services received at our facility. We also are willing to extend an additional 25% off all services if services are paid within 14 calendar days from the original date of service.
If you choose to pay in full at each visit you will receive a total of 50% off all services that we provide.
NOTE: NOT APPLICABLE FOR THE FOLLOWING

- *SURGICAL WT. LOSS SURGERY*
- *FAA EXAMINATIONS*
- *PLATELET RICH PLASMA INJECTIONS*

PAYMENT ARRANGEMENTS

Services are payable upon date performed or upon receipt of monthly statement. If extended terms are required on balances, The Physician Group of Arizona, Inc. Central Billing Office will need to be contacted to establish a payment schedule. For your convenience we accept VISA, MASTER CARD, American Express and DISCOVER CARD.

FINANCE CHARGE

The finance charge is an annual percentage rate of 18% applied to the 90 day balance after deducting payments and credits.

ATTORNEY/COLLECTION FEES

In the event if becomes necessary to refer the account to an ATTORNEY, or OUTSIDE COLLECTION AGENCY, you hereby agree to pay all attorney fees, court costs, and a 25% COLLECTION FEE.

YOUR BILLING RIGHTS (A copy of this notice may be provided upon request)

This notice contains important information about your rights and our responsibility under the Fair Credit Billing Act.

Patient is responsible to notify us in case of Errors or Questions regarding your bill:

If you think your bill (statement) is wrong, or if you need more information about a transaction on your bill, write or phone us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. **You can telephone us, however you must speak with a member of the business office, leaving a message will not preserve your rights.**

In your letter, the following information must be provided:
- Your Name and account number
- The dollar amount of the suspected error.
- Describe the error and explain, if you can, why you believe there is an error.

Your Rights and our Responsibilities After We Receive Your Written Notice:

We must acknowledge your letter within 30 days, unless we have corrected the error by then. Within 60 days we must correct the error or explain why we believe the bill was correct.

After we receive your letter, we cannot try to collect any amount you question, or report you as delinquent. We can continue to bill you for the amount NOT in question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question. If we find that we made a billing error on your account, you will not have to pay any finance charges related to any questioned amount. IF WE FIND YOUR ACCOUNT CHARGES TO BE CORRECT, YOU MAY HAVE TO PAY FINANCE CHARGES, AND YOU WILL HAVE TO MAKE UP ANY MISSED PAYMENTS ON THE QUESTIONED AMOUNT.

In either case, we will send you a statement of the amount you owe and the date that it is due.

IF AT THAT TIME, YOU DO NOT PAY THE BALANCE OF YOUR ACCOUNT, WE MAY REPORT YOU AS DELINQUENT.

MANAGED CARE/COMMERCIAL INSURANCE

PATIENTS ARE RESPONSIBLE FOR ANY CO-PAYS, DEDUCTIBLES OR NON-COVERED SERVICES AS DICTATED BY THEIR MANAGED CARE PLAN. **IT IS THE PATIENT'S RESPONSIBILITY BEFORE MAKING AN APPOINTMENT, TO CONFIRM WITH THEIR INSURANCE COMPANY WHETHER THE PHYSICIAN IS COVERED AS AN IN-NETWORK PROVIDER FOR THEIR PLAN. THE PATIENT IS RESPONSIBLE FOR SERVICES RENDERED BY THE PHYSICIAN GROUP OF ARIZONA, INC. PHYSICIANS THAT ARE NOT PROVIDERS OR IN-NETWORK PROVIDERS FOR THEIR PLAN.**

If an overpayment occurs, The Physician Group of Arizona, Inc. will refund the patient or the insurance company, whoever is due, within a reasonable length of time.