Mercy Grace Private Practice
1720 E. Boston St. Suite #101
Gilbert, AZ 85295

Personal Information

|**Patient First Name**| _____ | Initial|_____ | **Last Name**|_____

|DOB|_____ |Age|_____ |Social Security #|_____ |Email| _____

|Address| _____
Street Apt# City/State/Zip

|Home Phone| _____ |Work Phone| _____|Cell Phone|_____

|Gender| M F | Language| ENGLISH SPANISH Other _____ |Marital Status| S M W D O

|Race/Ethnicity| ___White ___ Black/African American ___ American Indian ___ Alaskan Native ___ Asian ___Hispanic/Latino

___Native Hawaiian/Pacific Islander ___Other: _____

Financially Responsible Party Information

|Responsible Party Name|_____|Relationship to Patient|_____

|DOB|_____|Age| _____|Social Security#|_____

Insurance Information

|**Primary Insurance**| _____|Policy #|_____|Group#|_____

|Policy Holder Name|_____|DOB| _____|Relationship to Patient| _____

|**Secondary Insurance**|_____|Policy #| _____|Group#|_____

|Policy Holder Name|_____|DOB| _____|Relationship to Patient|_____

Emergency Contact

|Emergency Contact Name|_____|Phone Number| _____

|Relationship to Patient| _____

Reason for Visit

|Primary reason for visit|_____|Date symptoms started|_____

|Were you seen at the Hospital/Urgent Care| YES NO |If YES, where?|_____

|Other issues you would like to discuss|_____

Allergies

☐ |No known food/pet allergy|
☐ |No known medication/drug allergy|

|Please list any food/pet allergies|

_____
_____
_____
_____

|Please list any medication/drug allergies|

_____
_____
_____
_____

Current Medications

|Medication/Dosage| _____|Frequency| _____

|Medication/Dosage| _____|Frequency| _____

|Medication/Dosage| _____|Frequency| _____

|Medication/Dosage| _____|Frequency| _____

|Medication/Dosage| _____|Frequency| _____

|Medication/Dosage| _____|Frequency| _____

|Medication/Dosage| _____|Frequency| _____

Preferred Pharmacy Information

|**Pharmacy Name**| _____|Phone #| _____

|Address| _____|City/State/Zip| _____

|**Mail-order Pharmacy**| _____|Phone| _____|Fax| _____

|Address| _____|City/State/Zip| _____

Statement of Patient Financial Responsibility

|**Patient Name**| _____|DOB| _____

Mercy Grace Private Practice appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

Should your account fall into a default status due to non-payment, your balance may be eligible for collections. Collections balances should be taken care of immediately to avoid disruption in services. Any account in collections status may be eligible for discharge. Arrangements for any balance should be made immediately. |Initial| _____

I have read the above policy regarding my financial responsibility to **Mercy Grace Private Practice** for providing rehabilitative services to me or the above names patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to **Mercy Grace Private Practice** the full and entire amount of my bill incurred by me or above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

|**Patient Signature**| _____|Date| _____

|**Guarantor Signature**| _____|Date| _____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patient at EACH VISIT. **Mercy Grace Private Practice** does NOT bill for co-pays. Thank you for your cooperation in this manner. |**Patient Signature of Acknowledgement**| _____

Authorization to Bill/Pay

I HEREBY AUTHORIZE MERCY GRACE PRIVATE PRACTICE TO AND ITS AFFILIATES TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT WHICH INCLUDE HIV, COMMUNICABLE DISEASE OR DRUG ABUSE INFORMATION. I ALSO HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BUSINESS OF MERCY GRACE PRIVATE PRACTICE AND ITS AFFILIATES FOR THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR THE SERVICES RENDERED. ***I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE. FURTHER, I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED IN THE COLLECTION OF MY ACCOUNT(S) AND WILL PAY ALL FEES INVOLVED SHOULD MY ACCOUNT(S) BE PLACED WITH A COLLECTIONS SERVICE.***

|**Patient/Guarantor Signature**| _____|Date| _____

|**Printed Name**| _____

Self-Pay

I agree to pay **Mercy Grace Private Practice** the full and entire amount for the treatment provided to me. |**Initial**|_____

Consent for Treatment and Authorization to Release Information

|**Patient Name**| _____ |DOB| _____

I hereby authorize **Mercy Grace Private Practice** through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize **Mercy Grace Private Practice** and its affiliates, to release appropriate agencies, any information acquired in the course of my, or the above named patient's, examination and treatment.

|**Patient/Guarantor Signature|** _____|Date| _____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to your appointment to cancel. Please initial the following:

_____ |If it is necessary to cancel an appointment, a 24 hour notice is required|

_____|If you miss an appointment or fail to provide 24 hours advanced notice, there will be a charge of **$50.00**. This charge will not and cannot be billed to your insurance company|

_____|I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of 4 appointments, I may be discharged from care|

Our office will notify you in writing, via mail, if you are discharged from care.

I have read and understand the above information and I agree to the terms described:

|Patient/Guarantor Signature|_____|Date| _____

HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been presented with **Mercy Grace Private Practice's HIPAA Notice of Privacy Practices.** My signature below is indicative of my acknowledgement and understanding. I am aware that I can obtain a copy of this in office or on www.mgppaz.com. All of my questions have been answered accordingly.

|**Patient Signature**| _____|Date| _____

Release of Information

I _____hereby authorize MGPP to release or discuss any and all information pertaining to myself or my child with |Name| _____|Relationship|_____

|I authorize MGPP to contact me at| HOME WORK CELL

|May we leave a message on your machine| YES NO |**Patient Signature**| _____