ARIZONA VASCULAR SPECIALISTS, L.L.C.

Vascular and Endovascular Surgery
Dr. Matthew Namanny, D.O., FACOS, RPVI, FSVS
Dr. Layla Corral Lucas, M.D., FACS, RPVI, FSVS

COPAY AND NO-SHOW POLICY

Thank you for choosing Arizona Vascular Specialists 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.

If you 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. For patients with a high deductible health insurance policy, this amount will be collected at the time your surgery is scheduled.

Considering your time and the physician's, our office requests **24-hour notice** to cancel or reschedule your office visit appointment. If you have an ultrasound doppler appointment or scheduled procedure in our office based lab, we require a **48-hour notice** to cancel or reschedule.

Any cancelations or rescheduled appointments that do not provide the appropriate cancelation notice will be assessed a **$25.00 fee for office visits, a $50.00 fee for ultrasound appointments, and a $150.00 fee for office procedures**. We appreciate your consideration and are available to answer any questions.

Patient Signature_____**Date** _____

6442 E. Speedway Blvd – Suite 102 – Tucson, AZ 85710 (520) 777-4090 FAX: (520) 641 -0414

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ARIZONA VASCULAR SPECIALISTS FINANCIAL POLICY

Thank you for choosing Arizona Vascular Specialists! The following financial policy is in place to assist you with any questions you may have regarding your financial obligation to this practice. All billing is completed as a courtesy to our patients on behalf of their health insurance provider. Patients are financially responsible for all medical services.

INSURANCE

Although we are participants of many insurance companies, it is ultimately your responsibility to confirm that Arizona Vascular Specialists, L.L.C., or your doctor, is a provider for your particular 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 the 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

Co-payments and deductibles are due before 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 before receiving them. "Self-pay" accounts are eligible for a discount, which is due before any services; NO payment arrangements are made when any discounts have been applied. If a circumstance arises where payment arrangements are approved, the discount will be taken after all payments are received. If you fail to adhere to your payment agreement, your full balance along with additional fees will be assigned to a collection agency. If your account is referred to a collection agency, you will be responsible for all costs. If you need to reschedule or cancel your appointment please contact our office 24 hours before your office visit appointment or 48 hours before your ultrasound doppler appointment or procedure. If there is not adequate notification given, there will be a $25.00 fee for missed office visits, $50.00 fee for ultrasound appointments, and $150.00 for office procedures. All appointments that are rescheduled a third time will require a prepayment charge of $25.00 which, is not associated with your required copay.

PAYMENT METHODS

For your convenience, acceptable forms of payment 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 Billing Department at (520) 777-4090. Our office hours are 8:00am – 4:30pm Monday through Friday.

ACKNOWLEDGEMENT AND AUTHORIZATION

I have read, 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 Arizona Vascular Specialists, L.L.C.

Signature_____ **Date** _____

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Authorization for Use and Disclosure of Protected Health Information

Patient Information

Printed Name:_____ Date of Birth: _____

Information To Be Released – Covering the Periods of Health Care

From (date)_____ To (date) _____

Please check the type of information to be released:

☐ **Entire medical record**	☐ All hospital records	☐ Progress notes
☐ Consultation report	☐ History and physical exam	☐ Discharge summary
☐ Ultrasound images/reports	☐ Operative report	
☐ Itemized bill	☐ Emergency room record	

Other (specify):_____

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

Name:_____

Contact Information:_____

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.

Check one and initial

☐ Yes	Initials
☐ No	

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

Check one and initial

☐ Yes	Initials
☐ 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 Arizona Vascular Specialists, L.L.C. 6442 E Speedway Blvd – Suite, 102 – Tucson, AZ 85710. This authorization is valid for six months from the 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 Arizona Vascular Specialists, L.L.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): _____

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Pain Management Policy & Consent

1. Your Arizona Vascular Specialist's physician will not prescribe any narcotics, pain pills, etc. other than over-the-counter medications before your scheduled operation.
2. After your operation, hospital inpatients will receive pain medications as determined by their daily inpatient assessment.
3. As an Arizona Vascular Specialist's patient, one refill for pain medications may be prescribed upon your discharge from the hospital.
4. At the physician's discretion, one refill of 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. A covering physician may prescribe, at their discretion, a small quantity of pain medication determined adequate until your surgeon returns.
7. There will be no pain medications prescribed after 3:00 pm Friday. If a patient requires a refill of pain medication, please contact the office after 8:00 am Monday.
8.

I understand and agree to the following:

- I will provide my physician with a complete and accurate treatment and medication history, including past medical records, past pain treatment, psychiatric history, alcohol usage, and other drug addiction history.
- I will take my medication as directed by my physician and will not horde, sell, or share my prescription.
- I will not take a prescribed narcotic with alcohol and/or other recreational drugs.
- 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 will notify my physician of any changes with my preferred pharmacy.
- I understand that if my narcotic medication should be lost, destroyed, stolen, etc., my physician will **not** refill it until the allotted time period for my refill.
- 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

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