



## Patient Information

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex M F  
                    First                    Middle                    Last

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Hm Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

SS#: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Are you a year-round resident of AZ? \_\_\_\_\_ If not, please note your other address below and length of stay in AZ.

\_\_\_\_\_

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Emergency contact (1): \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency contact (2): \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

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How were you referred to our office? T.V. \_\_\_\_\_ INS \_\_\_\_\_ Phone Book \_\_\_\_\_ Other \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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Primary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

Easy pay option: YES NO ( please see financial policy for description)

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Secondary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

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### Assignment of Benefits:

I hereby instruct and direct my Insurance Company to pay by check made out and mailed to: Understanding Women, P.C.. If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I authorize the release of any information needed to secure payment for any services. I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

***Understanding Women, P.C.***  
***Financial Policy***

Thank you for choosing Understanding Women for your gynecological needs. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. You will be responsible for all co-pay, coinsurance, and deductibles on the day of service. Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a Physician, Facility, Anesthesia and Lab fee. We will submit for the Physician and Facility. If a procedure is generally deemed to be “cosmetic” or “non medically necessary”, we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

**IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.**

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, or cash.

***All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.***

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Transworld Systems for further processing.

FEES: There will be a \$40 fee for the following: Copy of Medical records to a patient or insurance company, FMLA, or disability paperwork.

There will be a \$25 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

**It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.**

Understanding Women will not be sending patient statements, as this procedure will be a pre-arranged which will be authorized by the responsible party.

**I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient’s request.**

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT/RESPONSIBLE PERSON

\_\_\_\_\_  
DATE



## Patient Communication Authorization

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

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call my home phone number    Okay to leave a message?  yes  no

It's okay to call my mobile number        Okay to leave a message?  yes  no

It's okay to call my work phone number.    Okay to leave a message?  yes  no

Call only this number. \_\_\_\_\_        Okay to leave a message?  yes  no

Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

\_\_\_\_\_

\_\_\_\_\_

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_\_

# PATIENT-PHYSICIAN ARBITRATION AGREEMENT

**Section 1:** I agree to binding arbitration to resolve any claim I may have against Keri Sweeten, M.D., or her staff. If I wish to assert a claim for medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, I agree that such claim will be submitted to binding arbitration by the American Arbitration Association, and not by a lawsuit or resort to court proceedings. I agree that both parties to this contract are giving up their constitutional right to have any such claim decided in a court of law before a jury, and instead are agreeing to binding arbitration. I understand that binding arbitration means that a private arbitrator or arbitrators, and not a judge or jury, will decide my claim and that the arbitrator's decision ordinarily will be final.

**Section 2:** I agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to the treatment or services provided by Dr. Sweeten or her staff, including my spouse or heirs and any children, whether born or unborn. This Agreement covers all claims for monetary damages including, without limitation, suits for loss of consortium and companionship, wrongful death, emotional distress and punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against Dr. Sweeten and any employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of any parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement.

**Section 3:** I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

**Section 4:** I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE DR. SWEETEN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND LATER CHANGE MY MIND, I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO DR. SWEETEN WITHIN 30 DAYS STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT. I ALSO UNDERSTAND THAT I MAY HAVE MY ATTORNEY OR OTHER ADVISORS DISCUSS THIS AGREEMENT WITH DR. SWEETEN OR HER STAFF, AND THAT I OR ANY SUCH REPRESENTATIVE MAY REQUEST REVISIONS TO THIS AGREEMENT.

**Section 5. OPTIONAL: RETROACTIVE EFFECT**

If I intend this Agreement to cover services rendered before the date it is signed (for example, prior emergency treatment), I have indicated the earlier effective date below. Otherwise this Agreement covers only services rendered after this Agreement was signed.

Earlier effective date: \_\_\_\_\_ Patient's Initials: \_\_\_\_\_

**Section 6.** I have read and understood this Agreement. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

**BY SIGNING THIS CONTRACT I AM AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND TO GIVE UP MY RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 of THIS CONTRACT.**

\_\_\_\_\_  
(Patient, Parent, Guardian or Legally Authorized Representative) Dated: \_\_\_\_\_, 20\_\_\_\_.

If signed by other than patient, indicate relationship: \_\_\_\_\_

**PHYSICIAN'S AGREEMENT TO ARBITRATE**

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by arbitration on the terms set forth in this Agreement.

\_\_\_\_\_  
(Physician or Duly-Authorized Representative) Dated: \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Print name of Physician, Medical Group, Partnership or Association Dated: \_\_\_\_\_, 20\_\_\_\_.



## **Information about our Arbitration Agreement.**

To Our Valued Patients:

We would like to explain our policy regarding our Arbitration Agreement. We are concerned about the rising cost for medical liability insurance and the growing number of physicians who are leaving the practice of medicine because of the threat of malpractice litigation. It is our feeling that our Arbitration Agreement discourages frivolous litigation, and may help prevent increases in medical liability insurance premiums. Binding arbitration can also resolve claims more quickly and at less expense than court proceedings, and can avoid years of appeals. We believe this benefits both the patient and the physician.

The American Arbitration Association is a nationally-recognized organization which has qualified neutral arbitrators available to decide claims in a prompt and fair manner.

We are very grateful for your understanding and cooperation in this matter. Please feel free to discuss any concerns with our physicians or our office manager.

We will understand and respect your decision if you elect not to sign this Agreement. If you decide not to sign the Agreement, then we will happily see you in consultation today and for the next 30 days; after this 30-day period we would request that you seek further gynecologic care with another physician. We can provide you with the names of other gynecologists.

Sincerely,

Keri Sweeten, M.D.