Grace Zlaket-Matta, M.D., F.A.C.E.
Iyad Syoufi, M.D.
Board Certified Endocrinology

Welcome to our office. We thought it might be helpful to mention a few office procedures that will make your relationship with our office a very enjoyable one.

First, our office works diligently to accommodate patient's needs, therefore in order to ensure every patient is treated in a timely matter please arrive to your appointment **15 minutes early** if you are an existing patient, **½ hour** if you are a **new patient** to the office. If you're not able to keep your scheduled Doctor or US/BX appointment please give us at least 24 hours notice to avoid a **$50.00** no show fee.

We will call you a week prior to your appointment to remind you of your appointment. This reminder call is also to alert you to have you labs order done in the week prior to your appointment. Please return our call to confirm your appointment prior to your visit.

Second, all co-pays and previous balance owing are due at the time of service. It is the patient's responsibility to notify our office of any change to insurance coverage as soon as a change has been made. Failure to do so could result in a denial from your insurance company, making the patient responsible for the balance owing. If your insurance requires a referral you need to request that through your primary care doctor. If there is no referral on file, no appointment can be made.

Third, all medication refill request should be received from the patient's pharmacy. Please contact your pharmacy and request that they contact us directly. Please allow **72 hours** for all medication refills.

Last, please come prepared for your appointment. **Please bring a list of medication, you insulin pump download, your blood sugar logs, blood sugar meters, and any medical records for you visit**.

Sincerely,

Grace-Zlaket-Matta M.D., F.A.CE.

Iyad Syoufi M.D

Scottsdale Endocrinology
9336 Raintree Dr., Ste 150 - Scottsdale, AZ 85260
Phone: 480-219-5597 Fax 480-219-5547
www.scottsdaleendocrinology.com

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Misc. Office Fees:

Disability forms (single) or multiple same rate =	$25
Life insurance =	$25
FMLA =	$25
Jury Duty =	$25
Misc. =	$25

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SCOTTSDALE ENDOCRINOLOGY
REGISTRATION FORM

Today's date:	Please mark what Physician you will be seen today. Dr. Grace Zlaket- Matta, Dr. Iyad Syoufi

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Wid
Former Last name):	Date of Birth / /	Age	Sex: ❑F ❑ M
Street address:	Social Security:	Home/ Cell Phone: ( )	
P.O. Box:	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone: ( )	

Any Drug Allergies:_____

Reason for your visit today:_____

Name of Primary Physician	Phone:_____
Name of Referring Physician	Phone:_____

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Name of Primary Insurance

Subscriber's name:	Subscriber's S.S. :	Birth date: / /	Group:	Policy :	Co-pay: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group :	Policy :

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone. ( )	Work phone. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Scottsdale Endocrinology or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Grace Zlaket Matta MD.
Iyad Syoufi MD.
Board Certified Endocrinology
Medication List

Patient Name: *DOB:*

Name of Medication	Dosage (MG)	Times Taken	Pill or Injection
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
Name Of Insulin	**# of units per day**	**Time Taken**	**Pen Or Vail**
1.			
2.			
3.			
Name BS Meter	**Name of Test Strips**	**Name of Lancets**	**# of times you test a day**
1.			
Name Of Insulin Pump			
1.			
Name of Pharmacy	**Pharmacy Phone #**	**Address of Pharmacy**	**Nearest Cross Streets**
1.			

GRACE ZLAKET-MATTA, M.D., F.A.C.E.
IYAD SYOUFI, M.D.
BOARD CERTIFIED ENDOCRINOLOGY

PRESCRIPTION REFILL POLICY:

Prescription refill request must be made 7-10 days before running out of medication, also please allow up to 72 hours for the refill to be processed. Refills will only be approved if your follow–up visit has been kept per your physician's recommendation. Prescriptions will only be handled during business hours.

_____ Date: _____

Patient's Signature

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Iyad Syoufi M.D.
Broad Certified Endocrinology

As a patient or guardian for a patient receiving services from Dr. Grace Zlaket-Matta, or Dr. Iyad Syoufi, I understand that I am responsible to cancel appointments within appropriate time frames. I do hereby agree to the following:

1) I will cancel a scheduled appointment at least 24 hours before the appointment.

2) I agree to pay a **$50.00 No Show fee** for a scheduled and **confirmed appt/** as well as an **US/ Biopsy** when I fail to cancel my appointment without a 24 hour notice before the appointment.

3) Allowances will be made for failing to keep my appointment due to unavoidable or reasonably.

4) My Provider may terminate my services if I do not cancel or fail to attend three scheduled appointments.

5) Should my Provider terminate my services, they will send me a letter. This letter will explain a 30-day grace period will be given to enable me to secure alternative services, and will also allow prescription refills when medically appropriate for 30 days from the date of the termination of service letter.

Patient/Guardian Signature: _____ Date: _____

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IYAD SYOUFI M.D
BOARD CERTIFIED ENDOCRINOLOGY

Notice of Privacy Practices

Patient Name: _____ DOB: _____

I have the option to **receive** or **decline (circle one)** this practice **Notice of Privacy Practices** written in plain language. The notice providers in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices' legal duties with respect to my protected health information. This practice reserves the right to change the term of its Notice of Privacy Practices and to make new provisions effective for all protected health information that is that it maintains. I understand that I can obtain this practice's Notice of Privacy Practices on request.

I participate in an organized health care arrangement consisting of greater Phoenix metropolitan area hospitals as well as physicians who have medical staff privileges at one or more of these hospitals. Participants in this arrangement work together to improve the quality and efficiently of the delivery of healthcare to their patients. As a participant in this arrangement, we may share your PHI with other members of this arrangement for purpose of treatment, payment or the health care operations of this organized health care arrangement

Patient Signature: _____ Date: _____

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I'm a patient of: **Grace Zlaket-Matta M.D F.A.C.E**

I would like to request that my family member: _____

Be given access to my medical records and/ or medical condition, allowing the staff or physician to discuss my care and any medical changes.

Patient: _____

Date: _____

Witness: _____

Please note: All medical records are kept confidential; no information will be transmitted by phone, fax, or mail without written/verbal consent from the patient.

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Financial Policy

Dear Patient:

Thank you for choosing **Dr. Grace Zlaket-Matta MD and Iyad Syoufi MD** for your endocrinology care. We realize that questions may arise about our payment and collection policies and this notice is designed to provide an overview of these policies. Our goal is to provide quality medical care for our patients and it is important that we work together to assure that reimbursement of our services is straightforward and timely. Our practice administrator or billing department will be happy to discuss these policies with you.

Insurance:

- **You are directly responsible for making sure that either Grace Zlaket-Matta MD or Iyad Syoufi MD is contracted with your insurance and also within your NETWORK. You are directly are responsible for payment of your medical care and you are expected to pay for any co-payment, deductibles, co-insurance, or non-covered amounts at the time of your service**. Your insurance company may not pay for all of your health care costs. Insurance policies exclude some non-covered services. However, this does not mean that the services or tests are not necessary. It means that the insurance company may not pay for it. Please keep in mind that you insurance policy is a contract between you and the insurance company. **The physician has no control over which services the insurance company does or does not cover**.
- In order to bill your insurance company for your medical services, **you must provide our office with accurate billing information and your insurance card**. If you do not provide this information at each visit, please expect to pay in full at the time of the office visit for the services rendered. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in.

Billing:

- As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification, and your insurance card. If your insurance changes, it is your responsibility to provide us with updated insurance information.
- Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.
- In addition to co-payments, deductibles, and co-insurance you are responsible to pay for denied or non-covered services as determined by your insurance company. **If our physician is an "out of network" provider for your insurance, the deductibles and co-insurance amounts may be higher. Your insurance policy, not our office, determines these amounts.**
- You will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you, and which is still being processed by your insurance company. Patient balances are due and payable in full upon receipt of your statement.
- Delinquent accounts will be transferred to a collection agency when payments are not made in accordance with our policy. In the event of default, you will be required to pay collection costs. Accounts sent to collections are reported to all three major credit bureaus and are on file for seven years.

Procedure: FNA or Ultrasound:

Prior to your procedure, our office verifies your insurance benefits and obtains appropriate authorizations from your insurance company. Once your insurance company determines your deductible, co-payment, and/or co-insurance amounts due for your planned surgical procedure, our office will collect the full amount of your expected patient liability prior to your planned surgical procedure.

Please understand that maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

Patient/Responsible Party:

Signature _____ Print _____ Date _____

Witness:

Signature _____ Print _____ Date _____