Grace Zlaket- Matta, M.D.

Iyad Syoufi, M.D.

Emma Reeve, PA

Caitlin Adamowicz, NP

SCOTTSDALEENDOCRINOLOGY REGISTRATION FORM

Today's Date:_____

Last Name:_____First:_____M.I:_____D.O.B:_____Sex: _____

Address:_____City:_____State: _____ Zip Code: _____

Email:_____Marital Status: _____ Advance ***Directive:*** Yes or No

SSN:_____Home number:_____Cell number: _____

Occupation:_____Employer:_____Employer number: _____

Reason for Visit: _____

Name of Primary Care Physician:_____Phone#: _____

Name of Referring Physician:_____Phone#: _____

INSURANCE INFORMATION

Primary Insurance**:** _____ ID#: _____ Group#: _____

Card Holder:_____D.O.B:_____Phone#: _____

Relationship to cardholder:_____Employer:_____Occupation: _____

Address (if different):_____

Secondary Insurance: _____ ID#: _____Group#:_____

Card Holder: _____DOB: _____Phone# _____

Relationship to cardholder:_____Employer:_____Occupation:_____

Address (if different):_____SSN:_____

EMERGENCY CONTACT

Name:_____Relationship to patient:_____Phone#:_____

NOTE: 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 the office staff/biller of Scottsdale Endocrinology or insurance company to release any information required to process my claim

Signature of patient/guardian:_____Date:_____

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

Medication List

Patient Name: _____ DOB: _____

Drug Allergies: _____

Pharmacy /Mail Order	Pharmacy Phone #	Cross Streets	
Name of Medication	Dosage (mg}	Times Taken **(AM-PM)**	Pill/Injection
Name of Insulin	# of units per day	Times Taken **(AM-PM)**	Pen or Vials
Name of BS Meter	Name of Test Strips	Name of Lancets	# of times you test daily
Name of Insulin Pump			

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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 visits have been kept per your physician's recommendation. Prescriptions will only be handled during business hours.

Patient Signature:_____Date:_____

Scottsdale Endocrinology
9336 E. Raintree Drive suite 150, Scottsdale, AZ 85260
Phone: 480-219-5597 Fax: 480-219-5547
www.Scottsdaleendocrinolgy.com

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Iyad Syoufi M.D
Board Certified Endocrinology

As a patient or guardian for a patient receiving services from Dr. Grace Zlaket-Matta, Dr. Iyad Syoufi, or PA Emma Reeve, 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 No Show Fee** for a scheduled appointment and confirmed appointment 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 appointments 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 that 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 Signature:_____Date:_____

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Notice of Privacy Practices

Patient Name: _____ DOB: _____

I have the option to receive or decline *(circle one)* this practices **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 you PHI with other members of this arrangement for purpose of treatment, payment or the health care operations of this organized health care arrangement.

Signature_____Date:_____

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Iyad Syoufi M.D
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(Circle One)
I am a patient of: Grace Zlaket-Matta M.D., F.A.C.E

OR

Iyad Syoufi M.D

I would like to request that this individual:_____

Phone Number: _____

Relationship to individual:_____

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

Patient Signature:_____Date:_____

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 and Iyad Syoufi M.D 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 or Iyad Syoufi MD is contracted with your insurance and also within your NETWORK. You are directly 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 your 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 office 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 collections 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.

Signature_____Date:_____

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NEW OFFICE POLICY

IN ORDER TO SERVE YOU BETTER YOU MUST REGISTER FOR THE **PATIENT PORTAL!!!!**

How to access my Patient Portal go to

www.scottsdaleendocrinology.com

1. Make sure you register at the front desk or check out by giving them your email address.

2. You then will go to your email, Click on the link (asking to change your password)...

3. Once you have changed your password you are an active user in Scottsdale Endocrinology Patient Portal.

4. Once you're an active user, you will be able to receive and confirm your upcoming appointments; you can email us with any clinical questions, medication refills, medication prior auth or lab request. You can also access last office visit and lab results.

5. Our office staff will make every effort to get back to you within 24 hours.

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Iyad Syoufi, M.D.
Emma Reeve, P.A.
Caitlin Adamowicz, N.P.
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Authorization of Medical records

Patient Name: _____DOB: _____

The above authorizes:

Medical provider: _____

Phone: _____ Fax: _____

Purpose of release:

_____ Appointment/ Continuation of care other: _____

Medical records:

Specific records: _____ Date: _____

Radiology Reports: _____ Date: _____

Other: _____Date: _____

_____ _____

Patient Signature **Date**

PLEASE NO CD'S. THANK YOU!!!

To Release medical records information concerning the above mention patient to **Grace Zlaket-Matta MD , lyad Syoufi MD, Emma Reeve PA, or Caitlin Adamowicz N.P.**
This consent will expire in 90days after the signed date below. I have given my consent freely, voluntarily and without coercion, I may revoke this authorization at any time providing I notify them in writing to that effect. I understand that any release which wasn't made prior to revocation in compliance with this authorization shall not constitute a breach of my rights to confidentially. I understand subject to re- disclosure by the recipient and no longer protected by the privacy act.

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