BASSI CLINIC
YOUR HEALTH.OUR PRIORITY

11110 N Tatum Blvd., Ste 103, Phoenix, AZ 85028
Phone: 602.354.3311 • Fax: 602.354.3751

Patient Name: _____ Date of Birth: _____ Date: _____

Patient Authorization:

Notice of Privacy Practices:

Your name and signature below indicate that you have received/been offered a copy of the Bassi Clinic Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in the Bassi Clinic Notice of Privacy Practices, please ask for the Bassi Clinic Medical Director.

Medical Care/Treatment Financial Policy:

If Bassi Clinic has a contract with your health insurance company, we will file today's charges with that insurance company. You will be responsible for your co-payment, coinsurance and/or deductible, and the cost of any services not covered by your insurance. You may receive a bill from Bassi Clinic for any unpaid balance. If you do not have health insurance, or Bassi Clinic does not have a direct contact with your health plan, you will be required to pay for your visit in full at the time services are rendered. You can expect to pay an initial payment for medical services, based on the cost of a basic exam, which will be collected a check-in. You will be given further information on our cash pay rates.

Release of Medical Records, Assignment of Benefits, Financial Responsibility:

I authorize Bassi Clinic to submit claims to my insurance company as well as medical records to evaluate these claims for payment. I further understand payment of benefits, otherwise payable to me, to be made payable to Bassi Clinic. I understand that I am financially responsible for all charges not covered by my insurance company.

Consent for Medical Treatment:

I give permission to Bassi Clinic to perform the medical process, treatment and/or procedure that the physician and other non-physician providers and assistant me deem to be necessary. I authorize Bassi Clinic to release any information obtained during my examination and/or treatment to my health care insurer or the payer.

Signature of Patient/Guardian: _____ Date: _____

Print Name: _____ Date of Birth: _____