# Associated Health Care, LLC ~ Walter M. Gutowski, DC
## 8149 North 87th Place, Scottsdale, AZ 85258

**(PLEASE PRINT)**

**Legal Name:** Last ______________________________ First __________________________________ MI __________

Address ________________________________________________________________ Apartment # ________________

City _________________________________________________ State _______________ Zip Code ________________

Home Phone ( ) _______________________ Pager/Cell Phone ( ) ____________________________________

e-mail: ____________________________________________________________________________________________

Date of Birth ______________________________ Sex: M ___ or F ___ S.S. #: _____________________________

Employer: ________________________________ Work Phone ( ) __________________________ Ext. _________

**Marital Status:** Single _____ Married _____ Divorced _____ Widowed _____

Spouse/Partner's Last Name ____________________________ First Name __________________________ MI ________

Spouse/Partner's Date of Birth __________________________ S. S. # __________________________________________

Spouse/Partner's Employer ______________________________ Work Phone ( ) _______________ Ext. _________

**NEAREST LIVING RELATIVE **(SOMEONE OTHER THAN YOUR SPOUSE/PARTNER)****

Name _________________________________________ Relationship to Patient ___________________________________

Home Phone ( ) ____________________________ Work Phone ( ) _________________________ Ext. ______

Who Referred You To Our Office? _______________________________________________________________________

Who Is Your Primary Care Physician? ____________________________________________________________________

Were you in an automobile accident in the last 12 months? ______ If so, when? _________________________________

With whom may we discuss your medical information (i.e. spouse, children, friend, other relative)? ____________________

______________________________________________________________________________________________________

****MOST INSURANCE COVERAGE PAYS ONLY A PORTION OF THE COST OF SERVICES**CHECK YOUR BENEFITS ****

Primary Insurance Company _____________________________________________________________________________

Policy Holder's Name ________________________ Date of Birth: ________________ S. S. # _________________________

Secondary Insurance Company ___________________________________________________________________________

Policy Holder's Name ________________________ Date of Birth: ________________ S. S. # _________________________

**I understand I am responsible for ALL charges incurred regardless of possible insurance coverage, except as otherwise provided by contract or law. If my account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I hereby authorize Associated Health Care, LLC to file insurance on my behalf, where applicable, and to release any Protected Health Information necessary to process such claims. I hereby authorize my physician to file a lien with the County Recorder's Office documenting the existence of any outstanding charges owed by me to the physician. I hereby authorize payment directly to the physician of the medical benefits, if any, otherwise payable to me. I have read and completed all the information on this sheet and certify this information is true and correct to the best of my knowledge. I will notify the practice of any changes in my health insurance status or any changes in the above information. I am aware of the policies regarding payment and furthermore consent to treatment by Walter M. Gutowski, DC (Associated Health Care, LLC).**

Signature: ____________________________________________________________________ Date: ______________________

I, _____________________________________________ have reviewed my medical benefits policy manual, that was provided to me by my insurance company. I understand the reimbursement benefits, which include the deductible, coinsurance percent of payment, and /or co-pay amount and non-covered services that I am responsible for to the doctor from whom I am receiving services.

Co-pays, co-insurance and deductibles are due when services are rendered. The remaining balance, if any, is due upon receipt once your insurance company has processed your claim.

If you have Medicare, we **DO NOT** accept assignment. Our office will submit your Medicare charges, and as a courtesy we will file one claim, per date of service to your secondary/supplemental insurance company. If you have a plan that participates with medi-gap crossover, Medicare will automatically transfer this information to the insurance company direct.

If you have a **"PPO"** policy, please be advised that the doctor is **NOT** contracted with any **"PPO"** plans. What this means to you is you will be using your "Out of Network" benefits (if you have this benefit) so you will be subject to a higher out of pocket cost, which is normally a larger deductible and a higher co-insurance percent, if the charges are covered at all.

Patient Signature: ______________________________________________ Date: ____________________

Legally Authorized
Representative & Relationship: __________________________________ Date: ____________________
(If Patient Is Unable To Sign)

---

The law requires that we provide to the patient a copy of our Notice of Privacy Practices for health information. By signing below, the patient acknowledges receipt of such, or if you are the patient's legal representative or authorized agent, you acknowledge receipt of such.

Patient Signature: ______________________________________________ Date: ____________________

Legally Authorized
Representative & Relationship: __________________________________ Date: ____________________
(If Patient Is Unable To Sign)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ Other (please specify) _____________________________________________________________

Office Staff Signature: __________________________________ Date: ____________________________