□ **NEW REGISTRATION** □ **UPDATED** □

ARIZONA ADVANCED SURGERY, LLC

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS	CITY	STATE	ZIP	SEX □ MALE □ FEMALE

HOME PHONE #	EMAIL	CELL PHONE #	MARITAL STATUS: □ MARRIED □ SINGLE □ WIDOWED □ DIVORCED □ OTHER

REFERRING PHYSICIAN NAME AND PHONE NUMBER	PCP NAME & PHONE#

HOW DID YOU HEAR ABOUT US: □ PROVIDER REFERRAL □ INTERNET □ WORD OF MOUTH □ PREVIOUS PATIENT □ CURRENT PATIENT □ BROCHURE □ INSURANCE □ HOSPITAL □ CONCENTRA □ MAGAZINE □ RADIO □ OTHER

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE	**ETHNICITY**	**RACE**
□ ENGLISH □ SPANISH □ RUSSIAN □ CREOLE □ OTHER _____	□ LATINO/HISPANIC □ NON LATINO/NON HISPANIC	□ ASIAN □ NATIVE HAWAIIAN □ OTHER PACIFIC ISLANDER □ BLACK/AFRICAN AMERICAN □ AMERICAN INDIAN/ALASKA NATIVE □ WHITE □ REFUSE TO REPORT

RESPONSIBLE PARTY INFORMATION (financial responsibility)

LAST NAME	FIRST NAME	MI	HOME PHONE

ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY □ SELF □ SPOUSE □ CHILD □ OTHER

EMERGENCY INFORMATION

NEXT-OF-KIN OR CONTACT INFO –	PHONE

PHARMACY

NAME AND LOCATION	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SECONDARY INSURANCE	**SUBSCRIBER NAME AND SOCIAL SECURITY**	DATE OF BIRTH

GROUP NUMBER	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY TERMS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, agree to and signed the Arizona Advanced Surgery's Financial Policy. I agree I will be responsible for any unpaid balances for any reasons

I hereby authorize direct payment to Arizona Advanced Surgery, LLC of any medical benefits payable to me for the services provided at Arizona Advanced Surgery

X_____

Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE

I hereby authorize Arizona Advanced Surgery, LLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X_____

Patient Signature or Signature of Guardian or Parent Date

SONORAN SURGICAL CENTER

Health History - General Surgery

Name: _____ **DOB:** _____
Preferred Name (Nickname): _____
Pharmacy Name: _____ **Pharmacy Address:** _____
PCP/Referring Provider Name: _____
List of all doctors you see (Care Team): _____

Reason for today's visit: _____
When did your symptoms begin? _____
What triggers your symptoms? _____
What makes your symptoms better? _____
Grade your pain 0-10 (0= no pain and 10=worst pain): _____
What treatment have you had for your symptoms? _____

Was this a result of an injury? ☐ Yes ☐ No

If yes, please complete the following questions:

What type of injury? ☐ Auto ☐ Worker's Compensation ☐ Other

Date of Injury: _____

Describe how it happened? _____

If injured, is litigation ongoing? ☐ Yes ☐ No

Are you: ☐ Off Work ☐ Modified Duty ☐ Full Duty

ALLERGIES List all allergies to medications or foods and your reaction:

ALLERGY	REACTION

MEDICATIONS Please list all medicines you are currently taking (include over the counter such as vitamins):

NAME OF MEDICATION	DOSAGE	HOW OFTEN PER DAY

FEMALE PATIENTS ONLY:
Date of Last Mammogram: _____
Date of Last Menstrual Cycle: _____
Date of Last Pap Smear: _____

SONORAN SURGICAL CENTER

PAST MEDICAL HISTORY Have you ever been told you had one of the following? *Please check Yes, if you have now or have had in the past.*

	Yes	No		Yes	No
AFib (Atrial Fibrillation)	☐	☐	Gastrointestinal Disease (IBS, Gastritis, Ulcer, Acid Reflux)	☐	☐
AIDS	☐	☐	Hearing Loss	☐	☐
Anemia	☐	☐	Heart Attack (Myocardial Infarction)	☐	☐
Anesthetic Complication	☐	☐	Heart Disease/Valve Disease	☐	☐
Anxiety	☐	☐	Heart Rhythm Problem (Palpitations)	☐	☐
Asthma	☐	☐	Hernia (Hiatal, Inguinal, Umbical, Ventral)	☐	☐
Bladder Problems	☐	☐	High Blood Pressure (Hypertension)	☐	☐
Bleeding Problems	☐	☐	High Cholesterol (Hyperlipidemia)	☐	☐
Blood Clot (Deep Vein Thrombosis)	☐	☐	HIV	☐	☐
Breast Problem (Breast Lump/Pain/Discharge)	☐	☐	Implantable Pacemaker/Defibrillator/AICD	☐	☐
CAD (Coronary Artery Disease)	☐	☐	Liver Disease/Hepatitis	☐	☐
Cancer	☐	☐	Memory Loss (Dementia)	☐	☐
Celiac Disease	☐	☐	Mental Illness (Bi-Polar Disorder, Schizophrenia)	☐	☐
CHF (Congestive Heart Failure)	☐	☐	MRSA (Antimicrobial Resistance)	☐	☐
Claustrophobic	☐	☐	Neuropathy (Numbness, Pain, Tingling)	☐	☐
Constipation	☐	☐	Prior Blood Transfusion	☐	☐
COPD (Chronic Obstructive Pulmonary Disease)	☐	☐	Pulmonary Embolism (Blood Clot in the Lung)	☐	☐
Depression	☐	☐	Rheumatic Fever	☐	☐
Developmental Disorder	☐	☐	Seizure Disorder	☐	☐
Diabetes (Insulin Dependent)	☐	☐	Sickle Cell Anemia	☐	☐
Diabetes (Non-Insulin Dependent)	☐	☐	Sleep Apnea	☐	☐
Diarrhea	☐	☐	Stroke/TIA	☐	☐
Diverticulitis (Inflammation of the bowel)	☐	☐	Substance Abuse (Alcohol, Drug)	☐	☐
Edema (Swelling)	☐	☐	Thyroid Disease/Disorder	☐	☐
Eye Problems (Glaucoma, Retinopathy, Macular Degeneration)	☐	☐	Tuberculosis	☐	☐
Gallbladder Disease / Stones	☐	☐	Other Disease(s):	☐	☐
			Other:		

SONORAN SURGICAL CENTER

FAMILY HISTORY Please list any relative with the following medical problems and their relationship to you:

	Relationship
☐ Blood Clot (Deep Vein Thrombosis)	
☐ Breast Cancer	
☐ Colon Cancer	
☐ Depression	
☐ Diabetes (Diabetes Mellitus)	
☐ Heart Attack	
☐ Heart Disease (Other than heart attack)	
☐ High Blood Pressure	
☐ Other Cancer	
☐ Ovarian Cancer (Malignant Tumor of Ovary)	
☐ Stroke	
☐ Substance Abuse	

SOCIAL HISTORY

Tobacco Use	Do you currently use tobacco? ☐ Yes ☐ No Did you use tobacco in your past? ☐ Yes ☐ No How Long? _____ Year Quit: _____ ☐ Cigarettes-___/day ☐ Chew-___/day ☐ Cigars-___/day
Alcohol Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy How many days in the past year have you had a heavy drinking consumption (4+ female, 5+ male)? ____
Caffeine Intake	☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day _____
Live alone or with others?	☐ Alone ☐ With others
Able to care for self ?	☐ Yes ☐ No
Employment:	Occupation: Employer:
Is blood transfusion acceptable in an emergency?	☐ Yes ☐ No
Advance directive?	☐ Yes ☐ No

PAST SURGICAL HISTORY Have you ever had the following:

	Year		Year
☐ Abdominal Aortic Aneurysm Repair		☐ Gallbladder Surgery	
☐ Abdominal Surgery		☐ Heart Surgery (Cardiac)	
☐ Angioplasty		☐ Hemorrhoidectomy	
☐ Appendectomy		☐ Hernia Repair	
☐ Bariatric Surgery		☐ Hysterectomy	
☐ Breast Surgery (Lumpectomy, Biopsy, Implants)		☐ Kidney Surgery	
☐ Cancer Surgery		☐ Mastectomy	
☐ Cesarean Section		☐ Sinus Surgery	
☐ Colon Surgery		☐ Splenectomy	
☐ Coronary Artery Bypass Graft (CABG)		☐ Thyroid Surgery	
		Other Surgeries:	

Any other Medical/Surgical history/conditions, please inform the nurse.

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Review of Systems

Check all that apply:

Constitutional
☐ Yes ☐ No Recent Weight Change
☐ Yes ☐ No Decreased Appetite
☐ Yes ☐ No Fever
☐ Yes ☐ No Sweats
☐ Yes ☐ No Fatigue

Head
☐ Yes ☐ No Headaches

Eyes
☐ Yes ☐ No Vision Changes
☐ Yes ☐ No Eye Disease/Injury

ENMT
☐ Yes ☐ No Difficulty Hearing/Ringing
☐ Yes ☐ No Sinus Pain
☐ Yes ☐ No Nosebleeds
☐ Yes ☐ No Nasal Discharge
☐ Yes ☐ No Teeth/Gum Problems

Cardiovascular
☐ Yes ☐ No Heart Trouble
☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Swelling of Feet/ Ankles/Hands
☐ Yes ☐ No High Blood Pressure

Breast/Chest
☐ Yes ☐ No Breast Pain
☐ Yes ☐ No Breast Mass/Lump
☐ Yes ☐ No Nipple Discharge

Respiratory
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Cough
☐ Yes ☐ No Difficulty Breathing

Gastrointestinal
☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Appetite Changes
☐ Yes ☐ No Change in Bowel Movement
☐ Yes ☐ No Nausea
☐ Yes ☐ No Vomiting
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Constipation
☐ Yes ☐ No Rectal Bleeding
☐ Yes ☐ No Stomach Ulcer

Genitourinary
☐ Yes ☐ No Kidney Disease

Musculoskeletal
☐ Yes ☐ No Muscle Pain
☐ Yes ☐ No Joint Pain

Integumentary
☐ Yes ☐ No Rash/Mole Change
☐ Yes ☐ No Itching/Rash
☐ Yes ☐ No Change in Hair/Nails
☐ Yes ☐ No Change in Skin Color
☐ Yes ☐ No Varicose Veins

Neurologic
☐ Yes ☐ No Headaches
☐ Yes ☐ No Dizziness or Lightheadedness
☐ Yes ☐ No Numbness
☐ Yes ☐ No Memory Loss
☐ Yes ☐ No Loss of Coordination

Heme/Immunology
☐ Yes ☐ No Slow to Heal After Cuts
☐ Yes ☐ No Bleeding/Bruising Tendency
☐ Yes ☐ No Anemia
☐ Yes ☐ No Blood Clots
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Enlarged Glands

Allergic/Immunologic
☐ Yes ☐ No HIV

Skin Reaction or Other Adverse Reaction to:
☐ Yes ☐ No Penicillin/Antibiotics
☐ Yes ☐ No Morphine/Demerol Other Narcotics

Endocrine
☐ Yes ☐ No Glandular/Hormone Problem
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Excessive Thirst
☐ Yes ☐ No Excessive Urination

Psychiatric
☐ Yes ☐ No Problems with Sleep
☐ Yes ☐ No Memory Loss/Confusion

Financial Policies

Thank you for choosing Arizona Advanced Surgery for your surgical needs. We are committed to providing you with the highest quality medical care. Maintaining a good physician-patient relationship is our primary goal. Patients are ultimately responsible for the charges associated with their care. We realize you have choices for your medical care and appreciate you choosing Arizona Advanced Surgery.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card(s) and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any requested medical records, including tests and x-rays
- Paying your estimated portion of the charges at the time of service and paying any additional amount owed when due
- Providing us with at least 48-hour advance notice should you need to cancel or reschedule an office appointment to avoid $25.00 fee
- Providing us with at least 72-hour advance notice should you need to cancel or reschedule a procedure/surgery to avoid $250.00 fee

Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

For our patient's convenience we participate in most major health plans and have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid (AHCCCS). Our business office will submit claims for services rendered to a patient who is a member of one of these plans and assist you in any way we reasonably can to help get your claims paid.

It is the patient's responsibility to provide all necessary information at the time the appointment is scheduled. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you are insured by a plan, we contract with but don't have an insurance card with you, payment in full for each visit is required until you furnish us with a copy of the card and your coverage can be verified.

New Policy Effective 2020 Credit Card on File for Co-Pays/Deductibles/Co-Insurance
You will be asked to leave a credit card on file to be run after your insurance has processed your claim for any outstanding balances, refusal to do this will result in you paying your estimated patient responsibility such as copay, co-insurance and/or deductible amounts as required by your insurance carrier at the time of your appointment.
Your insurance company requires us to collect co-payments at time of service. Waiver of co-payments may constitute fraud under state and federal law. **We do not accept cash or checks**. We do accept the following credit cards: Visa, Master Card, Discover and American Express. If you do not have your co-payment your appointment may be rescheduled.

Surgery
If surgery is indicated, our office will either collect as a pre-payment any remaining deductible and/or co-insurance you may have prior to your surgery or you will be asked to leave a credit card on file to be run after your insurance has processed your claim. Your out of pocket cost is estimated based on your benefits and our fees. Anesthesia, facility, and other providers are separate fees. Our office will provide written notification to you detailing anticipated charges for **your surgeon ONLY**. If your remaining deductible is not applied to our claim by your insurance company, a credit will appear on your account and a refund will be promptly processed.

Motor Vehicle Accidents (MVA) Insured and Third-Party Patients
We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time; the bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles.
Workers' Compensation

If your visit is work-related, we will need the case number, date of injury, carrier name and phone number prior to your visit to bill the workers' compensation insurance carrier. If your claim is not yet accepted, we will bill your private insurance and if uninsured payment in full is expected.

Other Charges
No Show - Please provide us with at least **48 hours'** advanced notice if you need to cancel or reschedule an office appointment. **Procedure/surgery cancels** require a **72 hours'** advanced notice. Failure to cancel a scheduled office appointment will be subject to a **$25.00** fee and failure to cancel a scheduled surgery/procedure will be subject to a **$250.00** fee.

Forms

There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow 5 business days for us to complete the forms.

Payment Options - We only accept the following major credit/debit cards Visa, Master Card, Discover and American Express we will accept checks as a form of payment after your Insurance has processed your claim and you receive a statement indicating you have a balance due. We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts - We allow 30 days from date of filing for an insurance company to process and/or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. It is your responsibility to provide your insurance company with requested information needed to process a claim. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional services. Patient balances are billed immediately on receipt of your insurance company payment or receipt of Explanation of Benefits (EOB). Your remittance is due within 10 business days of your receipt of your bill.

Alternative Payment Arrangements - If you are unable to pay your balance when due, please contact our business office at 602-258-9900 option 1 to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Prior Bad Debt - Patients, who have previously never satisfied their payment obligations for prior episodes of care with Arizona Advanced Surgery, will be required to pay those in full before receiving additional care.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I acknowledge that I have been provided the Arizona Advanced Surgery, LLC Notice of Privacy Practices:

- It tells me how the organization will use my health information for the purpose of my treatment, payment for my treatment and its health care operations.
- The notice explains in more detail how the practice may use and share my health information for purposes other than treatment, payment and health care operations.
- The organization will also use and share my health information as required/permitted by law

Printed Patient Name	Patient's Date of Birth
Signature of Patient	Date
Signature of Client/Personal Representative	Relationship to Patient

☐ **I consent to receive calls from AAS providers/staff for my protected healthcare and other services at the phone numbers provided by myself, including my wireless number I provided. I understand that I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.**

Please list all family member(s)/guardian(s) that may access your medical records and/or financial and billing information. Please List ALL:

Name of Person	Relationship to Patient	Medical Only	Billing Only	Both
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Arizona Advanced Surgery, Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Arizona Advanced Surgery actually receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

To access our complete Notice of Privacy Practices, please visit our website at ArizonaAdvancedSurgery.com Or call the office to have a copy sent to you.

ARIZONA ADVANCED SURGERY

Credit Card Authorization Form

Patient Name: _____ DOB: _____

The purpose of this form is to authorize Arizona Advanced Surgery to retain a valid credit card number on file for you. This information will be kept secure and can only be accessed by authorized staff. Your credit card will ONLY be charged under the following circumstances:

Copays/Coinsurance/Deductible: AAS reserves the right to charge the credit card on file for all patient balances including copays, coinsurance, deductibles and any patient responsibility as directed from your insurance company. A receipt will be sent to you for all transactions. This notice serves as your consent to being charged for all current patient balances on your account.

No Show Appointment Fee: If a patient misses a scheduled appointment in the office without a 48-hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $25.00 fee. If a patient misses a scheduled surgery appointment without a 72-hour notice to cancel or reschedule, AAS reserves the right to charge the credit card on file a $250.00 fee.

Returned Payment Fee: If we receive notice that a payment is returned to us for any reason, AAS reserves the right to charge the card on file a $40 returned payment fee.

Self-Pay Patients: If you are a self-pay patient without insurance, AAS reserves the right to charge the credit card on file for services performed.

Refusal to sign: In the event you opt not to sign the credit card authorization form you will be required to prepay for all services according to your benefit plan. You will receive **ONE** statement for any remaining balances. If the balance is not paid within 14 days, you will incur a $25.00 service fee for each additional statement.

Other than the conditions mentioned above, under NO circumstances will AAS charge your credit card for anything not discussed with you personally. In conjunction with HIPAA regulations, all credit card information will be confidential and securely kept within our PCI compliant merchant service system. PCI compliance is required by credit card companies to make online transactions secure and protect them against identity theft. Any merchant that wants to process, store or transmit credit card data is required to be PCI compliant, according to the PCI Compliance Security Standard Council. Only authorized staff will be able to access this information.

By signing the credit card authorization form, you understand that as soon as your EOB (explanation of benefits) is received by our office from your insurance company your credit card will be charged for the balance due on your account.

Acknowledged, Agreed, & Accepted. Having read this form, my signature below acknowledges that I give my authorization and consent for my credit card to be charged for the conditions listed above.

_____ _____

Patient Signature Date Staff Signature Date

IMPORTANT NOTICE

Our new office policy requires every patient account have a credit or debit card stored on your secure patient account to take care of outstanding balances, copays or deductibles that are due.

ARIZONA ADVANCED SURGERY

Credit Card on File Refusal Form

Patient Name: _____ **DOB**: _____

By signing this form, I understand that by opting out of credit card on file I will be required to pre-pay for all services according to my benefit plan. I also understand that any remaining balances must be paid within 14 days of receiving the first statement or I will be charged a fee of $25 service fee for each additional statement generated.

_____ _____

Patient Signature Date Staff Signature Date

ARIZONA ADVANCED SURGERY

Financial Policy Acknowledgment:

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

Please initial below to acknowledge that you have read our financial policy, which reflects that you as the patient are ultimately responsible for the charges associated with your care.

Initial: _____

Please initial below to acknowledge that you are aware of our appointment cancelation/no-show policy which states:

If 48-hour notice is not given prior to an office appointment, you will be charged a $25 fee.

Initial: _____

If 72-hour notice is not given prior to a scheduled surgery, you will be charged a $250 fee.

Initial: _____

To access our financial policy, please visit our website at ArizonaAdvancedSurgery.com
Or call the office to have a copy sent to you.

Patient Signature: _____ Date:

Staff Signature:_____ Date:

SMS Communications Privacy Policy

Effective Date: November 26, 2024

Sonoran Surgical Center ("we", "us", "our") is committed to protecting the privacy of our patients. This Privacy Policy outlines how we collect, use, disclose, and safeguard your personal information when you receive text messages from us. By subscribing to our text messaging service, you consent to the practices described in this policy.

1. **Information We Collect**

   We may collect the following types of information when you opt-in to our text messaging service:

   - Phone Number: We collect your mobile phone number to send you SMS text messages.
   - Messages: We collect the content of the messages you send and receive from us.
   - Opt-In Information: If you opt to receive SMS text messages from us, we will store your consent information.

2. **Use of Your Information**

   We use the information we collect to:

   - Send you text messages related to send you appointment reminders and other communications relating to your care and treatment or let you know about treatment alternatives or other health-related services or benefits that may be of interest to you.

3. **Sharing Your Information**

   - We do not share your personal information with third parties except the providers who are associated with your care, treatment, and health.
   - SMS opt-in and phone numbers for the purpose of SMS will not be shared with third parties and affiliates for marketing purposes.

4. **Data Security**

   We implement reasonable and appropriate security measures to protect your personal information from unauthorized access, disclosure, alteration, or destruction.

5. **Opting Out**

   You have the right to opt out of receiving SMS text messages from us at any time. To do so, reply with 'STOP' to any message you receive from us. Once you opt out, you will no longer receive messages from us.

6. **Changes to this Policy**

   We reserve the right to update or change this Privacy Policy. We will notify you of any changes vis SMS text message, email, or by posting a notice on our website.

7. **Contact Us**

   If you have any questions, concerns, or requests related to your personal information, please contact us at:
   Sonoran Surgical Center
   5700 W Olive Ave Suite 106, Glendale, AZ 85302
   sonoransurgicalcenter@azadvanced.com

Please review this Privacy Policy periodically to stay informed about how we are protecting your information. Your continued use of our SMS text messaging service constitutes acceptance of any changes or updates to this policy.

This Privacy Policy is effective as of the date indicated above and applies to SMS text messaging services provided by Sonoran Surgical Center.

SMS Communications Terms & Conditions

Effective Date: November 26, 2024

Please read these SMS Communications Terms & Conditions (the "SMS Terms") carefully. By enrolling or otherwise agreeing to receive text messages from or on behalf of Sonoran Surgical Center, you agree to these SMS Terms, as well as Sonoran Surgical Center's Terms of Use and Privacy Policy. For purposes of these SMS Terms, "Sonoran Surgical Center," "the Company," "we," or "us" shall mean Sonoran Surgical Center/Arizona Advanced Surgery and any of its subsidiaries, divisions, or affiliates.

1. Opting into SMS Text Messages

By opting in to Sonoran Surgical Center's SMS text messaging service, you expressly consent to receive text messages related to appointment reminders and other communications relating to your care, treatment, or surgery as well as treatment alternatives or other health-related services or benefits that may be of interest to you at the cell phone number you provide us. Please note we may not be able to deliver messages to all mobile carriers. Message and data rates may apply. Information obtained as part of the SMS consent process will not be shared with third parties.

2. How to Opt-Out and Get Help

To stop receiving text messages from Sonoran Surgical Center, you agree to reply STOP to the number sending the message at any time. After replying STOP, you will receive additional communications confirming that your request has been received and processed. Once you opt-out, you will no longer receive messages from us. If you need further assistance, text HELP to the number sending the message, or contact Sonoran Surgical Center's office at 623-377-7011.

After opting out of receiving text messages and if you decide to opt-in again, you can re-enroll in our SMS text messaging service by contacting our office at 623-377-7011. We would be happy to welcome you back.

3. Cost

Message and data rates may apply for any messages sent to you from or on behalf of Sonoran Surgical Center, and messages you send to us. If you have any questions about your text plan or data plan, it is best to contact your wireless provider.

4. Changes to the SMS Terms

These SMS Terms may be updated by Sonoran Surgical Center at any time without prior notice. By continuing to be enrolled in our SMS text messaging service, or by providing your cell phone number for transactional, operational, or informational text messages, you agree to any changes.

5. Questions

For questions about these SMS Terms or Sonoran Surgical Center's SMS text messages, please contact our office at 623-377-7011 or sonoransurgicalcenter@azadvanced.com.

☐ **By checking this box, you agree to receive SMS text messages from Sonoran Surgical Center at the phone number you provided. Reply STOP to opt out at any time. Reply HELP to the number sending the message for Patient Care Contact Information. Messages and data rates may apply. Message frequency will vary.**