Arizona Family Geriatric Medicine

Patient Registration

Patient's Name (Last, First, MI): _____

Patient's Phone Number: _____ Alternative Phone Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Social Security #: _____

Email: _____ How did you hear of us?

Emergency Contact: _____ PH. #: _____ Relationship: _____

Marital Status: _____ Occupation: _____

Sex: ☐ male ☐ female ☐ transgender/ non-binary

Race (please ✔check below):

☐ Caucasian ☐ Asian or Pacific Islander ☐ African-American

☐ Hispanic ☐ American Indian ☐ Other: _____ ☐ Decline to answer

Primary Language: _____

PRIMARY INSURANCE

ID #: _____

Group #: _____

Policy Holder Name: _____

Policy Holder Date of Birth: ____/____/____

Policy Holder's SSN: _____

Patient Relationship to PolicyHolder: _____

SECONDARY INSURANCE

ID #: _____

Group #: _____

Policy Holder Name: _____

Policy Holder Date of Birth: ____/____/____

Policy Holder's SSN: _____

Patient Relationship to Policy Holder: _____

Preferred Pharmacy: _____ PH. #: _____ Cross Streets: _____

I hereby give permission to bill my insurance company(s) and accept payment from them. I understand my insurance company may assist me in paying my medical costs, but I am ultimately responsible for all medical services rendered. I authorize the release of any medical information necessary to process any claims to my insurance company.

Signature of Patient/ Parent or Guardian: _____

Date: _____

Medical History

INJURY/ILLNESS: List any past injury or illnesses.	Hospitalized Yes or No?	Date or year
SURGERY: List any history of surgery & reason *(for e.g., thyroid issues, knee surgery, diabetes, etc.)*		
Type of Surgery	Reason	Year
ALLERGIES: List any allergies & reactions to medication *(for e.g., hives, difficulty breathing, swelling, etc.)*		
Medication List:		
Name of medication	Reaction(s)	

Smoking History:

Have you ever smoked cigarettes: ____Yes ____No
Do you smoke now? ____Yes ____No
Number of packs per day: _____
Start year_____ End year_____
Do you use smokeless or chewing tobacco? ____Yes ____No
If yes, how much? _____

Alcohol & Drug Use:

Do you drink alcohol ____daily ____weekly _____occassionally____socially
How often: _____
Do you use marijuana: ____no ____medically _____socially
How often: _____
Do you currently or have you ever used any illegal substances: ____Yes _____No
Explain: _____

FAMILY MEDICAL HISTORY				
Relative	Deceased or Alive	Age	Cause of Death	Illness

Any other information the provider should be aware of?

_____

_____

SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO SPOUSE OR FAMILY MEMBER

Many of our patients allow family members, such as their spouse, significant other, parents, or children to call and request the results of tests, procedures, and financial information. Due to H.I.P.A.A. regulations *we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information and/or financial information released to any family members you must sign this form. You have the right to revoke this consent at any time by notifying Arizona Family Medicine and Geriatric PLLC in writing.*

Patient's Name: _____ Date of Birth: _____

I authorize Arizona Family Medicine and Geriatric, PPLC. to release my records and any information requested to the following individuals:

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

Patient's Signature: _____ Date: _____

Acknowledgement of General Consent and Right to Refuse Treatment

I understand that the care provided by Arizona Family Geriatric Medicine includes treatment from a multidisciplinary team, such as a physician, nurse practitioner, physician assistant, medical assistants, and other health care professionals

I understand that I have the right to participate in decisions about my medical care. I have been informed about my rights and responsibilities when I receive services at Arizona Family Geriatric Medicine.

I understand that the treating provider(s) involved in my care has the responsibility to explain the nature, purpose(s), and common risks of my diagnostic treatment.

I authorize the treating provider(s) involved in my care to carry out necessary examinations, assessments, and/or treatments that they consider advisable, in order to consult my health, injury, illness, and overall well being.

I understand I have the right to refuse any suggested examination(s), test(s), or treatment(s).

<u>Acknowledgement of Right to Refuse Treatment:</u>

I understand that I retain the right to refuse any particular examination(s), test(s), procedure(s), treatment(s), therapy or medical recommendations suggested by the treating provider(s).

I understand the risks of declining treatment, medication or testing recommended by the treating physician(s).

Signature of Patient/Parent or Guardian: _____
Date:_____

Financial Policy

Please carefully read and sign the statement below. This policy has been implemented to ensure that financial payments are recovered to allow us to continue to provide quality medical care to our patients. Our billing department can discuss these policies with you.

- I understand that I am required to provide a copy of all insurance plans that I currently have along with a valid photo ID. Failure to provide all insurance information may be considered fraudulent and may result in services not being rendered and/or dismissal from the practice
- I understand that if my insurance changes, it is my responsibility to update this information. If there is a non-payment for service(s) as a result of incorrect information or a lapse or change in health coverage, I am responsible for the charges incurred
- I understand that I am responsible for knowing my copay, deductible, co-insurance, and patient cost share
- I understand that not every service is covered by every insurance plan. Some or all of my services might not be covered or might not be considered medically necessary by my plan. If that is the case, I will be responsible for the full cost
- I understand that copayments are collected at the time of check-in. Any outstanding balances for prior visits will be collected before I can be seen. It is expected that my account will be in good standing at each visit
- If I bring a minor, under 18 years of age, the parent or guardian is responsible for any payments that are due at the time care or services are received. If a responsible adult is not present or if payment has not been arranged in advance, treatment that is not urgent may be rescheduled
- I understand that if my deductible is not met at the time of service, either a partial or full amount will be due at check-in. I will be billed for my outstanding balance

- I understand that if I am paying cash only (meaning no credit card or check payment) for my office visits, the full balance has to be paid at the time of the visit. There is a discount fee of 10% for cash paid visits. The discount does not apply to payments made with a credit card or check
- I understand that there is a $75.00 fee for each returned check
- I understand that there is a $150.00 fee for each appointment that I do not show up to. This fee is not payable by insurance
- I understand that there is a $150.00 fee for each last minute appointment cancellation. In order to avoid this fee, I need to cancel my appointment more than 24 hours from my scheduled appointment time. The appointment cancellation fee is not payable by insurance

- Services and procedures are coded and billed based on what the provider determines as medically necessary in accordance with national coding guidelines. Codes cannot be modified to fit a certain category of benefits
- I understand that if I am enrolled in a managed care organization or health maintenance organization (HMO), I must assign Dr. Minh Luong as my primary care provider before I can be seen
- I understand that if I have a HMO plan, I am required to have a referral from my primary care provider in order to see a specialist. Appointments are required for referrals and no retroactive referral can be issued

Signature of Patient/Parent or Guardian: _____
Date:_____

Acknowledge of Receipt of Privacy Notice

Arizona Family & Geriatric Medicine

5602 East Main Street. Mesa, AZ. 85205

⚠ This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Arizona Family & Geriatric Medicine, PLLC, is required by law to maintain the privacy and confidentiality of your protected information and to provide our patients with notice of our legal duties and privacy practices with respect to your healthcare information.

DISCLOSURE OF YOUR HEALTHCARE INFORMATION

- ➔ We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare options.
- ➔ We may disclose your healthcare information to your insurance provider for the purpose of payment or healthcare options.
- ➔ We may disclose you healthcare information as necessary to comply with States Worker's Compensation laws (only if they apply to your care)
- ➔ We may disclose your healthcare information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or death.
- ➔ As required by law, we may disclose your healthcare information to the public health authorities for purpose related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products or reaction to medications and reporting disease or infection exposure.
- ➔ We may disclose your healthcare information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, subpoena or other law enforcement purposes.
- ➔ We may disclose your healthcare information to coroners or medical examiners.
- ➔ We may disclose your healthcare information to organizations involved in procuring, banking, or transplanting of organs and tissues.
- ➔ We may disclose your healthcare information to researchers conducting research that has been approved by an Institutional Review Board.
- ➔ It may be necessary to disclose your healthcare information to appropriate persons in order to prevent or lessen a serious and imminent threat or safety of a particular person or to the general public.
- ➔ We may disclose your healthcare information for military, national security, prisoner and government benefits purposes.

- ➔ In the event that AZFGM is sold or merged with another organization, your healthcare information/medical records will become property of the new owner.
- ➔ You have the right to request restrictions on certain uses and disclosures of your healthcare information. This must be requested in writing. Please be advised, AZFGM is not required to agree to your request.
- ➔ You have the right to have your healthcare information received or communicated through an alternative method or sent to an alternative location other than the usual methods of communication or delivery, upon your written request.
- ➔ You have the right to inspect your healthcare information.
- ➔ You have the right to request that AZFGM amend your protected healthcare information by doing so in writing. Please be advised, AZFGM is not required to amend your protected health information. If your request to amend your healthcare information has been denied, you will be provided with an explanation of our denial reason(s) and information how you can disagree with the denial.
- ➔ You have the right to receive an accounting of disclosures of your protected healthcare information made by AZFGM.
- ➔ You have the right to a paper copy of this Notice of Privacy Practices at any time upon request (P) 480-854-9004 (F) 480-832-1858 5602 E Main St Mesa, AZ 85205
- ➔ AZFGM reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such an amendment is made, AZFGM is required by law to comply with this notice.
- ➔ AZFGM is required by law to maintain the privacy of your healthcare information and to provide you with notices of legal duties and privacy practices with respect to your healthcare information. If you have any questions about any part of this notice or if you want more information about your privacy rights please contact the Office Manager at 480-854-9004.
- ➔ This notice is effective as of today's date listed on the privacy acknowledgement form.

ACKNOWLEDGEMENT OF THE PATIENT'S PRIVACY NOTICE

By signing below, I agree that I have received a copy of The Patient's Privacy Notice.

Patient's Name (Print): _____

Patient's Signature: _____ Date: _____

Printed Name (if signed on behalf of patient): _____
Relationship to Patient: _____

Authorization to Release Medical Records

Patient Name:	**D.O.B.**

Please release the following information only as indicated below:

Medical Record	**Indicate using a ✔ mark next to record**
Last 2 office visits	
Recent lab reports	
Recent radiology reports	
Recent cardiac testing (e.g, *echo, stress test, ekg, cath report)*	
Other:	

I hereby authorize Arizona Family & Geriatric Medicine, PLLC. to

_____Release To _____Receive From

Physician/Entity Name:_____

Phone Number: _____ **Fax Number:** _____

I understand that I may revoke this authorization at any time. This consent will expire automatically one year from the date it is signed. Records released under this authorization shall not be considered part of the records of the receiving facility. Any further disclosure of medical records information by the recipient is not authorized without specific written consent of the person it pertains to.

Patient Signature: _____ ***Date:***_____