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:** _____

Secondary Address: _____
City: _____ **State:** _____ **Zip Code:** _____

Date of Birth:_____ **Social Security #**: _____

Email:_____ **Primary Language**: _____

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

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

Marital Status: _____ **Occupation:** _____ **Sex (please ✓check below):**
☐ male ☐ female ☐ transgender/ non-binary

Race (please ✓check below):
☐ Caucasian ☐ Asian or Pacific Islander ☐ African-American
☐ Hispanic ☐ American Indian ☐ Other: _____ ☐ Decline to answer

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: _____

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 illness	**Hospitalized?** Yes/ No	**Date or year**

SURGERY: List any history of surgery *e.g. back surgery*	**Reason** *e.g. scoliosis*	**Date or year**

MEDICATION LIST: Name of Medication	**DOSAGE and FREQUENCY**	**NEED REFILL(Yes)**	**NO**

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

Allergies:

Medications *Name of medication*	Reaction(s) *List and reactions e.g.*

Any other information the provider should be aware of?

_____

_____

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. 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: _____

General Consent and Right to Refuse Treatment

I understand that care provided by Arizona Family Geriatric Medicine may involve treatment from a multidisciplinary team, including physicians, nurse practitioners, physician assistants, medical assistants, and other health care professionals.
I understand that I have the right to participate in decisions regarding my medical care and have been informed of my rights and responsibilities when receiving services at Arizona Family Geriatric Medicine.
I understand that my treating provider(s) are responsible for explaining the nature, purpose, and common risks of recommended diagnostic tests, treatments, or procedures.
I authorize the treating provider(s) to perform examinations, assessments, and treatments that they consider necessary and advisable for my health, injury, illness, and overall well-being.
I also understand that I have the right to refuse any examination, test, procedure, treatment, therapy, or medical recommendation. I further acknowledge that refusing recommended care, medication, or testing may carry risks, and I accept responsibility for those risks.

Additional Consents & Acknowledgments

- **Notice of Privacy Practices (HIPAA):** I acknowledge receipt of the practice's Notice of Privacy Practices and understand my information may be used/disclosed for treatment, payment, and health care operations as permitted by law.
- **Telehealth Consent:** I consent to receive care via telehealth, understanding I may withdraw consent at any time.
- **Chaperone Policy:** I understand I may request a chaperone for any examination, and the practice may require one for sensitive exams.
- **Clinical Photography:** I consent to clinical photographs if recommended for documentation or treatment, with the understanding they become part of my medical record. (Separate consent may be requested at the time of photography.)
- **E-Prescribing:** I consent to the retrieval and review of my medication history from pharmacies, payers, and other providers to support my care.
- **Communication:** I consent to be contacted by phone, voicemail, text, or email regarding scheduling, care coordination, and billing. I understand I may opt out of texts or emails at any time.
- **Advance Directives:** I understand I have the right to name a health-care agent or provide advance directives, and I will inform the practice if I have appointed a decision-maker.
- **Scope of Consent:** I understand this consent covers routine medical care. Certain procedures may require a separate informed consent describing risks, benefits, and alternatives.
- **Right to Revoke:** I may revoke this consent in writing at any time, and revocation will not affect care already provided

Acknowledgment of Rights to Refuse

I acknowledge that I have reviewed and understand the practice's Rights to Refuse policy, which outlines circumstances under which treatment or services may be declined or discontinued.

Patient/Guardian Signature: _____ 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 must provide **insurance cards**, **all** current insurance **information**, and a **valid photo ID**. Failure to do so may be considered fraudulent and may result in **denial** of services or **dismissal** from the practice.
- I must **update** the office if my **insurance changes**. If services are unpaid due to incorrect or lapsed coverage, I am **responsible** for **all charges**.
- I am **responsible** for knowing my **copay**, **deductible**, **coinsurance**, and **cost share**.
- Not all services are covered or deemed medically necessary by every plan. I am **responsible** for the **full cost** of any uncovered services.
- Copays and outstanding balances are **due at check-in**. Accounts must be in **good standing** for services to be rendered.
- For **minors**, the parent/guardian is responsible for payment. Non-urgent care may be rescheduled if no **responsible adult** or **prior payment** arrangement is present.
- If my **deductible** is **unmet**, partial or full payment will be **due** at check-in. Remaining balances will be billed.
- 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.
- **Returned checks incur a $75 fee.**
- **Missed appointments: $50 fee.**
- **Late cancellations** (same day): **$50 fee**. Must cancel at least one day in advance to avoid charges.
- Services are coded and billed per provider determination under national coding guidelines. **Codes cannot be altered**.
- **HMO/managed** care patients must **assign Dr. Minh Luong** as PCP **before being seen**.
- **HMO plans** require referrals for specialists. Appointments are **required** for referrals; retroactive referrals are not issued.
- All **credit/debit** transactions include a **4% convenience fee**.

Acknowledgment of Financial Policies

I acknowledge that I have read and understand the financial policies outlined above, and I agree to comply with them.

Patient/Guardian Signature: _____ 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 your 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 purposes 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: _____

Patient Code of Conduct

Our practice is committed to providing a safe, respectful, and supportive environment for all patients, families, and staff. We ask that every patient uphold these standards by treating others with courtesy, honesty, and cooperation. By following this code of conduct, you help us ensure high-quality care, protect the dignity of all individuals, and maintain a positive and professional atmosphere within our practice.

The following behaviors are prohibited:

- Possession of a firearm or any other weapons on the premises.
- Physical battery i.e. causing physical harm to any individual on the premises
- Verbal assault i.e. verbal threats of harm towards any individual or property on the premises
- Intentionally damaging equipment or property
- Making menacing gestures towards other patients or staff
- Attempting to harass or intimidate individuals
- Harassment, offensive statements, or threatening statements through phone calls, letters, voicemail, email, or other forms of written, verbal, or electronic communication
- Offensive remarks based on race, gender, or creed

Photography and Videotaping Policy
For the privacy and protection of our patients and staff, photography, audio recording, and videotaping are strictly prohibited within the practice unless prior written authorization has been obtained. Unauthorized recording may result in dismissal from the practice.

Violators of the code of conduct are subject to discharge from the practice immediately with zero tolerance. If you witness any inappropriate behavior, please report it immediately to a staff member so the situation can be addressed promptly and appropriately. Our priority is to provide quality care in a safe and respectful environment for everyone.

Acknowledgment of Code of Conduct Policies
I have read, understand, and agree to abide by the policies outlined in this document, including the conduct and recording policies. I understand that failure to comply may result in dismissal from the practice.

Patient/Guardian Signature: _____ Date: _____

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:***_____