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PATIENT INFORMATION

Thank you for choosing us to take care of your health. To better help you, please take a moment to complete this packet. Please let us know if you have any questions.

Last Name: _____ First Name: _____ Middle: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - _____ Cell: ( ) - _____ Work: ( ) - _____

Email Address: _____

Date of Birth: __ / __ / ____ SSN (Optional): ___ - ___ - ____

Gender: O Male O Female Marital Status: O Married O Single O Divorced O Widowed

Referred By: _____

Employment: O Full-Time O Part-Time O Retired O Unemployed

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Full Name: _____

Phone: ( ) - _____ Relationship: _____

If you are a minor, please provide the responsible party information.

Full Name: _____ Relationship: _____

If at any time you need a physical copy of your full medial records (dating 2 years and back) we do charge a fee of $25.00.

Please check if you are providing a copy of any legal documents listed below, if applicable:

Living Will: O YES O NO **Advanced Directives:** O YES O NO **Power of Attorney:** O YES O NO

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INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ Date of Birth: ____ / ____ / ____

Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: ☐ Self ☐ Other: _____

Policy #: _____ Group #: _____

Customer Service #: (____) ____ - _____

Secondary Insurance (if applicable): _____

Policy Holder's Name: _____ Date of Birth: ____ / ____ / ____

Employer's Name: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Relationship to Patient: ☐ Self ☐ Other: _____

Policy #: _____ Group #: _____

Customer Service #: (____) ____ - _____

**** ASSIGNMENT OF BENEFITS ****

I hereby authorize direct payment to ASSOCIATED INTERNISTS of any medical benefits payable to me for the services provided at ASSOCIATED INTERNISTS.

I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due for any bills if this is not done.

_____ _____

Patient / Parent / Guardian Signature **Date:**

FINANCIAL RESPONSIBILITY FORM

(please read carefully and thoroughly)

I understand that payment is due at the time of service unless other arrangements have been made and that I will be given an insurance form in order to file for reimbursement.

<u>If, for any reason I am unable to pay the copay, due at the time of service, a $5.00 fee will be applied to my bill.</u>

I hereby assign my insurance benefits to be paid directly to Associated Internists of Ahwatukee | Sun Lakes. I understand that I am financially responsible for non-covered services.

I also authorize Associated Internists of Ahwatukee | Sun Lakes to release any information required to process the claim. I agree that this office may release records pertaining to treatment to my insurance company or other third parties responsible for the payment of my medical charges, including review activities related to my physician's participation with my plan.

Patient / Parent / Guardian Signature _____ Date: _____

AIA Withness _____ Date: _____

CANCELLATION AND NO SHOW FEE AGREEMENT

I understand that Associated Internists of Ahwatukee | Sun Lakes does require 24 hours notice when cancelling an appointment. If I choose not to call within the given time frame allowed,

I do understand that Associated Internists of Ahwatukee | Sun Lakes does have the right to charge a $25.00 fee. If I choose not to show up to my appointment, I understand that Associated Internists of Ahwatukee | Sun Lakes does have the right to charge a $25.00 "No Show" fee as well.

Patient / Parent / Guardian Signature _____ Date: _____

AIA Withness _____ Date: _____

MEDICAL RECORD POLICY

Our office will make every attempt to release your records in a timely manner. Most records are copied and sent within 30 days. Please advise us of any extenuating circumstances.

1) Medical Records requested by a physician's office for continuity of care are provided at no charge if picked up. There is a $5.00 charge for mailing. The record release form must come directly from the requesting physician's office.

2) For Medical Records released directly to patients, there is a $25.00 charge if picked up. There is an additional $5.00 charge for mailing.

Patient / Parent / Guardian Signature

Date:

USES AND DISCLOSURES

This notice describes how medical information about you may be used and disclosed and how you can get access to this inforamtion. Please review it carefully.

Our practice collects personal health inforamtion on you that may be used for three primary purposes:

1) Treatment: For example, we will prepare a record of information each time we see you in or out of the office while you are under our care. This medical record is used to keep track of changes in your condition as well as remind us of your past care, treatment, allergies and other facts relevant to your overall health. This information may be passed on to other providers as part of a coordinated health care program for you.

2) Payment: We must report elements of your personal health information, such as specific treatments, visits, tests and surgeries along with related diagnosis to third party payers to properly determine benefits payable on your behalf for the services we render. We only report the minimum necessary information to process the claim.

3) Health Care Operations: In order to provide you with high quality health care we often need to be able to use your personal health information for purposes such as pre-registering you at the hospital if you ever need to be admitted or providing your pharmacy with the prescription so that it is ready to pick up when you arrive. Again, we are committed to using the minimum necessary information to achieve these purposes.

In addition, we will use or disclosure your personal health information under the following circumstances:

-When we receive a valid authorization from you
-If you give us an oral authorization
-If we are required by law to disclosure your personal health information to others such as public health agencies

REQUIRED DISCLOSURES

We are required to disclose the information to you if you request it and we are required to disclose the inforamtion to us DHHS for compliance determinations of this practice. We may disclose information about you with out your aurthorization for the following reasons:

1) When required by law, for judicial proceedings or law enforcement
2) For Workers Compensation
3) For uses and disclosures about decedents
4) Uses and disclosures for cadaveric tissue donation
5) To avert a serious health threat to public health or safety
6) Disclosures about abuse, neglect or domestic violence

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization by writing to us at our practice address or delivering a written revocation to us in person.

We may periodically call you to remid you of appointments and we may advise you of treatments alternatives and benefits that may be of interest to you based on your health condition or status.

YOUR RIGHTS

1) You have the right to request restrictions on the use and disclosure of your personal health information. Our practice is not obligated to accept your restriction though. However, if we do accept the restriction, it must be compiled fully on our part.

2) You have the right to inspect and have a copy of your health inforamtion. If you would like a copy, please request the information in writing or use a form available in our office for the request.

3) You have the right to request amendments to your personal information. We will not amend any information we did not create. We are not obligated to make an amendment to your personal health information but we will include your request for the amendment as part of your personal health information.

4) You have the right to an accounting for the prior six years (but no earlier than the effective date of this notification) for uses and disclosures for purposes other than the treatment, payment and health care operations of this practice.

5) You have a right to a paper copy of this notification. The current version will be provided to you at your request.

OUR DUTIES

We are obligated by law to protect your privacy and we will do our utmost to fulfill that duty to you. We will abide by all the terms in this notification but we reserve the right to change the terms of this notice and the personal health information it protects. You are entitled to a copy of those changes. We will include updated copies with statements mailed to patients. We will do our best to make certain your rights are protected and we carry out our responsibilities to you. If you have any complaint, we encourage you to contact us. It is our sincere desire to preserve your privacy and fulfill our duties. We will take no retaliatory action against any person for exercising their right to the resolution of a grievance. To the contrary, we encourage your comments and criticisms. If we cannot resolve the issue, you have the right to file a grievance and make a complaint to the US Department of Health and Human Services.

To make a complaint or ask any question concerning this policy, please contact the office manager directly at (480) 961-2303 option 1 and ask for the Office Manager.

Effective Date: April 15, 2012

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Patient Name: _____ Date of Birth: _____

I acknowledge that I have received a copy of the practice's notice of privacy practicies.

_____ _____
Patient / Parent / Guardian Signature Date

_____ _____
Print Name if Representative of Patient Relationship to Patient

_____

Please list all the names and phone numbers of those individuals involved in your care or with whom you will allow us to share your health and treatment information.

Printed Name: _____ Phone: _____ Relationship: _____

Printed Name: _____ Phone: _____ Relationship: _____

_____ _____
Patient / Parent / Guardian Signature Date

_____ _____
Print Name if Representative of Patient Relationship to Patient

FOR OFFICE USE ONLY

Comments: _____

_____ _____
Office Personnel Signature Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In signing this form, you consent to the use and disclosure of your protected health information by Associated Internists of Ahwatukee and Sun Lakes, our staff and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had the opportunity to review our **Notice of Privacy Practices** prior to signing this consent. We encourage you to review our **Notice of Privacy Practices** carefully. It provides more details on how we may use and disclose your information. The **Notice of Privacy Practices** may change. A current copy may be requested when you are being seen as a patient.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a retriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke the consent in writing. However, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment or health care operations. Refer to the **Notice of Privacy Practices** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Patient / Parent / Guardian Signature _____ Date _____

FOR OFFICE USE ONLY

Failure to obtain consent, check the appropriate reason:

- ☐ Indirect Treatment Relationship
- ☐ Emergency Treatment
- ☐ Substantial Communication Barrier
- ☐ Refusal to Sign
- ☐ Other

Description: _____

Office Personnel Signature _____ Date _____

Witness _____ Date _____

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MEDICAL INFORMATION

Welcome to Associated Internists. Please fill out your health information to better server your healthcare needs. Thank you.

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Nickname: _____

Who was your prior primary care physician? _____

What is your local pharmacy & phone # or crossroads? _____

What is your mail order pharmacy? _____

What is your insurance company? _____

Allergies:

Medicine/Food/Latex/Adhesives	Reaction

Vaccinations:

Please list date of last OR provide a copy of your immunization record

_____ Influenza (Flu)

_____ Pneumovax (PPSV23)

_____ Prevnar 13 (PCV13)

_____ Tetanus: ☐ Td ☐ Tdap

_____ Shingles: ☐ Shingrix ☐ Zostavax

_____ HPV Vaccine (Gardasil)

_____ Hepatitis B

What are your current medications?

Please include prescription medication, over the counter and non-prescription medications, herbals, and supplements. Please ask for another sheet if needed.

Medication	Strength	How Often	When Started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Past Medical History (Check any medical problems you have now or have had in the past)

- ☐ Anxiety and/or ☐ Panic Attacks
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Insomnia/sleep problems
- ☐ Migraine Headaches
- ☐ Dementia
- ☐ Stroke/TIA
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder
- ☐ Neuropathy
- ☐ Restless Legs Syndrome
- ☐ Obstructive Sleep Apnea
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Allergies/Hay Fever
- ☐ Anemia
- ☐ Prior Blood Transfusion
- ☐ History of Blood Clots/DVT/PE
- ☐ Bleeding Disorders
- ☐ Arrhythmias/Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Coronary Disease/Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Diabetes or ☐ Pre-Diabetes
- ☐ Thyroid Problem:
  ☐ high ☐ low ☐ nodules ☐ other
- ☐ Reflux/Heartburn
- ☐ Stomach/Peptic Ulcer Disease
- ☐ Gallbladder Disease/Gallstones
- ☐ History of Pancreatitis
- ☐ Liver Disease or Hepatitis
- ☐ Colon Polyps
- ☐ Diverticulosis or ☐ Diverticulitis
- ☐ Hemorrhoids
- ☐ Celiac Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohns Disease
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Prostate Problems
- ☐ Erectile Dysfunction
- ☐ Breast Lumps or Masses
- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Genital Herpes
- ☐ Sexually Transmitted Infections
- ☐ Tuberculosis or ☐ Positive PPD
- ☐ Gout
- ☐ Back Problems
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other Autoimmune Disorders
- ☐ Osteoporosis or ☐ Osteopenia
- ☐ Other Chronic Joint Problems
- ☐ Chronic Hearing Problems
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Deficiencies of:
  ☐ B12 ☐ Vitamin D ☐ Iron
- ☐ Cancer (Location/Type/Year):

_____

_____

_____

_____

Other: _____

_____

_____

_____

_____

_____

List all major Surgeries/Procedures you have had in the past:

Surgery/Procedure	Date

Surgery/Procedure	Date

Have you had the following studies done?	Date of most recent study
EKG	
Stress Test	
Echocardiogram	
Cardiac Cath/Angiogram	
Sleep Study	
EDG/Upper Endoscopy	

Which medical specialist do you see?

Name	Specialty

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History: (Please list your family member's **RELATION TO YOU** and **AGES** of onset and/or cause of Death)

Alzheimer's _____ Blood Disease _____

Autoimmune Diseases _____ Kidney Disease _____

Coronary Heart Disease _____ Liver Disease _____

Diabetes _____ Asthma _____

High Blood Pressure _____ Alcoholism _____

High Cholesterol _____ Mental Illness _____

Stroke _____ Cancer/Type _____

Social History:

Marital Status: _____ Occupation: _____ Employer: _____

With whom do you live with: ☐ Self ☐ Spouse/Significant Other ☐ Children ☐ Assisted Living Facility ☐ Other

Sexual Orientation: _____ Religious Preference: _____

Regular Exercise: ☐ Yes ☐ No Type: _____ Hours per Week: _____

Tobacco Use: ☐ Yes ☐ No ☐ Former Smoker Type: _____

Amount: _____ Years of Use: _____ Year Quit: _____

Alcohol Use: ☐ Yes ☐ No Any history of heavy drinking (current or prior)? ☐ Yes ☐ No

Type: _____ Amount: _____ Frequency: _____

Caffeine Use: ☐ Yes ☐ No Type: _____ Amount: _____ Frequency: _____

Illicit Drug Use: ☐ Yes ☐ No Type: _____ Frequency: _____

Preventive Care:

When was your last general physical or annual wellness visit? _____

Last Cholesterol Check: Date: _____ Normal: ☐ Yes ☐ No

Last Colonoscopy: Date: _____ Normal: ☐ Yes ☐ No

Last Bone Density Scan: Date: _____ Normal: ☐ Yes ☐ No

Last Eye Exam with Ophthalmology or Optometry: Date: _____ Name of Doctor: _____

Do you have a living will or advanced directives? ☐ Yes ☐ No

Females Only:	**Males Only:**
Last Menstrual Period Date: _____	Last Prostate Exam Date: _____
Last Mammogram Date: _____ Normal: ☐ Yes ☐ No	Normal: ☐ Yes ☐ No
Last Pap Test Date: _____ Normal: ☐ Yes ☐ No	Last PSA Test Date: _____
History of Abnormal Paps: ☐ Yes ☐ No Year: _____	Normal: ☐ Yes ☐ No
# of Pregnancies Total: _____ Live Births: _____	

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MEDICATION LIST

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please use this form to add any additional medications, herbals or supplements you are taking.

MEDICATION	STRENGTH	HOW OFTEN	WHEN STARTED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Arizona Care Network A Better State of Care

ANNUAL SCREENING QUESTIONAIRE

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

PHQ-9 DEPRESSION SCREENING QUESTIONAIRE

Over the past 2 weeks, how often have you been bothered by the following problems?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed or hopeless?	0	1	2	3
Troubling falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself?	0	1	2	3
	TOTAL:			

☐ I decline completing this depression screening questionnaire.

☐ I have an active diagnosis of depression or bipolar disorder.

Please complete the following section only if you have Medicare or Medicare replacement plan.

MEDICARE ANNUAL RISK ASSESSMENTS

Are you taking Aspirin, another antiplatelet therapy medication or a blood thinner? ☐Yes ☐No
Are you currently using a tobacco product? *(cigarettes, cigars, chew, snuff, pipe, vaping)* ☐Yes ☐No
Have you had one or more falls within the past year? ☐Yes ☐No

When were these studies last done?

Test	Date	Normal	Abnormal
Mammogram *(Women)*			
Pap Testing *(Women)*			
Bone Density Scan			
Colon Cancer Screening ☐ Colonoscopy ☐ Sigmoidoscopy ☐ Cologuard ☐ Stool FIT/FOBT			
PSA test *(Men)*			
Dilated Eye Exam Provider Name:			

When did you last receive these vaccines?

_____ Flu vaccine
_____ Prevnar PCV 13
_____ Pneumovax PPSV23
_____ Zostavax Shingles
_____ Shingrix Shingles
_____ Tetanus (Td)
_____ Tetanus + Pertussis (Tdap) *(whooping cough booster)*

☐ I decline all vaccines.
☐ I decline only these vaccines: _____
_____

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4530 E Muirwood Dr., Ste 105 Phoenix, AZ 85048-7693
Phone: 480.961.2303 | Fax: 480.961.2306

Authorization Form for the Use and Disclosure of Protected Health Information by Associated Internists of Ahwatukee, P.C.

PLEASE PRINT:

Patient Name: _____ Date of Birth: ____/____/____

Social Security Number: ____-____-____

By signing this authorization form, I understand that I am giving my authorization to: (This is who we would be receiving the copy of the records from)

Name of Person(s) or Organization(s): _____

Street Address: _____

City, State, and Zip Code: _____

Telephone Number: (____) _____ Fax Number: (____) _____

Release my Protected Health Information (PHI), as described in more detail in the paragraphs below, to Associated Internists of Ahwatukee, P.C., at 4530 E Muirwood Dr., Ste 105, Phoenix, Arizona 85048-7693. If neither federal nor state privacy law applies to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy law.

I specifically authorize the use and disclosure of the following PHI:

☐ **Please check this box if you would like all medical records**

Or specify down below with a detailed description of the particular data and period of time you are requesting:

Emergency Records: _____

Hospital/Inpatient Records: _____

Outpatient Records: _____

Laboratory/Pathology Records: _____

Radiology Records: _____

Consultation/Other Records: _____

_____ _____

Signature of Patient or Surrogate Decision Maker | Date

_____ _____

Printed Name of Patient or Surrogate Decision Maker | Relationship to Patient

PLEASE FAX RECORDS TO 480.961.2306