Caring For Families

Caring For Families, PC
13838 S. 46th Place Suite 125
Phoenix, AZ 85044

Completion of ALL lines is required.

Patient Name: _____

Date of Birth: _____ Soc Sec #: _____

Sex: _____ Marital Status: _____ Race_____

Ethnicity_____ Preferred Language_____

Street Address: _____Apt: _____

City: _____ State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Indicate preferred phone number. Home_____ Work _____ Cell _____

E-Mail_____

For Secured Portal Use Only

Who referred you to our office? _____

Insurance Company Name:_____

Address on card for claims:_____

City – St – Zip:_____

Policy Holder: _____

(Name of PERSON whom all others are covered under)

Relationship to patient: _____

Date of Birth: _____ Soc Sec #: _____

(Policy holders) (Policy holders)

Employer: _____

Insurance Effective Date: _____

Emergency Contact Name: _____

Relationship & Phone #_____

Preferred Pharmacy:

Name: _____ Phone Number: _____

Address: _____

_____

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Your insurance card must be **presented on each visit**!!!
Copays must be paid each visit – NO EXCEPTIONS

I authorize the physician to give me reasonable and proper medical care by today's standards.
I understand that it is my responsibility to present the correct insurance information. If the information presented above is incorrect causing my claims to be denied for inaccurate information or not being filed in a timely manner, I acknowledge I will pay for the services received in full within thirty (30) days of being billed.

*Patient / Responsible Party Signature:*_____*Date:*_____

I authorize the release of any medical information to my insurance company or other third parties responsible for payment of my medical charges.
This authorization also allows the release of any medical information to my insurance carrier when necessary to process my claims. I also authorize payments under my insurance programs to be made directly to the above provider for any services furnished by this provider.
I further permit copies of this authorization to be used in place of the original.

*Patient / Responsible Party Signature:*_____*Date:*_____

Medication History Consent:
A medication history consent is a list of medications that Caring For Families, PC and other doctors have recently prescribed for a patient. It is collected from a variety of sources, including, a patient's pharmacy, health plans, other healthcare providers, and the Arizona State Pharmacy Board.

I give my consent to Caring For Families, PC to retrieve and review my medication history. I understand this will become part of my medical record.

Patient/Responsible Party Signature: _____*Date*_____

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Name: _____ DOB: _____

Due to *HIPAA* privacy laws, we can not leave messages on your answering machine or voice mailboxes without your expressed consent. Having your permission to do so may decrease the time it takes to relay valuable information to you. Many patients, like us, are very busy people and the efforts spent trying to talk to each other can be very frustrating. Our increasing incidences of "phone tag" messages take up valuable time and cause even further delays.

We have decided to give you the option of filing a permanent permission form that will be placed in your chart and will remain in effect until terminated by you.

I give permission for Caring for Families, PC to leave messages in the following manners:

- ☐ At my home telephone number answering machine _____
- ☐ At my work telephone number voice mail _____
- ☐ On my cell phone voice mail _____
- ☐ With my spouse
- ☐ With another resident at my house
- ☐ E-mail through Secured Portal Only

Please write in acceptable phone numbers.

Email address: _____

☐ I DECLINE TO GIVE PERMISSION TO LEAVE ANY MESSAGES

I give permission for Caring for Families, PC to leave messages concerning the following:

- ☐ Blood work
- ☐ Diagnostic testing
- ☐ Prescriptions _____
- ☐ Billing/Insurance issues
- ☐ E-mail through Secured Portal Only

Please give us your pharmacy phone number, if possible.

Email address: _____

I understand that Caring for Families, PC will never leave messages of an extremely sensitive or important nature. Examples are STD results, abnormal Pap smear results, or other abnormal results that may involve life-threatening conditions.

I understand that this document will remain in effect until a new form is completed and filed in the chart. It is my responsibility to keep this document current if my situation changes or if my phone number(s) change.

_____
Patient/Guardian signature

_____
Date

Patient name: _____ DOB: _____

Caring For Families

[Patient Label]

Illnesses

Indicate if you or a member of your family has had any of the following illnesses currently or in the past.

CONDITION	YOU	WHO IN YOUR FAMILY	CAUSE OF DEATH AND AGE AT DEATH
Alcoholism			
Alzheimer's			
Anemia			
Arthritis			
Asthma			
Back Injury			
Blood Clot			
Blood Transfusion			
Bowel Problems			
Breast Disease			
Bronchitis, severe			
Burns, severe			
Cancer			
Colitis			
Depression			
Diabetes			
Emphysema			
Fractures, Major			
Gall Bladder Problems			
Glaucoma			
Gout			
Head Injury			
Heart Attack/Disease			
Heart Murmur			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Problems			
Lupus			
Menstrual Problems			
Mental Health			
Migraine			
Obesity			
Osteoporosis			
Phlebitis			
Pneumonia			
Prostate Disease			
Recurrent UTI			
Rheumatic Fever			
Seizure Disorder			
Sexually Trans. Disease			
Shingles			
Stomach Ulcer/Problems			
Stroke			
Suicide			
Thyroid			
Tuberculosis			
Valley Fever			
Other			

Indicate surgeries you have had previously, if any

	YEAR		YEAR		YEAR		YEAR
Appendix		Hysterectomy		Eye		Kidney	
Bone & Joint		Gastero-Intestinal		Hernia		Prostate	
Breast		Gall Bladder		Heart		Other	

Patient name: _____ DOB: _____

Hospitalizations

CONDITIONS	YEAR	DETAILS

List current medications and dose including over the counter drugs and herbs

Allergies

Social History

Occupation_____

How many years have you lived in Arizona? _____ Where did you live prior to moving to Arizona and for how long? _____

Marital Status (circle) Married Single Partnered Divorced Widowed

List your household members _____

List your pets _____

	Yes	No		Yes	No
Do you have a living will?			Do you use a bike helmet?		
Do you travel outside the U.S.?			Do you roller blade?		
Do you use seatbelts?			If, so do you use kneepads?		
Do you have a smoke alarm?			Also, do you use wrist protectors?		

	Yes	No	How Much?
Do you exercise?			
Do you drink alcoholic beverages?			
Do you smoke?			
Do you drink caffeinated beverages?			
Do you use drugs?			

The Following Is Applicable to Women Only

Menstrual History			
Days between menses?	Duration of menses?	Flow: Heavy Medium Light	Age at onset of menses?
Any pain or cramping?	Date of onset of last period?	Contraception method	

Pregnancies					
# of pregnancies	Live Births	Still Births	Miscarriages	Abortions	C-Sec

Births					
Year	Gestation	Delivery Type	Complications	Weight	Sex

This is a confidential record of your medical history and will be made a permanent part of your medical record. Information will not be released except when you have authorized us to do so. Requires a separate consent for release of information.

_____

Patient Signature Date

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13838 S. 46th Place, Suite 125
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Financial Policy

Please read carefully and initial each statement and sign below.

This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our staff will be glad to discuss these policies with you.

1._____I understand that I am financially responsible for any copayments, deductibles, coinsurance and all charges that are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. My insurance company determines benefit payment. I understand that I may be rescheduled if I am unable to present my insurance card, or any payments for outstanding balances. I understand if I am uninsured that payment is due in full the day the services are rendered.

2._____ I understand that if I am unable to make a scheduled appointment, I need to contact the office at least 24 hours prior to my scheduled appointment. **A $25.00 fee will be assessed for all missed appointments without 24 hours in advance notice.**

3. _____ I understand there is a $25.00 charge for all forms which are completed by the Physicians/Nurse Practitioners (e.g. Disability, FMLA, Biometric Screenings, Sports Physicals, Letters, etc.) and I understand that I need an appointment with a medical provider to fill out these forms.

4._____ I understand there is a $25.00 charge for in-house copying of medical records. Records will not be copied until a signed release has been obtained.

5._____ I understand there is $30.00 charge for a Non-Sufficient Funds (NSF) check.

6._____ I have read and I understand the above Financial Policy and I agree to abide by its terms.

Signature of patient (or parent/guardian): _____

Print Name: _____ Date: _____

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(480) 783-7000

Notice of Privacy Practices

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

Uses and Disclosure Relating to Treatment, Payment, and Healthcare Operations

- We will use your personal health information to perform medical treatment, receive remuneration for services, and conduct normal healthcare office operations.
- Other uses and disclosure, as deemed necessary by your medical provider, not requiring your written authorization:
    - To public health agencies requiring disclosure of patient health information as it relates to matters of public health risk
    - Lawsuits and similar proceedings in response to court ordered subpoena
    - If required to do so by a law enforcement official
    - If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities
    - To federal officials for intelligence and national security activities authorized by law
    - To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official
    - For Workers Compensation and similar programs
- It is the policy of Caring for Families not to disclose any information to any person or entity without your knowledge and written authorization (including signature) with the exceptions listed above.

Uses and disclosure requiring your authorization

- Upon your written request, in the form of completion of our medical record request form, our copy service will copy your chart or situationally specific items from your chart and send it to another medical professional.

Your rights regarding your personal health information

- Your right to request restrictions on certain uses and disclosures
    - If in fact you request restrictions on the use and disclosure of your information as outlined above, please submit your request in writing.
    - The request will become effective, if approved by the Business Manager, within 10 days from the date of receipt of the request and you will be notified by mail.
    - If the restriction requested inhibits the practice's ability to collect payment for services rendered or the medical provider's ability to give the best care, you will be notified by mail within 30 days from the date of receipt of your request that it can not be honored.
    - Appeals to restriction requests not honored must be in writing and received within 30 days of the date of the letter sent denying the request.
    - All appeals will be reviewed by the Business Manager and medical provider and answered within 30 days.
    - Until a restriction request is approved, the practice will conduct business without incident to a pending restriction request.
    - All requests are singular in nature. Multiple requests must be submitted separately.
    - Submit your request to the Business Manager at the above address
- Your right to request restrictions on communication from our office
    - If there is a telephone number or address that you would like the practice to refrain from using in an attempt to contact you, it needs to be documented in writing.

    - If requesting a "preferred" phone number or address for use, it must be documented in writing by you, the patient, or legal guardian.
    - The restriction request will be effective within 24 hours from the time of direct receipt by the receptionist.
- Your right to access and copies of your medical and billing records
    - Copies of medical and billing records will be available 10-14 days after the request is received in writing to the medical records clerk.
    - There is a $25.00 charge for in-house copying, payable upon receipt.
    - Only you or an authorized representative can pick up copies of your medical and/or billing records.
    - Records can be mailed or faxed upon your written request and the practice's receipt of the $25.00 in-house copying charge.
    - Your right to copies of medical and billing records is superceded and denied in the following situations:
        - It will endanger your life or the life of another individual named in the record
        - The records reference another individual and disclosing such information would violate their privacy.
        - Psychotherapy notes can not be viewed or copied
        - Information collected and compiled in anticipation of legal action or preceding
        - Confidential information related to lab tests under CLIA
        - Information requested by a legal guardian or representative on your behalf that the medical professionals feel may cause harm to you or someone else.
- Your right to request an amendment of your medical information
    - If you believe your medical information is incorrect or incomplete, you may submit a written request for the information to be amended.
    - Requests must be submitted in writing and include detailed support to the Business Manager.
    - Each request must be detailed and submitted separately.
- Your right to a copy of this notice
    - If you would like additional copies of this notice, please ask the receptionist.
- Your right to file a complaint
    - If you feel that your rights regarding privacy have at all been violated, you may file a formal written complaint with the Business Manager.
    - You will not be penalized for filing a complaint.
    - Complaints may also be taken by the Secretary of the Department of Health and Human Services.
- Your right to provide an authorization for other uses and disclosure
    - Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
- Your right to receive an accounting of all disclosures outside of the practice setting and with other individuals
    - You may request to view a list of all disclosures.

The practice reserves the right to make changes to this notice at any time and which will become effective on the date of the change, superceding all previous versions. The version number and date of update are located on the bottom left hand corner of each page.

If you have any questions regarding this notice or our health information privacy policies, please contact our Business Manager at (480) 783-7000.

Patient Signature_____Date_____

Signature of Parent or Guardian_____Date_____