Caring For Families

# Completion of ALL lines is required.

Patient Name: _____

Sex: _____ Marital Status: _____ Race_____

Ethnicity_____ Preferred Language_____

Street Address: _____Apt: _____

City: _____ State: _____Zip: _____

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

E-Mail_____

Date of Birth: _____ Soc Sec #: _____

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 #_____

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

*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 HCFA (Health Care Financing Administration) when necessary to process my claims. I also request payment of government benefits to the party who accepts assignment.*
*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:_____*

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.

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.***

_____

- ❒ **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
- ❒ Billing/Insurance Issues
- ❒ Prescriptions (Please provide your pharmacy address and phone number.)

---

- ❒ Email Through Secured Portal Only

_____

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

# Caring For Families, PC
# Child's Medical History

**Child's Name: _____, _____, ____**
Last First MI

Adopted_____ Gender _____ Race_____ Ethnicity _____

Any difficulties with this pregnancy? YES NO If yes explain: _____
_____

___Smoking ___Alcohol ___Medications ___Toxemia ___Drug abuse

___ Blood Pressure Problems ___ Infections

Any problems with labor or delivery of this child? YES NO If yes Explain: _____
_____

___Vaginal Delivery ___C-Section ___Breech Delivery ___Birth Injury

Birth weight____ Apgar____ Blood Type_____

**Newborn period:**

___no problems ___ premature ___full term ___jaundice ___ breathing problems

___feeding problems ___infection ___temperature problems ___sugar problems

___Birth defects

**Nutrition:**

___breast fed to ____months ___bottle fed to ____months

Feeding problems? Yes No If yes explain: _____

_____

**Yes or No**

____ gained weight well ____ gained weight slowly

____milk intolerance ____ food intolerance

If yes please explain: _____

_____

# Caring For Families, PC
# Child's Medical History

**Child's Name: _____, _____, ____**
Last First MI

**Development: (Please indicate age in months)**

rolled over____ crawled____ pulled to stand____ walked alone____ single words____

2 word sentences____ toilet trained (daytime) ____ toilet trained (nighttime) ____

Gave up bottle____

**Please indicate "Yes" and explain if your child has had any of the following:**

____Allergies to medications: _____

____Hospitalizations: _____

____Surgical procedures: _____

____Chronic or long term illnesses: _____

____Chronic medications: _____

____asthma ____bladder/kidney infection ____bronchitis ____ cerebral palsy ____chickenpox
____convulsions with fever ____convulsions without fever ____congenital heart disease
____ear infections ____encephalitis ____heart murmur ____hepatitis ____measles (hard/red)
____meningitis ____ mental retardation ____mononucleosis ____mumps
____pneumonia ____rubella (three day/German) ____sinusitis ____tonsillitis

____vision problems ____hearing problems ____speech problems ____walking problems
____sleep problems other illness: _____

**Immunizations:** Current Yes No

**Siblings: Brothers#____ Ages_____ Sisters#____ Ages_____**

**For children over 5 years of age, please indicate the following with a check:**

____wets the bed ____wets during the day ____constipated ____soils pants with stool
____poor school performance ____weight loss ____overweight ____behavioral problems

**Parents: ___Married ___Separated ___Divorced ___Widowed ___Single ___Partnered**

# Caring For Families, PC
# Child's Medical History

**Child's Name: _____, _____, ____**
Last First MI

**Family History:**

___Alcoholism ___ADD ___Allergies ___Asthma ___ Bleeding problems
___ Bone/joint disease ___Cancer ___Cystic fibrosis ___Depression ___Diabetes
___Drug use ___ Emphysema ___Epilepsy ___Heart defects ___Hay fever
___High Cholesterol ___Kidney Disease ___Liver Disease ___Mental retardation
___ Migraines ___Seizure Disorder ___SIDS ___Thyroid disorder
___Sudden death

**Pets:**
_____

**Second Hand Smoke exposure: _____**

**Additional information about family or home that may be helpful in caring for your child: _____**
_____
_____
_____
_____

# Caring for Families, PC

13838 S. 46th Place
Suite 125
Phoenix, AZ 85044
(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_____