

Patient Information			
Full Name: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
<small>Last</small>	<small>First</small>	<small>MI</small>	
Home Phone: (____) _____	Cell Phone: (____) _____	Contact Preference: <input type="checkbox"/> Cell <input type="checkbox"/> Home	
Address: _____		City: _____	State: _____ Zip: _____
Email: _____	SSN: _____	Birthdate: _____	

Marital Status: Minor Single Married Widowed Separated Divorced

Preferred Language: English Spanish Other:

Race: White Black/African American Asian
 American Indian/Alaska Native Hawaiian/Pacific Islander

Ethnicity: Hispanic/Latino Not Hispanic/Latino

I give Caring For Families P.C. permission to communicate messages regarding appointments, prescriptions, billing, referrals, and test results as follows: Voicemails on cell number Voicemails on home number Messages sent via patient portal
 With a family/spouse member listed here: _____

Insurance Information	
Primary Insurance Name : _____	
Insurance Billing Address: _____	
Member ID #: _____	Group #: _____
Policy Holder (Last, First, MI): _____	Birthdate: _____
SSN: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female Relationship to Patient: _____

Employment Information	
Employer Name: _____	Employer Phone: _____
Street Address: _____	
City State, Zip: _____	

Emergency Contact	
Name: _____	Relationship to Patient: _____
Primary Phone: _____	Alternate Phone: _____

Release of Benefits and Information
I attest that the above information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process my claim. I authorize payment of insurance benefits to my physician for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered or fees associated with my care.

Patient Signature: _____ Date: _____
 Parent/Guardian (if minor): _____ Date: _____

Insurance card(s), picture ID, and pharmacy benefit card/information need to be provided to the front desk.

Financial Policy

Caring For Families has adopted the following Financial Policy. We require that you read it carefully, initial each numbered section in the space provided, and sign at the bottom prior to the start of any treatment.

_____ **1. Insurance:** Caring For Families **does not** verify any insurance benefits. It is your responsibility to know your insurance benefits including deductibles, copayments, contracted lab, radiology, hospital facilities, etc. If you are not insured by a plan, payment in full is expected at each visit. Your insurance policy is a contract between you and your insurance company. Please contact your insurance company with any questions you may have regarding your coverage. It is your responsibility to notify our office of any change in your insurance coverage. We do not submit any secondary claims, upon request we will provide you with claim information for you to forward to your secondary payer.

_____ **2. HMO Plans:** It is the patient's responsibility to ensure our practice is a contracted provider and that one of our providers is the designated Primary Care Physician with your Plan. If your plan requires referrals to a specialty physician, you must adhere to our office referral policy. If you seek care without a proper referral/authorization, you will be financially responsible for the specialists visit(s).

_____ **3. Co-Payments, Deductibles & Co-Insurance:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments can be considered a breach of contract. Deductibles and Co-Insurance amounts will be billed monthly after services are billed and insurance responds.

_____ **4. Non-Covered Services:** Coverage varies by health plan. Please be aware that some of the services you receive may be determined to be "not covered" by your health plan. You must pay for these services in full.

_____ **5. Proof of Insurance:** We will bill your insurance with the information you provide us at the time of service. This requires us to copy your current insurance card. Failure to provide us with the correct information could result in the denial of your claim. If this occurs, you assume responsibility for the entire amount of the claim. An up to date insurance card is required at the time of each office visit.

_____ **7. Billing Statements:** Patient's balance statements are sent out on a monthly basis via mail. In the event that the address we have on file has changed, you must provide us with any address changes.

_____ **8. Non-Payment:** Accounts over **90 days** past due with no response to our billing department will be sent to collections. Any accounts in collections will need to be paid in full before any further office visits can be scheduled (this includes any collection fees that the agency may add in addition to the general balance).

_____ **9. No Show / Late Cancellation Fees:** We charge \$25 for missed appointments and for appointments not cancelled with a notice of **at least 24 hours from scheduled appointment time**. These charges are your responsibility and will be billed directly to you. Please help us serve you better by keeping your scheduled appointment.

_____ **10. We Do Not File Third Party Claims:** We can provide care for you in accident cases, but we will only file with your medical insurance or accept cash at the time of the visit. We do not file Worker's Comp or accept Liens. Any accident/work comp claims denied by medical insurance are the patient's responsibility.

_____ **11. Paperwork Filled Out By Our Physicians:** Any paperwork that needs to be completed by one of our physicians (FMLA, Disability, Letters, etc.) may require an appointment, and there is a \$25.00 fee for paperwork that is 1-2 pages and a \$50.00 fee for paperwork 3+ pages. Fees for documents must be paid in full before they are released.

_____ **12. Copies of Medical Records:** There is a \$25.00 fee for any in-house copying of medical records (there is no fee for a transfer of records between physician offices). Records will not be copied without a signed release form.

_____ **13. Insufficient Funds Check:** There is a \$30.00 charge for a Non-Sufficient Funds (NSF) check.

Signature of Patient or Representative: _____ Date: _____

Printed Name: _____

Patient Name: _____

Date: _____

Notice of Privacy Practices

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services from your insurance company or other third party payer.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected

health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically. You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you at your next visit and on our website. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our administration in person or by phone at 480-783-7000. Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

I have read and understand the privacy policy and agree to abide by its guidelines.

Signature of patient or responsible party

Date

Please list 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.

_____ Name (please print)	(_____)_____ Primary Phone Number	_____ Relationship
_____ Name (please print)	(_____)_____ Primary Phone Number	_____ Relationship
_____ Name (please print)	(_____)_____ Primary Phone Number	_____ Relationship

Signature of Patient or Representative: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient (if representative)** _____

Personal Information

Full Name: _____ Today's Date: _____
Last *First* *DOB*

Pharmacy Name: _____ **Address/Cross Streets:** _____

Pharmacy Phone: (____) _____ **Preference for Rx:** 30 day or 90 day supply

Current Medication: <i>(Including Supplements)</i>	Dose	Times/day	Dose	Times/day
1. _____		5.		
2. _____		6.		
3. _____		7.		
4. _____		8.		

Any Allergies & Reactions (including medications): _____

Medical History

- | | | | | |
|------------------------------------|---|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes - Type: <input type="checkbox"/> I <input type="checkbox"/> II | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Migraines | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> GERD | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Cancer – Type: _____ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Other: _____ |

Surgeries (if any): Please list year

- | | | | | | | |
|---|---|---------------------------------------|---|---|---|------------------------------------|
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Bone & Joint _____ | <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Gastrointestinal _____ | <input type="checkbox"/> Gall Bladder _____ | <input type="checkbox"/> Eye _____ |
| <input type="checkbox"/> Hernia _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Kidney _____ | <input type="checkbox"/> Prostate _____ | <input type="checkbox"/> Other _____ | | |

OBGYN (Applicable to Women Only)

Days Between Menses: _____ Duration of Menses: _____ Flow: Heavy Medium Light Age at onset of menses: _____
 Date of last period: _____ Contraception method: _____ Last PAP: _____ with PCP OBGYN
 Pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____

Family Medical History

<input type="checkbox"/> Adopted (Skip to Preventative Care)	Mother	Father	Siblings	Grandparents
	Age: _____ Age at Death _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Cause of Death _____ Medical Issues:	Age: _____ Age at Death _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Cause of Death _____ Medical Issues:	Number of Brothers: _____ Number of Sisters: _____ Cause of Death _____ Medical Issues:	Maternal Grandma <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Maternal Grandpa <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Paternal Grandma <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Paternal Grandpa <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Medical Issues:
Alcoholism				
Anxiety				
Asthma				
Depression				
Diabetes				
Heart Disease				
Cancer	Type:	Type:	Type:	Type:
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Migraines				
Obesity				
Osteoporosis				
Other:				
Other:				

Medical History & Lifestyle (Ages 17 & Under)

Patient Name _____ Date of Birth _____

Pregnancy & Birth: This child is yours by: Birth Adoption Stepchild Other: _____

Any medical problems/complications during pregnancy? _____

Type of Delivery: Vaginal 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 Any additional medical problems? _____

Other hospitalizations /surgeries & approx. Date: _____

Nutrition: Excellent Good Average Needs Improvement Poor

Breast fed to _____ months Bottle fed to _____ months Feeding Problems? Explain _____

Gained weight well Gained weight slowly Milk intolerance Food intolerance If yes, explain: _____

Development (indicate age in months): Rolled Over _____ Crawled _____ Pulled to stand _____ Walked alone _____

Single Words _____ 2 Word Sentences _____ Toilet Trained _____ Gave up Bottle _____

For Children over 5, please indicate the following: Wets the bed Wets during the day Constipated Soils pants with stool

Weight loss Overweight Behavioral problems

Who does the child live with? _____ Hobbies? _____ Pets? _____

Years in AZ? _____ Previous states? _____ What grade is your child in? _____

School performance/grades? _____ Any problems at school? _____

Exercise: None Types: _____

Indicate if your child has had: Chicken Pox Cerebral palsy Convulsions with fever Ear infections Encephalitis Measles
 Mumps Mental retardation Meningitis Mononucleosis Rubella Tonsillitis Tuberculosis

Does anyone in the household use: Cigarettes Illicit Drugs

Parents: Married Single Divorced Widowed Partnered

Date of last Physical/Well Visit: _____

Is your child up to date on vaccinations? Yes No

*** PLEASE BRING A COPY OF YOUR CHILD'S SHOT RECORD TO THE APPOINTMENT ***

How did you hear about us? _____

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____