**RAJIV PARIKH, M.D.**
*Board Certified Family Physician*
1964 E. Baseline Rd., Suite 103
Tempe, AZ 85283
Telephone: (480) 897-1725
Fax: (480) 897-1737

# PATIENT HISTORY QUESTIONNAIRE

Name_____Age_____Birthdate_____ Today's Date_____
Address_____Phone_____
Email_____Ethnic Background_____Religion_____
Occupation_____Previous Occupation_____
List other doctors treating you_____
Is it OKAY to leave messages on your home answering machine?_____Who referred you to this office?_____
List all medicines that you are currently taking: (Use another page if necessary)

| Medicine | Dose | Frequency | For what illness? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you allergic to any medicines or foods? ☐ Yes ☐ No If so, list: _____
_____
List all past operations and serious illnesses:

| Operation or Illness or Hospitalization | Month and Year | City, State | Outcome |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever been advised to have any surgical operation which has not been done? ☐ Yes ☐ No If yes, explain:
_____
Do you have a Living Will(Advanced Medical Directive)? ☐ Yes ☐ No If no, would you like information regarding living Wills? ☐ Yes ☐ No
Do you smoke cigarettes? ☐ Yes ☐ No How much?_____When did you stop?_____
How much before stopping?_____
Do you drink alcohol? ☐ Yes ☐ No How much?_____When did you stop?_____
How much before stopping?_____
Have you ever used any street drugs or illicit drugs?_____
How physically active are you?_____
FAMILY HISTORY:

| | Age | State of Health | Age at Death | Cause of Death |
|---|---|---|---|---|
| Father: | | | | |
| Mother: | | | | |
| Brother/Sister(circle one) | | | | |
| Brother/Sister(circle one) | | | | |
| Brother/Sister(circle one) | | | | |

| Has any blood relative ever had: | | | |
|---|---|---|---|
| | Cancer | ☐ Yes ☐ No | Relative:_____ |
| | Tuberculosis | ☐ Yes ☐ No | Relative:_____ |
| | Diabetes | ☐ Yes ☐ No | Relative:_____ |
| | Heart Trouble | ☐ Yes ☐ No | Relative:_____ |
| | High Blood Pressure | ☐ Yes ☐ No | Relative:_____ |
| | Stroke | ☐ Yes ☐ No | Relative:_____ |
| | Epilepsy | ☐ Yes ☐ No | Relative:_____ |

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# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**DATE:**_____

| | | | |
|---|---|---|---|
| **Patient Name:** | | **DOB:** | |
| **Insurance:** | | **Insurance ID:** | |
| **Practice Name:** | **Rajiv Parikh** | **TIN:** | **860986198** |

Over the past 2 weeks, how often have you been bothered by any of the following problems?
Circle number to indicate your answer

| | Not at all | Several Days | More that half the days | Nearly Every Day |
|---|---|---|---|---|
| 1) Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2) Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3) Trouble falling asleep, staying sleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4) Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5) Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6) Feeling bad about yourself- or that you're a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7) Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8) 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 |
| 9) Thoughts that you would be better off dead or off hurting yourself in some way | 0 | 1 | 2 | 3 |

For office coding: _____+ _____ + _____+_____
= Total Score_____

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If you checked off <u>any</u> problems, how <u>difficult</u> have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

---

**PHQ-9 scoring for severity determination-***For healthcare professional use only*
**Scoring—add up all checked boxes on PHQ-9**

For every: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3.

| Total Score | Depression Severity |
|---|---|
| 0-4 | None |
| 5-9 | Mild |
| 10-14 | Moderate |
| 15-19 | Moderately Severe |
| 20-27 | Severe |

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TODAYS DATE:_____

## Patient Information

NAME _____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
DRIVERS LICENSE #_____State_____
PHONE #_____
RACE:
□American Indian or Alaska □Asian
□Black or African American □White
□Native Hawaiian or other Pacific Islander
□Other_____

AGE_____DATE OF BIRTH_____
MARITAL STATUS_____
EMAIL_____
ORGAN DONOR_____
PREFERRED LANG_____
ETHNICITY:
□Hispanic or Latino □Not Hispanic □Other_____
SEX ASSIGNED AT BIRTH:
□Male □Female □Choose not to disclose
PRONOUNS:
□She/Her □He/Him □They/Them □Other_____

**FOR AGES 18 AND OLDER:**

GENDER IDENTITY:
□Male
□Female
□Male to Female
□Female to Male
□Genderqueer (neither male or female)
□Choose not to Disclose
□Other:_____

SEXUAL ORIENTATION:
□Lesbian, Gay or Homosexual
□Straight or Heterosexual
□Bisexual
□Choose not to Disclose
□Other:_____

## Miscellaneous

Drug allergies?_____
Effect (Nausea, rash, etc.)_____
In case of emergency, notify_____ Relation to Patient_____
Phone #_____

## Primary Insurance

INSURANCE CO._____ POLICYHOLDER'S NAME_____
ADDRESS:_____ POLICYHOLDER SSN_____DOB_____
CITY/ST/ZIP_____ POLICY #_____
PHONE #_____ GROUP#_____

## Assignment and Release

The patient acknowledges that all of the above information is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee collection should be necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I herby authorize and request that payments under my insurance plan be made directly to Rajiv Parik, MD for any services furnished to me. I also authorize the release of any information required to process insurance claims including any information relating to alcohol, drug abuse, and/or AIDS.

I hereby consent to the administration of all diagnostic procedures and/or treatments which in the judgment of my physician may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

Signature_____ Date_____

(If patient is a minor- signature of parent/guardian)

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Patient Name:_____ Date:_____

Patient's Date of Birth_____

## Authorization, Assignment of Benefits & Release

I acknowledge that the information supplied on the patient registration form is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to Rajiv Parikh, M.D. for any services furnished to me.
I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgement of Dr.Parikh may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.
I also authorize the release of any information required to process insurance claims including any information relating to alcohol abuse, drug abuse, and/or AIDS/HIV.

## Financial Arrangements

For your convenience, our office participates in a wide range of insurance plans. If you are not covered under one of the plans with which we participate, payment is expected at the time of service. Please check the option which you prefer. If you have any questions concerning financial arrangements or need special arrangements, please ask for assistance.

- ☐ Bill my insurance (A copy of your insurance card is required)
- ☐ Cash
- ☐ Personal check w/valid driver's license
- ☐ Credit Card □ Visa □ MasterCard
  Card #_____ Expiration Date_____

## Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Rajiv Parikh, M.D.'s "Notice of Privacy Policies", detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I place no additional restrictions(s) concerning my personal medical information:

_____

This authorization may be revoked in writing by me at any time.

Signed:_____ Date:_____

Signature_____ Date:_____
(if patient is a minor- signature of parent/guardian)

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# NOTICE OF NO SHOW FEE

**Please be advised that our office requires 24 hours notice to cancel or reschedule your appointment. Missing an appointment hinders our ability to care for you as well as others, because we lose a time slot that could have been used to help another patient. For this reason, you will be responsible for a $50.00 no show fee each time you do not show for your scheduled appointment.**

**If a patient fails to show up for more than three appointments within 6 month without giving proper notice, he/she may be dismissed from the practice for failure to follow physician's recommendations. We very much want to serve you, so we urge you to make every effort to keep all of your appointments.**

**I _____ understand that if i do not show for my scheduled appointment, cancel or reschedule my appointment 24 hours before that scheduled time, I will be charged a $50.00 no show fee.**

_____ _____

**Print Name** **Date**

_____

**Signature**

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# CONSENT TO DISCLOSE MEDICAL INFORMATION

**I,_____give**
**(Name of Patient)**
**Permission to Rajiv Parikh, M.D. to disclose medical information to_____**
**(name of Authorized party)**

**I agree that the above named person can also:**

**_____ receive results**
**(Initials)**
**_____ make/ change appointments**
**(Initials)**
**_____ pick up documents**
**(Initials)**

**I understand that a record of this consent will be kept in my file and can be retracted with written consent stating otherwise.**

_____
**Signature of Patient**

_____
**Date**

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"I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider."

Patient Name:_____ Today's Date_____

Patient Signature_____

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# FINANCIAL POLICY

Patient Name:_____DOB:_____Date:_____

Thank you for choosing us as your primary care physician. We are committed to providing you with quality and affordable health care. In order to reduce misunderstandings, we have adopted the following Financial Policy. We require that you carefully read, initial each numbered section, and sign the bottom prior to the start of any service or treatment.

**1. Insurance:** If you are insured by a plan we are not in-network and contracted with, payment in full is expected at each visit. If we accept your insurance but you don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. It is your responsibility to know your insurance benefits including deductibles, co-insurances, and copays as well as contracted labs, radiology, and hospital facilities. 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. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, benefits and coverage will be verified by our office, however, the explanation we are given is not a guarantee and until your claim is processed there is no guarantee of coverage. There are guidelines set forth by your insurance company directly.
**INITIALS:**_____

**2. Co-Payments, Deductibles & Co-Insurance:** All co-payments, deductibles and/or co-insurances must be paid at the time of service. This agreement is part of you contact with your insurance company. Failure on our part to collect co-payments can be considered fraud. Patients with deductibles and/or co-insurances are expected to pay 100% of the contracted rate for covered services at the end of each visit. A co-pay will be collected at each visit. Any office visit combines with Annual Wellness Visit/ Physical will have a co-pay. **INITIALS:**_____

**3. Non-Covered Services:** All health plans are not the same, and they do not always cover the same services. 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 and a quote may be given prior to any treatment or service. **INITIALS:**_____

**4. Proof of Insurance:** We will bill your insurance on the information you provide us at the time of service. This requires us to copy your current insurance card. We will also require you to confirm your registration information. Your 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. **INITIALS:**_____

**5. Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance may need you to supply certain information directly. If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you.
**INITIALS:**_____

**6. Billing Statements:** Patient balance statements are mailed out on a monthly basis. Please make sure we are informed of your current address. In addition, patients with scheduled appointments will also be expected to pay any outstanding statements due. **INITIALS:**_____

**7. Past Due Balance:** Any unpaid balances after 2 billing cycles will be sent to collections. An additional fee of 35% will be added to your account balance. In order to be seen after an account is sent to collections, balance must be paid in full along with a $50 reinstatement fee.
**INITIALS:**_____

**8. No Show / Late Cancellation Fees:** We charge $50 for missed appointments and $30 for appointments not canceled with at least 24 hour notice. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your scheduled appointment.
**INITIALS:**_____

**9. Minors:** A parent/legal guardian must accompany a minor patient on his first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent/guardian only if we have a notarized written consent. The adult accompanying the minor patients is responsible for the payment of the rendered services at the time of service. **INITIALS:**_____

**Miscellaneous Charges:**
FMLA $25
Disability Forms $25-50 (physician discretion)
Legal Forms $25-300 (physician discretion)

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. A copy will be available upon request.

I have read and understand this payment policy. By signing below you agree to those terms.

_____ _____
Signature of Patient or Responsible Party Date