CARING FOR FAMILIES P.C. – NEW PATIENT REGISTRATION

PLEASE PRINT CLEARLY

Patient Information

Full Name:_____ ☐ Male ☐ Female
Last *First* *MI*

Home Phone:(_____)_____ Cell Phone:(____)_____ Contact Preference: ☐ Cell ☐ 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:_____ ☐Male ☐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 eachnumbered 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 analternative 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: *(Including Supplements)*	*Dose*	*Times/day*		*Dose*	*Times/day*
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Any Allergies & Reactions (including medications): _____
_____

Medical History

□ ADD/ADHD	□ Arthritis	□ Diabetes - Type: □I □ II	□ Hypothyroidism	□ Sleep Apnea
□ Allergies	□ Asthma	□ Erectile Dysfunction	□ Migraines	□ Suicide
□ Anemia	□ COPD/Emphysema	□ GERD	□ Osteoporosis	□ Cancer – Type: _____
□ Anxiety	□ Depression	□ High Blood Pressure	□ Skin Disorder	□ Other: _____

Surgeries (if any): Please list year

□ Appendix_____ □ Bone & Joint_____ □ Breast_____ □Hysterectomy_____ □ Gastrointestinal _____ □ Gall Bladder_____ □ Eye_____
□ Hernia_____ □ Heart_____ □ Kidney_____ □ Prostate_____ □ 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

☐Adopted (Skip to Preventative Care)	**Mother** Age: _____ Age at Death_____ □ Alive □Deceased Cause of Death _____ Medical Issues:	**Father** Age: _____ Age at Death_____ □ Alive □Deceased Cause of Death _____ Medical Issues:	**Siblings** Number of Brothers: _____ Number of Sisters: _____ Cause of Death _____ Medical Issues:	**Grandparents** Maternal Grandma □ Alive □Deceased Maternal Grandpa □ Alive □Deceased Paternal Grandma □ Alive □Deceased Paternal Grandpa □ Alive □Deceased Medical Issues:
Alchoholism				
Anxiety				
Asthma				
Depression				
Diabetes				
Heart Disease				
Cancer	**Type:**	**Type:**	**Type:**	**Type:**
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Migraines				
Obesity				
Osteoporosis				
Other:				
Other:				

Patient Name_____ **Date of Birth**_____

Lifestyle (Ages 18+ only)

Marital Status: □ Married □Single □ Divorced □Widowed □Partnered

Children: Boys: _____ Girls: _____ Pets: _____ Occupation: _____

Who do you live with? _____

Years in AZ? _____ Previous States?_____

Are you sexually active? □ Yes □ No Sexual Orientation: I prefer □ Men □ Women □ Both

Tobacco: □ Yes □ No □Former Years:_____ Cigarettes_____packs/day □Cigars □Smokeless

Alcohol: □ Yes □ No Amount: drinks per Day_____ Week_____ Month_____ Year_____

Drugs: □ Yes □ No □ Former If yes, type:_____

Nutrition: □Excellent □Good □Average □Poor

Exercise: □ None Types: _____ Frequency: For _____minutes _____days/week

Do you Travel outside of the U.S.? □ Yes □ No

Do you have a living will? □ Yes □ No

Preventative Care

Date of last:

Physical _____ Colonoscopy_____ Eye Exam_____ Foot Exam _____

Blood Cholesterol _____ Prostate Exam _____ Mammogram_____ DEXA Scan _____

Pap _____ Breast Exam _____

Vaccines: Tetanus_____ Pneumonia_____ Flu_____ Shingles_____

How did you hear about us? _____

Patient Signature:_____**Date:**_____