Welcome to our office. Please fill out the information requested as completely as possible. A copy of your driver's license or a photo ID <u>And</u> your insurance card is required for identification.

<u>PATIENT INFORMATION:</u>

Name: _____

Date of Birth: _____/_____/_____ SSN#_____ Gender: Male Female

Home Phone: _____ Cell: _____

Local Address: _____

City: _____ State: _____ Zip code: _____

Secondary/Billing Address: _____

City: _____ State: _____ Zip code: _____

Email: _____ Pharmacy Name & Number: _____

Marital Status: MARRIED DIVORCED SEPARATED SINGLE WIDOWED CHILD

<u>RESPONSIBLE PARTY INFORMATION:</u> *(For insurance and billing purposes)*

Name: _____

Date of Birth: _____/_____/_____ SSN# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to patient: SELF SPOUSE FATHER MOTHER CHILD STEP PARENT GUARDIAN

Primary Insurance: _____ Policy Holder: _____

Secondary Insurance: _____ Policy Holder: _____

<u>EMERGENCY CONTACT:</u>

Name: _____ Phone: _____

Relationship: _____

_____ _____

Signature of patient or parent/guardian Date

ADULT HEALTH HISTORY FORM

Name: _____

Date of birth: _____ **Date:**_____

PERSONAL MEDICAL HISTORY: (Check all that apply)

	Allergies		Diabetes		Hypothyroid
	Anemia		Enlarged Prostate		Lung Cancer
	Arthritis		Fractures		Obesity
	Asthma		Gallstones		Osteoporosis
	Blood clots		GERD		Pancreatitis
	Cancer-type _____		Graves' disease		Peptic Ulcer Disease
	Carotid Artery Blockage		Headache-Migraines		Prostate Cancer
	Colon Cancer		Heart Attack		Seizures
	Coronary Artery Disease		Heart Palpatations		Skin Cancer
	Congestive Heart Failure		Hepatitis		STD's
	COPD		High Cholesterol		Stroke
	Depression		Hypertension		Urinary Tract Infections- Frequent

FAMILY MEDICAL HISTORY: (Check all that apply for immediate family)

__Adopted __ Unknown

	Allergies		Heart attack		Renal Failure
	Alzheimer's Disease		High blood pressure		Seizure
	Arthritis		High cholesterol		Sleep Apnea
	Asthma		Hypertension		Stroke
	Cancer-type _____		Leukemia		Sudden Death
	Congestive heart failure		Loss of vision		Suicide
	Coronary artery disease		Lymphoma		Thyroid disorder
	COPD		Malignant melanoma		Ulcerative colitis
	Depression		Obesity		Varicose veins
	Diabetes		Osteoporosis		Vision problems
	Hearing loss		Pancreatitis		Other:

SURGERIES: (Check and write year)

	Abortion		Gall Bladder		Shoulder
	Adenoids		Gastric Bypass		Sinus
	Appendix		Heart Bypass		Tonsils
	Ankle		Heart Stent		Tubal Ligation
	Breast		Hernia		Vasectomy
	C-Section		Hysterectomy		Other:
	Ear tubes		Joints		Other:

HOSPITALIZATIONS/INJURIES: (Not including above surgeries)

_____

_____

MEDICATIONS: (List all medications/doses)

_____ _____ _____

_____ _____ _____

_____ _____ _____

MEDICAL ALLERGIES: (Include reaction)

_____ _____ _____

_____ _____ _____

PREVENTATIVE EXAMS:

When was your last colonoscopy? Month/Year _____ When was your last EKG? Month/Year _____

When was your last DEXA? Month/Year _____ When was your last cholesterol test? Month/Year _____

When was your last Physical? Month/Day/Year _____ When was your last eye exam? Month/Year _____

MEN ONLY:

When was your last PSA blood test? _____

FEMALE ONLY:

When was your last pap smear? _____ When was your last mammogram? Month/Year _____

Current method of birth control? _____ Number of pregnancies____ Number of births _____

Number of miscarriages _____ Number of abortions _____

SOCIAL HISTORY:

Married Single Divorced Widowed

What is your occupation?_____ Employer: _____

Do you exercise regularly? Y N Type/Frequency: _____

Do you currently smoke tobacco? Y N If yes, how much per day? _____

How long have you smoked? _____ Do you vape? Y N

If no, have you ever smoked tobacco? Y N How long did you smoke? _____

Do you drink alcohol? Y N If yes, how often do you drink? _____

If no, are you a recovering alcoholic? Y N How long ago did you quit? _____

Do you have a Power of Attorny? Y N Do you have a living will? Y N

Do you have a signed 'do not resuscitate'? Y N

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 READ CAREFULLY

This notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care options and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data that can be used to identify you. This health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

Uses and disclosures of your protected health information:

- Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual.
- Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person.
- Protected health information contains specific information that identifies a person or can be used to identify a person. Protected health information is health information created or received by health care provider, health plan, employer, or health care clearinghouse. Brown Road Family Medicine, can act as each of the above business types. This medical information is used by Brown Road Family Medicine, in many ways while performing normal business activities.
- Your protected health information may be used or disclosed by Brown Road Family Medicine, for purposes of treatment, payment, and health care operations. Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. Brown Road Family Medicine, may use or disclose your health information for case agreement and services. Brown Road Family Medicine may send the medical information to insurance companies, Medicaid, or community agencies to pay for services provided to you.
- Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.
- Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

➢ Reporting abuse of children, adults, or disabled persons.
➢ Investigations related to a missing child.
➢ Internal investigations and audits by the department's divisions, bureaus, and offices.
➢ Investigations and audits by the state are inspector General and Auditor General and the legislature's Office of Program Policy Analysis and government Accountability.
➢ Public health purposes including vital statistics, disease reporting, public health surveillance, investigations, interventions and regulation of health professionals.
➢ District medical examiner investigations.
➢ Research approved by the department.
➢ Court orders, warrants, or subpoenas.
➢ Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Individual Rights

You have the right to request Brown Road Family Medicine, to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The BRFM privacy department is not required to agree to any restriction.

You have the right to inspect and receive a copy of your protected health information. Brown Road Family Medicine may mail or call you with health care appointment reminders. We will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information. Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law. If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to dent access. This licensed health care professional will be designated by BRFM privacy department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. Brown Road Family Medicine may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department,
- Is not protected health information,
- Is by law not available for your inspection, or
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department will respond to your letter in writing. You also may file a complaint, as described below in section titled Complaints.

You have the right to receive a summary of certain disclosures Brown Road Family Medicine, may have made of your protected health information. The summary does **not** include:

- Disclosures made to you**.**
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payments, and health care operations.
- Disclosures for public health.
- Disclosures for health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to [Practice decides date here].

This summary **does** include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than 6-year period from the date of your request if you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

Complaints

You have the right to express complaints to the provider and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the provider by contacting the provider's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The provider's contact person for all issues regarding privacy and your rights under the Federal privacy standards is the Privacy Officer. Information regarding matters covered by this notice can be requested by contacting the Privacy Officer. Complaints against the provider can be mailed to the Privacy Officer by sending it to: **2310 E. Brown Rd. Mesa, AZ 85213**

Effective Date

This Notice of Privacy Practices is effective beginning March 28, 2011, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

By signing below you acknowledge that you have read and understand the privacy practices of Brown Road Family Medicine.

Patient Printed Name:

_____

Patient Date of Birth: _____

Patient/Guardian Signature:

_____

Today's Date: _____

OFFICE POLICIES

This is written for your information and hopefully will answer any questions you may have about our policies and procedures. Please read and sign, then return this form to our staff.

- Payment is expected as services are rendered unless prior financial arrangements have been made. We accept cash, checks, Visa and Mastercard.

- A charge of $25.00 will be made for personal checks drawn insufficient funds.

- A charge of $5.00 will be added to co-pays that are not paid at time of service.

- There will be a charge of $25.00 for missed appointments or appointments not cancelled 24 hours in advance.

- If you do not provide current insurance information at the time of visit, you will be responsible for the bill. If your insurance company denies payment for our services for any reason, you are responsible for the bill. Patient accounts are expected to be paid within 60 days.

- Our staff will be happy to answer any questions you may have in reference to these issues.

- Please inform us immediately of any changes in your address, phone number, or insurance.

_____ _____

Patient/Guardian Date

2310 E. Brown Road Main Line (480) 649-9000 Main Fax (480) 248-9213
Mesa, AZ 85213 **www.brownroadfm.com** Nurse Fax (480) 248-9206

Promise to pay note

- All patients are required to sign this form upon the first visit and it will remain in place as long as you are a patient in this office.

- We will send claims to all insurance companies that we are contracted with. If you have an insurance company that we are not contracted with, we will let you know before you are seen by a provider so you can make other arrangements for payment.

- We verify the eligibility of every patient before they are seen. However, if at a later date you become ineligible and the claim is denied by your health plan, you will be responsible for the bill. Ultimately, it is the responsibility of patient to be sure they have adequate insurance for doctor's office visits.

- We expect that your account will be paid in full within 90 days of the date of service. We expect that you will be actively involved in facilitating the claims being processed by watching for statements from our office and from you insurance company.

My signature below indicates that I have read and understand the above changes in policy and consider this form to be a promise to pay note.

Printed patient name _____Patient DOB_____

Patient/Guardian Signature_____

Relationship to patient_____

Date _____

Brown Road Family Medicine
2310 E. Brown Road
Mesa, AZ 85213

Main Line (480) 649-9000
www.brownroadfm.com

Main Fax (480) 248-9213
Nurse Fax (480) 248-9206

Release Form for Individuals Involved in Care of Patient

I, _____ give Brown road Family Medicine permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans, and payment for health services I receive.

This consent is valid until such time as I provide a written revocation of it.

Brown Road Family Medicine may speak with:

Name: _____

Relationship: _____

Information to be released:

☐Treatment ☐Diagnosis ☐Schedule ☐Payment ☐Other:_____

Name: _____

Relationship: _____

Information to be released:

☐Treatment ☐Diagnosis ☐Schedule ☐Payment ☐Other:_____

Permission to leave lab and any medical results on voicemail:

☐Medical Assistant may leave lab results on voicemail

☐Medical Assistant may not leave lab results on voicemail

Patient Signature: _____Date of birth:_____

Date Signed: _____

Account Number: _____