Office Use Only

DEMO	INS	EML	PHMCY	SIGN

East Valley Family Practice - Patient Registration

Patient Information (USE CAPITAL LETTERS ONLY)

Last Name: _____ First Name: _____ MI: _____ SS #: _____-_____-_____

Date of Birth _____/_____/_____ **Gender** (circle) Male OR Female **Marital Status** (circle) Married Single Divorced Widowed

Address: _____ City: _____ State: _____ Zip: _____

Contact Information (USE CAPITAL LETTERS ONLY)

Home: (_____) _____ - _____ Cell: (_____) _____ - _____ Work: (_____) _____ - _____

Email: _____ **Best Way to Contact via phone: (circle)** Home Cell Work

Emergency Contact: _____ Relationship: _____ EC Phone: (_____) _____ - _____

Can we leave voicemails and/or emails in regards to medical conditions, appointments, and/or medications? (circle) YES or NO

Employment Information

Employer Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Information

- **Insurance cards** are REQUIRED for ALL new patients and ALL insurance or policy information changes.
  - If for any reason, you DO NOT have your card, we MUST have the WHOLE table below filled out.
  - If you **HAVE your card, just write in the name of the insurance**, effective date and then sign.
- If you have an **HRA account** (not HSA, HRA Pays Automatically), please provide a Document Showing HRA Account, otherwise, pre-payments may due per financial policy later in forms.
- If your insurance is an **HMO insurance that requires a change of PCP** (primary care provider) prior to your office visit have you called to change the PCP? (circle) YES NO If yes please provide date of call: _____/_____/_____ and Reference Number for the call _____

Name of PRIMARY Insurance Company: (MUST HAVE)	**Name of SECONDARY Insurance Company: (MUST HAVE)**
Effective Date	**Effective Date**
Responsible Party (if patient is a minor)	Responsible Party (if patient is a minor)
Primary Insurance Policy (ID) #	Secondary Insurance Policy (ID) #
Primary Insurance Group #	Secondary Insurance Group #
Primary Insurance Phone # For Providers	Secondary Insurance Phone # For Providers
Primary Insurance Claims Address	Secondary Insurance Claims Address
Subscriber's Name & DOB	Subscriber's Name & DOB

I hereby authorize the East Valley Family Practice physician(s) to release information acquired in the course of my examination for treatment to any referred/referring physician(s) or insurance(s) listed above.

➔**Patient or Guardian Signature:** _____ **Date:** _____/_____/_____

East Valley Family Practice - Financial Policy

Your Responsibility

You are financially responsible for the services we provide you. You as the patient are responsible for **any and all** co-insurance, co-pay and deductible payments due. Charges for deductibles, co-pays, and co-insurances WILL BE DUE AT TIME OF SERVICE. As a courtesy to you we will file insurance claims on your behalf, when supplied with current and precise insurance information. If you present without this information please be prepared to either pay cash or reschedule your visit. It is your sole responsibility to know the individual coverage and benefits of your insurance plan. It is your responsibility to ensure our practice is a contracted provider with your plan.

Patients without Insurance/Self Pay

It is our pleasure to provide services to patients that do not have insurance. However, you will be expected to pay Self-Pay for your services at the time of the visit. We do not bill self-pay accounts.

Medicare Patients

We will bill your secondary insurance if you provide us with the information. You are, however, solely responsible for any coinsurance, deductibles or any charges for non-covered services. You may be required to sign an advanced beneficiary notice for any immunizations or procedure performed.

HMO AND/OR AHCCCS Patients

It is the patient's responsibility to ensure our practice is a contracted provider and that Dr. Gupta is designated as your Primary Care Physician with your plan. If your plan requires referrals to specialty physicians you must adhere to our office referral policy. If you seek care without prior authorization, you will be financially responsible for the specialist visit(s).

Short-Term or Indemnity Insurances Etc.

For certain type of insurances, practice retains the right to charge a minimum fee of $100 for new patient visits and $75 for established office visits.

We Do Not File Third Party Liability Insurance Claims

We will provide medical care for you in accident cases, but will only file with your medical insurance or accept cash at the time of visit and will precollect since many times health insurances don't cover Auto Accidents

We Do Not File Workman's Comp

If you forgot to mention about sickness of injury from Workman's comp, you will be responsible for charges.

Methods of Payment

We accept cash, Visa, MasterCard or Discover cards and checks. A $25.00 charge will be assessed for any returned checks (NSF) checks.

Prior Balances

Patients with an account showing a prior balance will be asked to pay the balance in full before being seen. If the balance cannot be paid in full, you may be asked to meet with our billing department to arrange for payment. There may also be additional fees if balances get sent through collections.

Form Filling Charges

There will be a charge assessed for the completion of any disability, insurance or special forms. Rates are $10 for single pages and $35 for multiple pages. These charges are not covered by insurance carriers and are due at time of service, in addition to any applicable office visit fees.

Information Change/Update

It is your responsibility to notify our office of any changes to address, phone number, or insurances changes promptly. You MAY be asked once a year to fill out demographic information, or to initial that what is on file is current and correct.

Methods of Payment

Labs and imaging (except screening mammograms) will be conveyed by staff in timely fashion. Please contact our office if you don't hear from office. All abnormal labs and imaging require an office visit where Dr will visit a plan of care.

No Show - 24 Business Hr Reschedule30 mins Same Day Apt Fees

Please notify us IN **24 BUSINESS hours** in advance if you must cancel or reschedule your appointment, this allows us time to schedule another patient and **IN < 30 MINS OF SAME DAY APT**, otherwise, you could be billed a $25.00 Charge. If the appointment cancellation with 24 business hrs is for a hospital visit, the charge will only get waived once you make a hospital follow-up appointment

Collection Procedures

Prompt payment for services rendered is expected in full. Failure to reply to communications from our office may result in your account being turned over to an outside collection agency and/or discharged from our practice. I understand that in the event that my account is assigned to a collection agency (usually after 2 billing cycles, but can be sooner), I agree to pay an additional collection fee of 33.33 % of the outstanding balance assigned.

➔Patient Name: _____DOB: _____/_____/_____

➔Patient or Guardian Signature: _____Date: _____/_____/_____

East Valley Family Practice - Policies

Acknowledgement of Notification of PRIVACY POLICY & HIPAA Access

I acknowledge that I have been notified and reviewed the Privacy Policy for East Valley Family Practice. I acknowledge know where I can obtain copies of this policy and its updates as I feel it is warranted. I understand that my information will only be shared with those are involved in the maintenance of my care and individuals that I provide the office and they are as follows. (please list all the names and phone numbers of individuals involved in your care that you are allowing our practice to release information to if it is warranted)

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

➔Patient or Guardian Signature: _____Date: ___/_____/_____

Acknowledgement of Notification of NARCOTIC POLICY

Our facility ***DOES NOT PRESCRIBE NARCOTIC MEDICATIONS*** for treatment of pain/chronic pain conditions. We reserve the right to treat "acute" pain only. Acute Pain is defined as pain that is temporary and resulting from something specific such as a surgery, infection or injury.

Please sign below indicating you agree and understand these terms and conditions.

Patient Name: _____ Date of Birth: _____/_____/_____

➔Patient or Guardian Signature: _____Date: _____/_____/_____

East Valley Family Practice - Acknowledgements of Consents

Consent for Treatment

1. I, hereby voluntarily consent to outpatient care at East Valley Family Practice, encompassing routine diagnostic procedures, examinations, and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), taking of x-rays, heart tracings, and administration of medications prescribed by the physician(s)
2. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by East Valley Family Practice clinics and any medical staff as it is deemed necessary in the medical staff's judgment.
3. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend and are cared for at any East Valley Family Practice Clinic or by any of associated Providers.
4. I hereby authorize my insurance carrier(s) to pay East Valley Family Practice Clinics any and all benefits due to me, if any, by reason of the services described in the statements rendered as and provided for in the policy contract with my insurance carrier(s).
5. This form has been explained to me and I fully understand and am willing to comply with all of its contents.
    - If patient is unable to consent please provide reason of the inability in the spot provided below.

_____

_____

Patient's Name: _____ DOB: _____/_____/_____

Consenter signing in behalf of the patient: _____ Relationship: _____

➔Patient or Guardian Signature: _____ Date: _____/_____/_____

Beneficiary Agreement

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE BENEFITS!!!

Listed are some services that some insurance carriers may deny coverage on some of the commercial, Medicare, and Medicaid (AHCCCS) insurances will cover:

- Anxiety and/or Depression
- Vitamin B-12 injections
- Cosmetic Surgery
- Custodial Care
- Dental Care and/or TMJ
- Depo-Provera Injections
- Drug Abuse
- Flu Injections
- Insulin Injection
- Obesity
- Psychiatric Care
- Bariatric referrals and or care
- Routine immunizations for adults and/or children
- Routine physical exams/services – Adult
- Routine well child exams
- Routine well woman exams/Pap
- Smoking/alcoholism
- Sports/School physical
- Supplies _____
- Other _____

I understand that these items may or may not be a covered benefit of my health insurance plan. I understand that I am responsible for these charges if the insurance denies any of these AND/OR ANY OTHER services.

Patient's Name: _____ DOB: _____/_____/_____

➔Patient or Guardian Signature: _____ DATE: _____/_____/_____

East Valley Family Practice

Pharmacy Information

➔Pharmacy Name: _____

➔Pharmacy Phone: _____

Pharmacy Address or Cross Streets:

_____

_____

If you are unsure of a pharmacy contracted with your plan please provide the name of a pharmacy you would like to use. We will be able to correct the pharmacy information when a contracted pharmacy is known.

Appointment Confirmations

- **DEFAULT SELECTED = YES**

YES (REMAIN ON SCHEDULE)

YOU WILL BE CALLED TO REMIND AND THEN MARKED CONFIRMED, WILL INCUR FEE IF YOU DON"T SHOW UP

NO (REMOVE FROM SCHEDULE)

You WILL BE CALLED TO REMIND AND REMOVED FROM SCHEDULE IF NO CONFIRMATIONS IS HEARD BACK 24 BUSIENSS HRS BEFORE THE APT TIME (WE CALL 2 DAYS BEFORE THE APT)

Healthcare Providers involved in your care

To be able to provide the best of care for you we would like to get the names, specialties and contact information for any providers you may have seen in the past. Please provide us with that information in the table below.

Physician Name	Specialty	Phone Number	Fax Number

Patient's Name: _____ DOB: _____/_____/_____

➔Patient or Guardian Signature: _____Date: _____/_____/_____

Authorization to Release Medical Records

As required by the Health Information Portability Accountability Act of 1996 and Arizona State Law, you have a right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason of why the request will not be granted. Your right to access does not extend to information complied in reasonable participation of, or for use in, a civil, criminal, or administrative action or proceeding, or to information we have received in confidence from someone other than another health care provider.

I understand and hereby also consent to the release of any and all alcohol and/or drug abuse information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or psychiatric treatment records under the same conditions outlined below. I understand that such information cannot be released without my specific consent.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I Authorized Healthcare Information To Be Released To:

East Valley Family Practice

Phone: 480-269-8436
3885 South Val Vista Drive, Suite 103
Gilbert, Arizona 85297

Fax: 480-553-9856

Please only send 40 pages in a single fax.
If more than 40 pages please send multiple faxes to insure proper receipt of all documentation.

This Authorization Applies to the Following Information:

- All Healthcare Information
- Last 3 Chart Notes, and all Labs, Testing, and Imaging
- _____

It Is Authorized To Be Acquired From:

Clinic or Physician's Name: _____

Physician's Office Address (if known): _____

Phone Number: _____ Fax Number: _____

This Authorization to Release Healthcare Information Applies Solely to The Name Listed Below:

Patient's Name: _____ Patient's Date of Birth: _____/_____/_____

Guardian's Name: _____ Relationship to Patient: _____

➔**Signature: _____** **Date Authorization Signed: _____/_____/_____**

East Valley Family Practice Health Questionnaire

Patient's Name: _____ Date: _____/_____/_____

Patient's DOB: _____/_____/_____ AGE: _____

Personal Past Medical History (Please select all that apply to active **and** inactive past history)

- ○ Diabetes
- ○ High Blood Pressure
- ○ Heart Disease/Cardiac Stent/Cardiac Bypass
- ○ Heart Failure/CHF
- ○ Irregular Heart Rhythm/Atrial Fibrillation
- ○ High Cholesterol
- ○ Sleep Apnea
- ○ Migraines/Headaches
- ○ Stroke/TIA
- ○ Seizure
- ○ Memory Loss
- ○ Multiple Sclerosis
- ○ Glaucoma/Cataracts
- ○ Blood Clots/DVT
- ○ Anemia
- ○ Bleeding/Blood Disorder
- ○ Stomach Ulcers
- ○ Acid Reflux/GERD
- ○ Irritable Bowel Syndrome
- ○ Liver Disease
- ○ Hepatitis
- ○ Asthma
- ○ COPD/Emphysema
- ○ Allergic Rhinitis
- ○ Tuberculosis
- ○ Kidney Disease
- ○ Kidney Stones
- ○ Thyroid Disease
- ○ Osteoporosis
- ○ Arthritis
- ○ Gout
- ○ Fibromyalgia
- ○ Lupus
- ○ Depression
- ○ Anxiety
- ○ Bipolar Disorder
- ○ Cancer (Type) _____

Other medical history not included above:

_____

_____

Medication: (please list **ALL** medications **BOTH** prescribed and non-prescription) (examples such as over the counter supplements or vitamins)

Medication Name and Dosage:	Medication Directions of Administration/Use:

Allergies: (list **ALL** allergies to medications and/or medical supplies (latex, tape, adhesive, dyes, etc) even if it was as a child and if none put none)

Allergy to:	Reaction:

East Valley Family Practice Health Questionnaire

Patient Name: _____ **Date of Birth:** _____/_____/_____

Surgical History (list all surgeries and/or procedures you have had in the past)

Type of Surgery or Name of Procedure	Date (if you're unsure just provide the year)

Family Health History (please select all that apply)

- ○ Diabetes
- ○ High Blood Pressure
- ○ Coronary Heart Disease
- ○ High Cholesterol
- ○ Stroke
- ○ Headache/Migraines
- ○ Blood Disease/Disorder/Clots
- ○ Asthma
- ○ Allergies
- ○ Stomach Ulcers
- ○ Kidney Disease
- ○ Liver Disease
- ○ Arthritis
- ○ Tuberculosis
- ○ Hepatitis
- ○ Autoimmune Disorder/Disease
- ○ Depression/Anxiety
- ○ Cancer
- ○ Other (Please Specify)

_____
_____
_____
_____
_____

Social History

Tobacco Usage: (circle) Yes or No or Former Type: _____ Length of use: _____ Quit Year: _____

Alcohol Usage: (circle) Yes or No or Former Type: _____ Length of use: _____ Quit Year: _____

Recreational Drug Usage: (circle) Yes or No or Former Type: _____ Length of use: _____ Quit Year: _____

Caffeine: (circle) Yes or No or Former Type: _____ Frequency of use: _____

Marital Status: (circle) Single Married Divorced Widowed

Employment/Occupation: _____

Children: (circle) Yes No If Yes, how many children: _____

Advanced Directives (circle if any apply if none apply please put N/A in the spot to specify)

Living Will Power of Attorney Health Care Proxy Other Directives: (specify) _____

Health Maintenance: (please provide most recent date of completion for ALL of the following that is applicable)

Women Only

Mammogram: _____/_____/_____ Pap Smear: _____/_____/_____

Men Only

Prostate Exam: _____/_____/_____

All Patients

Colonoscopy: _____/_____/_____ Bone Density: _____/_____/_____

Vaccines: (please list any and all you can remember)

Influenza: _____/_____/_____ Pneumonia: _____/_____/_____ Tetanus: _____/_____/_____

_____

_____