Phoenix Internal Medicine

9515 W Camelback Rd, Suite 114
Phoenix, AZ 85037
Phone: 623-777-1720
Fax: 623-777-1799

REF: RELEASE OF MEDICAL RECORDS:

I HEREBY AUTHORIZE : DR _____

(Your previous Doctors and Specialists) _____

_____

TO RELEASE ANY AND ALL MEDICAL RECORDS FOR:

NAME DATE OF BIRTH

1. _____

TO

Phoenix Internal Medicine.
9515 W Camelback Rd
Suite 114.
Phoenix, AZ 85037.
Phone: 623-777-1720
Fax : 623-777-1799

_____ _____
PATIENTS SIGNATURE WITNESS

MEDICAL RECORD / SS # _____

PLEASE SEND ALL COPIES OF RECORDS TO THE ABOVE ADDRESS. THANK YOU

PHOENIX INTERNAL MEDICINE

Personal Demographic Information

Name_____ Sex _____ Marital Status_____
Social Security No _____ Date of Birth _____
Address:_____ Home Phone_____
City _____State ____ Zip _____ Cell Phone _____
Employer _____ Work Phone _____
Referred by _____ Email_____

Race:

- ◉ Asian
- ○ Caucasian
- ○ African American
- ○ Native Hawaiian/Other Pacific Islander
- ○ American Indian/Alaska
- ○ Prefer Not to Answer

Ethnicity:

- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ I Prefer Not to Answer

Primary Language _____
Preferred Pharmacy (Cross Streets) _____

Insured (Card Holder)/Responsible Party (If not Patient)

Name _____ Relationship to Patient _____
Social Security No _____ Date of Birth _____
Address: Street _____ Home Phone _____
City _____ State____ Zip _____ Work Phone _____

PLEASE PRESENT YOUR INSURANCE CARD(S)

Emergency Contact

Name _____Relationship to Patient _____
Home Phone_____ Work Phone_____
Signature of Responsible Party _____ Date _____

I wish to be contacted with my health information in the following manner:
Check all that apply: Home Phone ☐ Work Phone ☐ Cell Phone ☐

Check one of the following:
It is OK to leave phone message reporting ***normal*** results ☐
It is ***not*** OK to leave phone message reporting ***normal*** results ☐

You have my permission to leave results and to discuss my private Health information with the following people:
Name _____ Name _____

We are required by law to provide you with a notice of our legal duties and Privacy practices with respect to protected health information. Signature below is acknowledgment that you have ***received*** this Notice of our Privacy Practices.

Signature _____ Date _____

PHOENIX INTERNAL MEDICINE

Personal Medical History

Last Name_____ **First Name**_____

Today's Date _____
Exercise Type and Frequency _____
Alcohol Type and Frequency _____
Tobacco Use and Frequency _____
Last Time you had a Fall _____
Reason for Today's Visit _____
Name of Previous Primary Care Physician _____
When did you Last See Your Physician _____
Names of Current Medical Care Provider's _____
_____
Date and Place of Last: Physical Exam _____
Chest X-Ray_____
EKG_____
Colonoscopy _____
For Females: Mammogram _____
Bone Density _____
Pap Smear _____

Immunization Record

Hepatitis A _____
Hepatitis B _____
Influenza _____
MMR _____
Pneumococcal _____
Tetanus _____

PHOENIX INTERNAL MEDICINE

GENERAL MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
○	○	Alcoholism	○	○	Depression	○	○	Kidney Infections
○	○	Allergies/Hay fever	○	○	Diabetes Type 1	○	○	Kidney Stone
○	○	Anemia	○	○	Diabetes Type 2	○	○	Migrane
○	○	Anxiety	○	○	Epilepsy	○	○	Multiple Sclerosis
○	○	Asthma	○	○	Fracture	○	○	Obesity
○	○	Atrial Fibrillation	○	○	Gastric Ulcer	○	○	Old MI
○	○	Blood Transfusions	○	○	Gastrointestinal Disea	○	○	Osteoarthritis
○	○	CAD	○	○	GERD	○	○	Osteoporosis
○	○	Cancer	○	○	Gestational Diabete	○	○	Pneumonia
○	○	Cardiac Pacer	○	○	Glaucoma	○	○	Progresive Neurological Disorder
○	○	Cardiovascular Disease	○	○	Heart Murmur	○	○	Pulmonary Disease
○	○	CHF	○	○	Hepatitis	○	○	Rheumatic Fever
○	○	Cirrhosis	○	○	High Cholesterol	○	○	Rheumatoid Arthritis
○	○	Colitis	○	○	Hyperlipidemia	○	○	STD
○	○	COPD	○	○	Hypertension	○	○	Terminal Illness
○	○	CRF	○	○	Hyperthyroidism	○	○	Thyroid Disease
○	○	Chrons Disease	○	○	Hypothyroidism	○	○	TIA
○	○	CVA	○	○	Insulin Pump	○	○	Tuberculosis
○	○	DVT	○	○	Joint Pain	○	○	Valvular Problems

ANY ALLERGIES

_____

MEDICATIONS

_____

_____

_____

HOSPITALIZATIONS

_____

_____

SURGICAL/ PROCEDURES

- ☐ No Prior Surgical History
- ☐ Appendectomy
- ☐ Breast Lumpectomy
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Cone Biopsy
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Gall Bladder
- ☐ Heart Surgery
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Tubal Ligation

Other Surgical History

_____

_____

_____

General Family History - Mother

☐ Living ☐ Deceased Age_____ ☐ In Good Health ☐ Adopted

Yes	No		Yes	No		Yes	No	
○	○	Alcoholism	○	○	Congenital Anomaly	○	○	Hypertension
○	○	Anemia	○	○	COPD	○	○	Hypothyroidism
○	○	Anxiety	○	○	Crohn's Disease	○	○	Kidney Disease
○	○	Asthma	○	○	Depression	○	○	Liver Disease
○	○	Birth Defects	○	○	Diabetes	○	○	Multiple Births
○	○	CAD	○	○	Epilepsy	○	○	Osteoarthritis
○	○	Cardiovascular Disease	○	○	GERD	○	○	Osteoporosis
○	○	CHF	○	○	High Cholesterol	○	○	Pulmonary Disease
○	○	Cancer	○	○	Hyperlipidemia	○	○	Stroke

***Type of Cancer**:*

_____

_____

_____

***Other Conditions**:*

_____

_____

_____

General Family History - Father

☐ Living ☐ Deceased Age_____ ☐ In Good Health ☐ Adopted

Yes	No		Yes	No		Yes	No	
○	○	Alcoholism	○	○	Congenital Anomaly	○	○	Hypertension
○	○	Anemia	○	○	COPD	○	○	Hypothyroidism
○	○	Anxiety	○	○	Crohn's Disease	○	○	Kidney Disease
○	○	Asthma	○	○	Depression	○	○	Liver Disease
○	○	Birth Defects	○	○	Diabetes	○	○	Multiple Births
○	○	CAD	○	○	Epilepsy	○	○	Osteoarthritis
○	○	Cardiovascular Disease	○	○	GERD	○	○	Osteoporosis
○	○	CHF	○	○	High Cholesterol	○	○	Pulmonary Disease
○	○	Cancer	○	○	Hyperlipidemia	○	○	Stroke

***Type of Cancer**:*

_____

_____

_____

***Other Conditions**:*

_____

_____

_____

PHOENIX INTERNAL MEDICINE

FINANCIAL POLICY

9515 W Camelback Road, Suite 114
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Phone: 623-777-1720
Fax: 623-777-1799

Please bring your insurance card to every visit. Without proof of insurance coverage, we are unable to bill your insurance carrier, and you will be responsible for the charges.
Payment will be due at the time of service.

Patients will not be seen if copays are not paid at the time of the visit. We do not bill copays. If you're insurance deductible has not been met, full payment will be collected at the time of service. If your deductible has been met, your coinsurance will be collected at the time of service. If you have no insurance or an insurance that we do not participate with, full payment is expected at the time of service. We accept cash, check, MasterCard and Visa.

Once an account is placed in collection status, all future services must be paid in full at the time of service, regardless of insurance. Any balance assigned to a collection agency will be assessed a 30%40% fee to offset the recovery expense.

Any appointment cancellations must be done no later than one business day prior to your appointment. If you cancel on the day of your appointment, or if you do not show for an appointment, you will be charged $25.00 as a late cancellation or no show fee.

I agree to pay for any and all medical services I receive from the doctors/providers of
Phoenix Internal Medicine. This office will file a claim on my behalf; However, if my insurance company denies payment for any reason (i.e., non- covered preventive medicine visit), I will be responsible for payment.

I understand that this office can only code for my visit(s) with a diagnosis that was encountered and documented in my medical record. To ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and fraudulent.

I agree to be responsible for a charge of $25.00 if I do not cancel a scheduled appointment at least one business day prior to that appointment.

Signature: _____Date: _____

Phoenix Internal Medicine
General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job title
Signature of Witness	**Date**

Phoenix Internal Medicine

Patient Consent for Use/Disclosure of Protected Health Information

Last Name: _____ First Name: _____

Date of Birth: _____

I understand that my/the patient's health information is private and confidential. I understand that Phoenix Internal Medicine works hard to protect my/the patient's privacy and preserves the confidentiality of my/the patient's health information.

I understand that Phoenix Internal Medicine may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other health care operations. [In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Phoenix Internal Medicine has a detailed document called the "Notice of Privacy Policies". It contains more detailed information about how we may use and disclose patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.

Phoenix Internal Medicine may update this "Notice of Privacy Policies". If I ask, Phoenix Internal Medicine will provide me with the most current "Notice of Privacy Policies".

Under terms of this consent, I can ask Phoenix Internal Medicine to restrict how my/the patient's health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Phoenix Internal Medicine does not have to agree to my/the patient's request. I understand that Phoenix Internal Medicine will follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing and dating a form that Phoenix Internal Medicine can give me, called "Revocation of Consent for Use and Disclosure of Healthcare Information" or
2) Writing, Signing, and dating a letter to Phoenix Internal Medicine. If I write a letter, it must say that I want to revoke my/the patient's consent to authorize the use and disclosure of my/the patient's health information for treatment, payment, and healthcare operations.

If I revoke this consent, Phoenix Internal Medicine does not have to provide any further healthcare services to me/the patient.

My signature below indicates that I have been given the chance to review a current copy of Phoenix Internal Medicine's "Notice of Privacy Policies". My signature means that I agree and consent to allow Phoenix Internal Medicine to use and disclose my/the patient's protected health information to carry out treatment, payment, and healthcare operations.

_____ _____ _____

Patient or Legally authorized individual signature Date Time

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative,etc.)