



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 Native Hawaiian/Other Pacific Islander
 Caucasian American Indian/Alaska
 African American 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 _____

GENERAL MEDICAL HISTORY

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

ANY ALLERGIES

MEDICATIONS

HOSPITALIZATIONS

SURGICAL/ PROCEDURES

- | | | | |
|---------------------------|----------------------|---------------|----------------|
| No Prior Surgical History | Colectomy | Gall Bladder | Hysterectomy |
| Appendectomy | Cone Biopsy | Heart Surgery | Laparoscopy |
| Breast Lumpectomy | D&C | Hemorrhoids | Mastectomy |
| Cataract Surgery | Endometrial Ablation | Hernia | 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 Yes No	Deceased Age _____	In Good Health Yes No	Adopted Yes No	
					Alcoholism
					Anemia
					Anxiety
					Asthma
					Birth Defects
					CAD
					Cardiovascular Disease
					CHF
					Cancer
					Congenital Anomaly
					COPD
					Crohn's Disease
					Depression
					Diabetes
					Epilepsy
					GERD
					High Cholesterol
					Hyperlipidemia
					Hypertension
					Hypothyroidism
					Kidney Disease
					Liver Disease
					Multiple Births
					Osteoarthritis
					Osteoporosis
					Pulmonary Disease
					Stroke

Type of Cancer:

Other Conditions:

PHOENIX INTERNAL MEDICINE
FINANCIAL POLICY

9515 W Camelback Road, Suite 114

Phoenix, Arizona 85037

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 your 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 the payment.

I agree to have the office store my credit card on file to pay all the balances due and I agree with a payment plan. I agree to have the office charge my credit card for payment which can be the entire balance amount that is owed by me or as a payment plan divided into smaller amounts over a period of few weeks until the balance is paid in full. I agree to receive communication in form of email and text messages for payment reminders for the balances owed by me. 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.]

I agree to receive text and email messages as a form of communication for appointment reminders, scheduling, billing, payments, office correspondence communication, test results and medical records. We will use reasonable means to protect the security and confidentiality of e-mail and text message information sent and received; however, because of the risks involved with this kind of communication we cannot guarantee the security and confidentiality and we will not be held liable for the improper disclosure of confidential information that is not caused by our intentional misconduct.

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.)