

Please PRINT AND complete ALL sections below!

PATIENT'S PERSONAL INFORMATIONMarital Status: Single Married Divorced Widowed Sex: Male Female

Name: _____ last name _____ first name _____ initial _____

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

PATIENT'S / RESPONSIBLE PARTY INFORMATIONRelationship to Patient: Self Spouse Child Other: _____

Name: _____ last name _____ first name _____ initial _____

Date of Birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____ Marital Status: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt. #: _____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

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

Name of insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse
 Child Other

Policy #: _____ Group #: _____ Copay: \$ _____

SECONDARY Insurance Name: _____

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

Name of insured: _____ Date of Birth: _____ Relationship to insured: Self Spouse
 Child Other

Policy #: _____ Group #: _____ Copay: \$ _____

EMPLOYMENT INFORMATION

Employer: _____ Name of Employed: _____

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

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

WHO REFERRED YOU?

Name: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

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

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Consent • Assignment of Benefits • Financial Agreement

I hereby authorize the physicians and assistants associated with Citrus Medical Clinic to furnish the necessary treatments/exams. I acknowledge that no assurance has been made to me as to the results of treatment. I also offer lifetime authorization for payment of insurance benefits to be made directly to Citrus Medical Clinic, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Family (Primary) E-mail Address: _____ (For General information from office)

CITRUS MEDICAL CLINIC

2051 W Warner Road, Ste 5, Chandler, AZ 85224 (480) 659-6695

Notice of privacy practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA): This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records related to you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of all health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information: 1) How we may use and disclose your PHI. 2) Your privacy rights related to your PHI. 3) Our obligations concerning the use and disclosure of your PHI. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. We may use and disclose your PHI in the following ways:

- | | | |
|--------------|--------------------------|---------------------------------------|
| 1. Treatment | 3. Healthcare operations | 5. Treatment options |
| 2. Payment | 4. Appointment reminders | 6. Health-related benefits & services |

**These items may include leaving answering machine messages or information with family members*

- | |
|---------------------------------------|
| 7. Individuals assisting in your care |
| 8. Disclosures required by law |

C. Use and disclosure of your PHI in certain special circumstances:

- | | | |
|-----------------------------------|----------------------------|--|
| 1. Public health risks | 4. Law enforcement | 7. Research |
| 2. Health oversight activities | 5. Deceased patients | 8. Serious threats to health or safety |
| 3. Lawsuits & similar proceedings | 6. Organ & tissue donation | 9. Military |

- | |
|---------------------------|
| 10. National security |
| 11. Inmates |
| 12. Workers' Compensation |

D. Your rights regarding your PHI:

1. **Confidential communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting restrictions.** You have the right to request a restriction in our use or disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must describe in a clear and concise fashion: 1) Information you wish to restrict; 2) Whether you are requesting to limit our practice's use, disclosure or both; 3) To whom you want the limits to apply.
3. **Inspection and copies.** You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: 1) already accurate and complete; 2) not part of the PHI kept by or for the practice; 3) not part of the PHI which you would be permitted to inspect and copy; or 4) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice may have made of your PHI for purposes not related to treatment, payment or operations. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a paper copy of this notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
7. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

I have read Citrus Medical Clinic's Privacy Practices. PATIENT SIGNATURE: _____

Relation to Pt. _____

Signed By: _____ Date: _____

If you have any questions about this Notice or our health information privacy policies, please contact the SHFM Office Manager at the above address.

[] I request an expanded copy of Citrus Medical Clinic Privacy Policy with detailed explanations and examples.

We are dedicated to providing first-rate care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa and MasterCard.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor - in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them. If you have a co pay, you are required to pay it at the time of your visit. If you are insured, but do not present your insurance card, you will be required to pay for the visit in its entirety at the time of service. After presenting your insurance card to us, we will be happy to file charges related to your visit with your insurance company. We will then be happy to refund your payment at the time we receive payment from your insurance company. You will always have the option to reschedule your visit should you not desire to pay at the time of service.
4. If you are insured by a plan that we do not have a prior arrangement with, we will give you proper documentation prior to your leaving that you may submit to your insurer for reimbursement.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the entire charge. Payment is due upon receipt of a statement from our office.
6. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
7. If your account becomes delinquent, you will receive a collection letter and possibly a phone call stating you have 10 days to pay your account in full. Payment plans must be set up through our billing office or our administrator. Most payment plans will not be extended beyond three months. If a balance remains unpaid or you fail to make the agreed upon payments, we may refer your account to a collection agency. A "billing and scheduling block" will be placed upon your accounts and you will need to meet with the practice administrator before being allowed to schedule an appointment. If thereafter, your balance remains unpaid, the practice may in extreme cases choose to terminate you and your family from the practice. If this occurs, you will be notified by certified mail that you have 30 days to find alternative medical care. During the 30 day period, our providers will be able to treat you on an emergency basis only.
8. All Patients must complete the following forms: 1) Patient Registration & Consent to Treat 2) Notice of Privacy Practices 3) Financial Policy.
9. A \$50.00 Missed Appointment Fee may be added to your account if you fail to cancel any appointment at least 1 hour prior to your scheduled appointment. As a courtesy to other patients, it is greatly appreciated if cancellations are made more than 24 hrs in advance, whenever possible.
10. Other charges you may incur include, but are not limited to, copying of medical records and form completion (examples: Family and Medical Leave Act, Disability, certain school or employment forms). Such fees will be disclosed prior to the provision of services.

I have read and understand the practice's financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if minor)

Date

Please print the name of the patient

FJ/Forms/Financial Policy Hybrid

Patient's Name: _____

Medical History Questionnaire

DOB: _____

Today's Date: _____

What are you seeing the doctor for? _____

Do you have any medication allergies? Yes No List: _____

Current Medications (including vitamins/herbals): _____

Have you been diagnosed with any of the following medical conditions, if not, please check "None of the Above":

- Abnormal Heart Rhythm
- Alcoholism
- Anxiety
- Arteriosclerosis - hardening of arteries
- Arthritis
- Asthma
- Blood Clots
- Bronchitis/Bronchiolitis
- Cancer
- Cholesterol/Triglyceride Disorder
- COPD/Pulmonary Diseases - lung disease
- Congestive Heart Failure
- Depression
- Diabetes
- Drug Addiction/Dependency
- Fainting/ Dizzy Spells
- Gallbladder Disease
- Glaucoma

Headaches:

- Migraine
- Tension
- Hearing Problems
- Hiatal Hernia
- High Blood Pressure/Hypertension
- Kidney Disease/Uremia
- Kidney Stones
- Low Blood Pressure/Hypotension
- Lung Disease

Fatigue:

- Marked
- Moderate
- Muscle Disease
- Psychiatric Illness
- Psychotic Illness
- Pulmonary Hypertension
- Renal Disease
- Seizure Disorder
- Sleep Disorders
- Stomach/GI Disorders

- Stroke
- Thyroid Disorders
- Tremor
- Ulcer Disease
- Urinary Infections
- Visual Impairment
- Weight Fluctuations
- None of the Above

Children, Ages 10 and under

- Problems In-Utero - problem during pregnancy
- Premature Birth/Complications
- Ear Infections
- Febrile Seizure - seizure caused by high fever
- None of the Above

Surgeries-Procedures

- Appendix Removal
- Blood Transfusion
- CABG (Heart Surgery)
- Gallbladder Removal
- Hernia Repair
Hysterectomy: - removal of uterus
 - Total
 - Partial
- Pacemaker
- Tonsils Removed
- Tubal Ligation
- TURP - prostate surgery
- Stomach Surgery
- Thyroid Surgery
- Spleen Surgery
- None of the Above

Weight: _____ Height: _____

BP: _____ Temp: _____

Pulse Ox: _____ RR: _____

HR: _____

Please check any positive family medical history below:

	Deceased	Diabetes	Asthma	Cancer	Hypertension	Coronary Artery Disease	None	List
Mother:	<input type="checkbox"/>							
Father:	<input type="checkbox"/>							
Sibling:	<input type="checkbox"/>							

Please check social history below:

Smoker:	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Alcohol:	<input type="checkbox"/> Never	<input type="checkbox"/> Rarely
Recently Traveled Abroad:	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Occasional Heavy