Scottsdale Family Physicians, PLLC
New Patient Registration Form

PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Last First MI

Address: _____ Gender: M or F Age: _____
Street

_____ Marital Status: S M D W
City State Zip

Phone numbers: Home _____ Cell _____ Work _____

Email: _____ Occupation: _____

Primary Language: _____ Race: _____ Ethnicity: _____

How did you hear about our office? _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder/Guarantor_____ D.O.B: _____

ID/Policy #: _____ Group #: _____

Address: _____ Phone _____
Street City State Zip

Secondary Insurance: _____ Policy Holder/Guarantor_____ D.O.B: _____

ID/Policy #: _____ Group #: _____

Address: _____ Phone _____
Street City State Zip

Emergency Contact Person:

Name: _____Phone: _____Relationship to Patient: _____

Pharmacy Information (optional):

Name: _____Cross streets: _____Phone _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to ask you:
Do we have permission to discuss your case with certain specified relatives and/or friends of your choosing:

Spouse? YES NO Name: _____ Others? Name/Relationship: _____

Do we have your permission to leave messages on your voicemail at home/work or cell phone? YES NO

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient /Guardian Signature: _____ Date: _____

Name of Patient: _____ Date: _____

MEDICATIONS

List all current prescription, non-prescription medications, vitamins, and herbal products. Please INCLUDE even occasional use of aspirin or anti-inflammatory medication for arthritis.

Name of Medication	Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT'S MEDICAL HISTORY (active or inactive) Circle those that are applicable

Angina	Gall Stones	Kidney Stones
Anemia	Heart Attack	Chronic Kidney Disease
Coronary Artery Disease	Congestive Heart Failure	Migraine Headaches
High Blood Pressure	Colitis	Diabetes/High Sugar
Stomach Ulcers	Heart Valve Disease	Seizures
Acid Reflux, GERD	Atrial Fibrillation	Pancreatitis
Thyroid Disease	Osteoporosis	Hepatitis
-CANCER-	Stroke	Colon Polyps
Breast	High Cholesterol	Rheumatoid Arthritis
Skin	Hay Fever	Degenerative Arthritis
Prostate	Asthma	Glaucoma
Colon	COPD; Emphysema	Depression
Other: _____	Sleep Apnea	Bipolar Disorder

Other medical problems not listed above:

_____

_____

Preventive Medicine Screening Tests (check all that apply – most recent month and year):

____ Colonoscopy	_____ (month & year)	____ PAP Smear	_____ (month & year)
____ Mammogram	_____ (month & year)	____ PSA /Prostate Exam	_____ (month & year)
____ Cholesterol test	_____ (month & year)	____ Exercise Stress Test	_____ (month & year)

Immunizations:

____ Pneumonia	_____ (month & year)	____ Measles	_____ (month & year)
____ Chicken Pox / Shingles	_____ (month & year)	____ Tetanus	_____ (month & year)
____ Hepatitis A	_____ (month & year)	____ Flu	_____ (month & year)
____ Hepatitis B	_____ (month & year)	____ Meningococcal	_____ (month & year)

ALLERGIES ☐ NONE

INCLUDE allergies to medications and other medical products (examples: tape, latex, and iodine).

Name of Medicine or Product:	Description of Reaction:
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY ☐ None

Type of Surgery and Reason	Year

PREGNANCY HISTORY # of pregnancies: _____ # of children: _____

FAMILY HEALTH HISTORY

	AGE	HEALTH PROBLEMS/cause of death		AGE	HEALTH PROBLEMS/cause of death
Father		**Living:** ☐ Y ☐ N	**Children**		M F
Mother		**Living:** ☐ Y ☐ N			M F
Sibling		**Living:** ☐ Y ☐ N M F			M F
		Living: ☐ Y ☐ N M F			M F
		Living: ☐ Y ☐ N M F	**Grandmother** *Maternal*		**Living:** ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandfather** *Maternal*		**Living:** ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandmother** *Paternal*		**Living:** ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandfather** *Paternal*		**Living:** ☐ Y ☐ N

HEALTH HABITS AND PERSONAL SAFETY Occupation: _____

EXERCISE: How often: _____ Which Activities: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____ How many drinks per week? _____

Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes – pks./day _____ # of years _____ ☐ or year quit _____

☐ Chew - #/day_____ Do you currently use recreational or street drugs? ☐ Yes ☐ No

I have received and read the clinic's Privacy Notice: _____ (initials)

Financial Policy
Scottsdale Family Physicians, PLLC

Please carefully read each statement and sign below. This policy has been put in place to ensure that financial payments due are recovered so that we may continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our staff will be glad to discuss these policies with you.

_____ initial

I understand that if I do not have my insurance card, referral, and/or co-payment that my appointment may be rescheduled until such time that I can provide the required documents or payments.

_____ initial

I understand that reminder appointment calls from the office are a courtesy only, and that I am responsible for keeping track of my appointment and being on time.

_____ initial

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges which are not covered by my insurance. ***I understand that verification of coverage is not a guarantee of payment of benefits.*** My insurance company determines benefit payments. I understand I will be responsible for the portion not covered by my insurance.

_____ initial

I understand that if I am unable to make a scheduled appointment I need to contact the office at least 24 hours prior to my scheduled appointment. A $25-$75 FEE MAY BE ASSESSED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 1 BUSINESS DAY WITH A 24 HOUR NOTICE.

_____ initial

I understand there is a $25 charge for a Non-Sufficient Funds (NSF) check.

_____ initial

I understand there may be a $10-$40 charge for all forms deemed appropriate, filled out by the Physician (e.g. Disability, FMLA, etc.). When dropping forms off, I must allow 5-7 days for completion.

_____ initial

I understand if my account is not paid in full within 90 days, I may be turned over to a collection agency for further processing and incur an additional 35% fee. Legal action fee will be 50%. In addition, I will be discharged from the practice.

_____ initial

I have read and I understand the above Financial Policy and I agree to abide by its terms.

_____ _____

Signature of the Patient or the Patient's Legal Representative Date

_____ _____

Print Name

If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

Scottsdale Family Physicians, PLLC
Acknowledgment of Privacy Practices and Instructions for Release of Personal Health Information/HIPAA

PATIENT NAME:_____

DATE OF BIRTH:_____

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES:_____

I give permission to Scottsdale Family Physicians, PLLC to communicate messages regarding APPOINTMENTS as follows:
_____You may leave a message on my voice mail/answering machine.
_____You may leave a message with _____
_____You may communicate with me through the Patient Portal.
_____Please communicate appointment messages as follows:_____
_____

I give permission to Scottsdale Family Physicians, PLLC to communicate messages regarding REFERRALS TO ANOTHER PHYSICIAN as follows:
_____You may leave a message on my voice mail/answering machine.
_____You may leave a message with _____
_____You may communicate with me through the Patient Portal.
_____Please communicate appointment messages as follows:_____
_____

I give permission to Scottsdale Family Physicians. PLLC to communicate messages regarding LAB RESULTS, XRAYS, AND OTHER TESTS as follows:
_____You may leave a message on my voice mail/answering machine.
_____You may leave a message with _____
_____You may communicate with me through the Patient Portal.
_____Please communicate appointment messages as follows:_____
_____

Names of individuals who we have permission to release health information to:
_____
_____

Signature Of Patient, Parent, Legal Guardian:_____

Date:_____

Privacy and Your Health Information

Your Privacy Is Important to All of Us

Most of us feel that our health and medical information is private and should be protected, and we want to know who has this information. Now, Federal law

- Gives you rights over your health information
- Sets rules and limits on who can look at and receive your health information

Your Health Information Is Protected By Federal Law

Who must follow this law?

- Most doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other health care providers
- Health insurance companies, HMOs, most employer group health plans
- Certain government programs that pay for health care, such as Medicare and Medicaid

What information is protected?

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

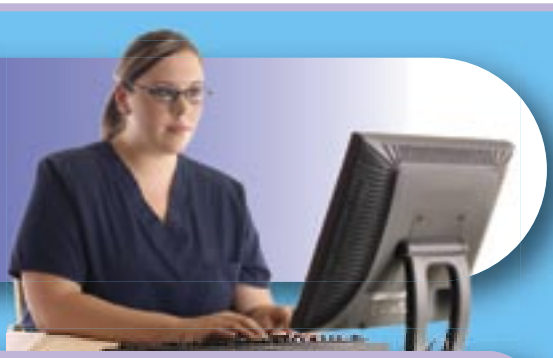
The Law Gives You Rights Over Your Health Information

Providers and health insurers who are required to follow this law must comply with your right to

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can
  - File a complaint with your provider or health insurer
  - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint, from the website at www.hhs.gov/ocr/hipaa/

PRIVACY



The Law Sets Rules and Limits on Who Can Look At and Receive Your Information

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and help run their businesses
- With your family, relatives, friends or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your mental health counseling sessions

For More Information

This is a brief summary of your rights and protections under the federal health information privacy law. You can learn more about health information privacy and your rights in a fact sheet called *"Your Health Information Privacy Rights."* You can get this from the website at www.hhs.gov/ocr/hipaa/.

Other privacy rights
Another law provides additional privacy protections to patients of alcohol and drug treatment programs. For more information, go to the website at www.samhsa.gov.

Published by:

U.S. Department of Health & Human Services Office for Civil Rights

The Law Protects the Privacy of Your Health Information

Providers and health insurers who are required to follow this law must keep your information private by

- Teaching the people who work for them how your information may and may not be used and shared
- Taking appropriate and reasonable steps to keep your health information secure