Patient Registration Information

Please PRINT AND complete ALL Sections below

PATIENT'S PERSONAL INFORMATION

Marital Status: ❑Single ❑Married ❑Divorced ❑Partner ❑ Separated ❑ Widowed

Gender: ❑Male ❑Female

Name: ______________________________________ ________________________________ __________
last name first name middle initial

Date of Birth: _____ /_____ / _____ Social Security #: ______- ______ - ______ Driver's License #____________________

Home Phone: (_____) __________________ Cell Phone: (_____) _________________ Work Phone: (_____) _____________

Address: ___________________________________ Apt#: ______ City: ________________________ Zip:______________

REFERRAL INFORMATION

Who may we thank for this referral? Name:_______________________________________ Current Patient? ❑YES

How did you hear about our practice? ❑Google ❑Yahoo ❑Kudzu ❑Bing ❑Wellness.com ❑Yelp ❑Vitals.com ❑Yellow Pages ❑ Other:_________________

RESPONSIBLE PARTY

Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other: ____________________

Name: ______________________________________ ________________________________ __________
last name first name initial

Date of Birth: _____ /_____ / _____ Social Security #: ______- ______ - ______ Driver's License #____________________

Home Phone: (_____) __________________ Cell Phone: (_____) _________________ Work Phone: (_____) _____________

EMERGENCY CONTACT

Name: ____

Phone (Home):______________________ Phone (Cell):______________________ Phone (Work):______________________

Email:____

Practice Policy and Financial Agreement | Permission to Contact by e-mail | 3900 East Camelback Road Suite 150 Phoenix, AZ 85018

I hereby give authorization for payment of insurance benefits to be made directly to **ANNE-MARIE REED DO PLLC | CAMELBACK HEALTH CARE**, and any assisting Physicians, nurse practitioners, registered dieticians, physicians assistant, or any other legal health care providers for services rendered. I also give permission for the practice to communicate news, events, promotions, as well as information regarding my care at this practice via ***email, electronic means of our choosing, or telephone***. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Additionally, preventive visits do not include any **ACUTE OR ADDITIONAL PROBLEMS EVALUATED** outside of the preventive visits. In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits as well as render my health care. I further agree that a photo-copy of this agreement shall be valid as the original.

Date:________________________ Signature____ Print Name____

Child Health History (Newborn – Age 18)

Your answers on this form will help your health care provider better understand your child's medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Child's Age_______ How would you rate your child's general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What is the main reason for today's visit? ____

Are there any other concerns? ____

BIRTH HISTORY:

Birth date: ____________________ Birth Weight ____________________ Was the baby born at term? ☐ Yes ☐ No `

Early? ______________ Late? __________________ If early, how many weeks' gestation? ______________________

During pregnancy, did the mother: Smoke: ☐ Yes ☐ No Drink alcohol: ☐ Yes ☐ No

Take drugs or other medication ☐ Yes ☐ No If yes, What? ___________________When?_______________________

Did the mother have any illness or problem with her pregnancy? ☐ Yes ☐ No

Explain____

Was the Delivery ☐ Vaginal ☐ Cesarean. If cesarean why? ____

Did the baby go home with the mother from the hospital? ☐ Yes ☐ No Explain_________________________________

Did the baby have any problems right after birth? ☐ Yes ☐ No Explain_____________________________________

Was initial feeding : ☐ Breast ☐ Bottle

DEVELOPMENT:

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain______________________________

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No

Explain____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain_______________________________________

Is your child in school? ☐ Yes ☐ No Where?____

Has he/she failed or repeated a grade in school? ☐ Yes ☐ No Explain____

Is he/she in special or resource classes? ☐ Yes ☐ No Explain____

How is he/she doing in academic subjects? ____

GENERAL:

How would you rate your child's diet? ☐ Good ☐ Fair ☐ Poor

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain______________________________

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain_____________________________________

Does the child get 60 minutes of exercise regularly? ☐ Yes ☐ No

Is violence at home a concern for you? ☐ Yes ☐ No

<u>Has he/she ever had:</u>

Chicken pox? ☐ Yes ☐ No Explain____

Frequent ear infections? ☐ Yes ☐ No Explain____

Allergies? ☐ Yes ☐ No Explain____

Asthma, bronchitis, bronchiolitis, or pneumonia? ☐ Yes ☐ No Explain____________________________________

Any heart problem or heart murmur? ☐ Yes ☐ No Explain____

Frequent abnormal pain? ☐ Yes ☐ No Explain____

Constipation requiring doctors visit's? ☐ Yes ☐ No Explain____

Frequent bladder or kidney infections? ☐ Yes ☐ No Explain____

Diabetes? ☐ Yes ☐ No Explain____

REVIEW OF SYMPTOMS: Please check any current symptoms your child may have

Constitutional:
____ Recent fevers/sweats
____ Unexplained weight loss/gain
____ Unexplained fatigue/weakness

Respiratory:
____ Cough/wheeze
____ Coughing up blood

Skin:
_____ Rash
_____ New or change in mole

Gastrointestinal:
____ Heartburn/reflux
____ Blood or change in bowel
____ Nausea/vomiting/diarrhea

Neurological:
____ Headaches
____ Memory loss
____ Fainting
____ Pain in abdomen

Eyes:
____ *Change in vision*

Ears/Nose/Throat/Mouth:
____ Difficulty hearing/ringing in ears
____ Hay fever/allergies/congestion
____ Trouble swallowing

Genitourinary:
____ *Unusual vaginal bleeding*
____ Painful/bloody urination
____ Leaking urine
____ Nighttime urination
____ Discharge: penile or vaginal

Psychiatric:
____ Aniexty/Stress
_____ *Sleep problems*

Musculoskeletal:
____ Recent back pain
____ Muscle/joint pain

Blood/Lymphatic:
____ Easy bruising/bleeding
____ Unexplained lumps

Endocrinology:
____ Cold/heat intolerance
____ Increased thirst/appetitie

Cardiovasuclar
____ *Palpitations*
____ *Shortness of breath w/exertion*
____ Chest pains/discomfort

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, etc.

Medication: Dose (e.g. , mg/pill): How many times per day?

____

____

____

Does your child have any allergies or reactions to medications? ☐ Yes ☐ No

Explain: ____

IMMUNIZATIONS:

Please list the date of your child's most recent immunizations or provide copies of these records:

DTaP________ Hepatitis A ________ Hepatitis B ________ HIB ________ HPV________

Influenza (flu) ________ IPV ________ MVC________ MMR________ PCV13 ________

Rotavirus________ Tdap (tetanus & pertussis) ________ Varicella (Chicken pox) ________

SURGICAL HISTORY: Please list all prior operations along with the dates of the operation

Operation:	Date:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

FAMILY HISTORY:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

Alcoholism ______________________ Depression/Suicide ______________________
High Cholesterol ______________________ Bleeding or Clotting Disorder ______________________
Heart Disease ______________________ High Blood Pressure ______________________
Diabetes ______________________ Asthma/COPD ______________________
Stroke ______________________ Genetic Disorders ______________________
Cancer (please specify type) ____
Other ____

SOCIAL HISTORY:

Living situation: ☐ Mother ☐ Father ☐ Both ☐ Other Legal guardian ______________________

Please list all those living in the child's home

Name: ________________ Relationship to Child ______________Birth Date ____________
Name: ________________ Relationship to Child ______________Birth Date ____________
Name: ________________ Relationship to Child ______________Birth Date ____________
Name: ________________ Relationship to Child ______________Birth Date ____________
Name: ________________ Relationship to Child ______________Birth Date ____________

Children:

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

I, ______________________, am a parent or legal guardian of the above-named child/children. By signing below, I affirm that there is not a court order barring me from making health care decisions and/or seeking medical treatment for my child/children. I also grant permission for the adults listed below to seek medical treatment and/or make health care decisions for my child/children in my absence.

All individuals listed must be at least 18 years of age:

Name: ______________________Relationship: ______________________
Name: ______________________Relationship: ______________________
Name: ______________________Relationship: ______________________
Name: ______________________Relationship: ______________________

This authorization shall remain in effect for 12 months from the last date initialed. It may be withdrawn at any time in writing or by submitting a new form.

Signature: ______________________Relationship:______________Date:______________

Office Policies

Dear Valued Patient:

Thank you for entrusting Camelback Health Care (CHC) to be your primary care physician. Please read this policy and sign in acknowledgement. CHC is here to give you advice and to impart up-to-date knowledge and treatment options.

1. CHC strives to be on time, only double-booking in urgent cases. If you are going to be late for your appointment, please call us at (602)368-5861 to discuss rescheduling or to make sure we are still able to see you.
2. If you cannot make your appointment, please cancel at least 24 hours in advance. We reserve the right to charge a $35.00 no-show fee if you do not cancel. We often have a waiting list for patients, cancelling ahead allows them to be seen.
3. If you "No Show" for two appointments without calling or notifying the office, you will be discharged from CHC. This means you will be asked to leave our practice.
4. We need at least 72 hours to process referrals. You must first be seen by a provider for the condition for which you are referred in order for a referral to be done because we have to obtain a Prior Authorization from your insurance. While we are prompt in preparing referrals, we must wait for the insurance to reply.
5. Prescription refill requests:
   - For refills past the number on the original prescription, please make an appointment for an evaluation.
   - Refill requests for controlled substances are monitored by the DEA, and require an office visit for proper evaluation.
   - Please request any refills through your pharmacy, and they will contact us for you.
6. Your medical records can be sent to any of your doctors free of charge as long as you have filled out the request form to do so. If you would like a copy for your personal records, there is a $35.00 printing fee.
7. Insurance:
   - It is your responsibility to know your insurance plan. Every plan is different, and every company offers different plans. It is impossible for the office staff to know the intricate details of your plan.
   - If you have a high deductible plan without an HSA, you may be asked to make a $92 deposit towards your visit. This will depend on your coinsurance and deductible amount.
   - Copays are due at the time of service. If you do not have the copay, you may be asked to reschedule your appointment.
   - Coinsurance can be charged by your insurance company even if you have a co pay plan. This is a cost-sharing arrangement between you and your insurance company. We do not determine this fee.
8. Balances:
   - If you have an outstanding balance, payment is expected at the time of subsequent service.
   - We are happy to set up a payment plan for any balances you may incur if you are unable to pay at time of service in full.
9. Lab or imaging results will be relayed to you as soon as possible. Depending on the facility, results can take up to 10 days. After 3 unsuccessful attempts to contact you with these results, we will mail you a card.
10. If you need to use the phone for transportation services, we will dial for you, but you must make the call.

We look forward to a long and healthy relationship with you, and we are once again grateful that you have chosen CHC for your primary health care needs. We wish you good luck and good health.

Sincerely,

Camelback Health Care

Acknowledged by:

____________________________ ____________________________ ________________

Print Signature Date

Lab Consent

Laboratory services provided by LabCorp, Sonora Quest, or any other laboratory service have no direct financial or other affiliation with Camelback Health Care (CHC). Laboratory work done by LabCorp or Sonora Quest is billed entirely by those individual companies. The services and billing remain the same regardless of whether you had those laboratory services done by the lab facility available at CHC or at an outside lab.

Onsite lab services are offered as a convenience to our patients by LabCorp. We are not affiliated with LabCorp. If you know your labs need to be sent to a specific facility, please tell the phlebotomist. The lab has its own hours; we cannot make exceptions for you. If you have missed the lab cut-off time, you may come in another time or prepare a lab slip for you to take anywhere you find convenient.

We are not aware of how your insurance company determines which labs are covered and which labs are not covered. If you are unsure, it is your responsibility to call your insurance company and ask. It is not the responsibility of the staff to call for you, or to know the specifics of your individual plan. Our policy is to order labs based on your individual medical needs according to the standard of medical care guidelines. Blood work ordered for wellness exams is determined at the annual medical review prior to your wellness visit/complete physical exam/well woman visit. There are no medical guidelines to support routine labs ordered without prior medical evaluation. Because of this, it is our policy for you to first be seen by a provider to ensure the proper blood work is being ordered. You will have 90 days from your appointment to get the labs recommended by your provider drawn. If you do not get the recommended labs drawn within 90 days you will needto be re-evaluated and labs will need to be ordered again.

CHC has no involvement with how labs are billed to your insurance. If you have a question about a bill, it is your responsibility to contact the Billing Department for LabCorp or Sonora Quest. We will not change codes after the service is obtained. In some cases, it may be more cost effective for you to pre-pay for your labs and submit the claim directly to your insurance company. If you would like quotes or have questions, please discuss this with the onsite phlebotomist.

I understand and agree, by my signature, that any laboratory testing obtained onsite is solely my financial responsibility. I understand that Camelback Health Care will not agree to requests to negotiate payment to LabCorp or Sonora Quest Laboratories.

____ ____________________

Signature **Date**

I refuse labs recommended by my physician

____ ____________________

Signature **Date**

Physician-Patient Email Communication Consent Form

Risks Of Using Email: The physician offers patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via email without understanding and accepting these risks. The risks include, but are not limited to, the following.

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.
- The physician uses encryption software as a security mechanism for email communications.

Conditions Of Using Email - The physician will use reasonable means to protect the security and confidentially of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication. Thus, patients must consent to the use of email including agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- Although the physician will endeavor to read the respond promptly to an email from the patient, the physician cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies of other time-sensitive matters.
- The patient should not use email for communication regarding sensitive medication information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physicians will not discuss such matters over email.
- The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Instructions For Communication By Email - To communicate by email, the patient shall:

- Limit or avoid using an employer's or other third parties computer.
- Inform the physician of any changes in the patient's email address.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by e-mail or written communication to the physician.

Patient Acknowledgement And Agreement - I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the physician and me, and consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with patients by email. I acknowledge the physician's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient Name: ____

Legibly Printed Patient Email Address: ____

Patient Signature: ______________________________ Date: ________________

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been provided a copy of the HIPAA Notice of Privacy Practices. I also acknowledge that I read and understand the notice, as evidenced by my signature below.

Patient Name: ______________________________________

Patient Signature: ___________________________________ Date: __________________________

MEDICAL INFORMATION RELEASE

I give consent to have my medical records made available to the party/parties designated below. This is an authorization with my full understanding that any and all information contained within my medical records is confidential and may contain sensitive data. I understand that I have received and reviewed the Patient Privacy Act in force at Camelback Healthcare. I also understand that if I no longer wish to authorize the release of health information, I must fill out a request in writing.

For results and voice messages, please call: ☐ Home ☐ Cell Phone # ____________________

If unable to reach me:

Leave a detailed message of my full results________ OR Leave a message to return your call ________

I authorize Camelback Health Care to release information, including the diagnosis, records and examination rendered to me, as well as claims information. This information may be released to:

Individual's Full Name: ____________________________________ Relationship: ______________________

Individual's Full Name: ____________________________________ Relationship: ______________________

☐ **Information is not to be released to anyone**

Patient Signature or Legal Representative: _________________________________ Date: ______________________