INTERNAL MEDICINE AZ Geriatric Specialties of AZ

P.C. Patient Registration Form

PATIENT INFORMATION:

Patient Name (Last)_____ First: _____Middle Initial: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: ( )_____ Business: ( )_____ Cell: ( )_____
Date Of Birth _____/_____/_____ Age: _____ Sex: Male Female
Social Security Number: _____--_____--_____ Email: _____
Employer/ Occupation: _____ Employer Phone Number: ( ) _____
Emergency Contact (Name) _____ Relationship to Patient_____
Home phone: ( )_____ Business: : ( )_____ Cell: ( )_____
How did you did you hear about us? _____

RESPONSIBLE PARTY:

Guarantor Name: _____ Relationship to Patient: Insured Spouse Child Other
Street Address:_____ City: _____ State: _____ Zip: _____
Home phone: ( )_____ Business: : ( )_____ Cell: ( )_____
Date Of Birth _____/_____/_____ Age: _____ Sex: Male Female
Social Security Number: _____--_____--_____ Employer: _____
Occupation: _____ Employer Phone Number: ( )_____

INSURANCE INFORMATION: **FILL OUT COMPLETELY EVEN IF WE SCANNED CARD**

Primary Insurance
Insurance Co. Name:_____
Address_____
City, State, Zip:_____
Policy Number:_____
Group Number:_____
Policy Holder Name:_____
Relationship to Patient: Insured Spouse Child Other

Secondary Insurance
Insurance Co. Name:_____
Address_____
City, State, Zip:_____
Policy Number:_____
Group Number:_____
Policy Holder Name:_____
Relationship to Patient: Insured Spouse Child Other

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Geriatrics Specialties of Arizona, P. C., to release any information required in the course of my examination or treatment which could include HIV, communicable disease or drug abuse information.

AUTHORIZATION TO PAY: I hereby authorize payment directly to the business office of Geriatric Specialties of Arizona P.C., for the surgical and/ or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all changes, whether or not my insurance company pays them, and any COPAYS and Deductibles are due at the time of service. Also, a $50.00 return check fee for all returned checks. Failure to pay this portion will result in a collection fee of $25.00. No show fees are $50.00 per missed appointment.

SIGNED (Patient or Parent, if minor) _____ DATE_____/_____/_____

PLEASE FILL OUT COMPLETELY

INCLUDING INSURANCE FOR 2024

New patient History

Name _____ Date _____

Primary Physician _____ Birth Date _____

Chief Concern/ Complaint: _____

Current Medications: Please list all medications you are on, including vitamins, herbal supplements, and contraception.

Medicine:	**Dosage/ Times per day:**	**Medicine:**	**Dosage/ Times per day:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: Please all medicines AND the "allergic reaction" as well as the approximate date or age.

Medicine:	**Reaction:**	**Approximate date/ age:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Operations: Please list all surgeries and the approximate year it was done or age, such as, "appendectomy, age 10"

_____ _____
_____ _____
_____ _____

Past Medical History: Please list all major illnesses you have had and the date or age at diagnosis.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other Physicians: Please list any other physicians involved in your care and their specialties.

_____ _____
_____ _____

Social History:

Marital Status: (Circle one) Married Single Divorced Widowed How many years married (divorced or widowed)____

Children: _____ _____
(Please list name, age, and any major illnesses _____ _____
_____ _____

Occupation _____ Education Level _____

Years in Arizona _____ Born and raised City _____ State_____

Do you smoke? (Circle one) Yes/ Never/ Quit Packs per day: How many years?_____ Quit date: _____

Other tabaco? (Circle any) Pipe/ Cigars/ Chew Number of times per day:_____ Quit date:_____

Alcohol use: On average, how many drinks per day?_____, Per month?_____ Type: Beer/ Wine/ Liquor

Do you have a living will or advance directive? Yes / No

Family Medical History: Only applies to genetically related relatives. List those with condition and age at onset

Cancer (type if known):	_____	Arthritis:	_____
Heart Attack:	_____	Asthma:	_____
High blood pressure:	_____	Depression:	_____
Stroke	_____	Seizures:	_____
Diabetes:	_____	Other:	_____

Review of Systems: Please circle those symptoms you have frequently or apply to you.

General Weight gain/ loss Number of pounds_____ over the past_____ months or _____years.

Head:	Headache Dizziness Injury	**Cardiac:**	Chest pain Palpitations Rheumatic Fever Short of breath with activity	**Urinary:**	Frequent urination Burning with urination Blood Dribbling Leaking Slow stream
Eyes:	Blurred vision Pain Sports or Lines	**GI:**	Heartburn Trouble swallowing Loss of appetite Nausea Bloody or black stool Constipation Diarrhea Cramping Hemorrhoids	**Genital:**	History of herpes Other STD's Decrease sex drive Decrease sexual performance
ENT:	Hearing loss Ringing Nasal Congestion Nosebleeds Postnasal drip	**Lungs:**	Short of breath Wheezing Cough Pain with breathing	**Women:**	Last menstrual period: _____ Number of pregnancies: _____ Number of births: _____ Number of miscarriages/ abortions: _____/_____ History of abdominal Pap? Yes/ No
Skin:	Rash Changing Moles				

Preventative Medical History: Please list the month and year you last had the following:

Pap: _____ Mammogram: _____ Bone Density: _____

Prostate Exam/ PSA: _____/_____ Colonoscopy: _____ Complete Physical: _____

Vaccinations: Hepatitis A (total of 2 shots) _____ Hepatitis B: (series of 3 shots) _____ Tetanus: _____

Pneumonia: _____ Flu: _____ Other: _____

ADVANCE CARE PLANNING

(ADVANCE Directives)

For patients 18 years and older

Advance Care Planning refers to a process of mapping out the types of medical and non-medical care you would like to receive at some future points should a life threatening, or terminal disease make it impossible for you to express your wishes at that time. This type of planning is an ongoing process. It is a process of thoughtful discussion between you and your care providers, spouse, family, and significant others. While this conversation often results in a document it is more than just a piece of paper. It is an effort to better educate yourself about alternatives regarding the end of life and an opportunity to educate you physician, spouse, family, and others about your values, goals, and wishes related to end-of-life care. This communication between you and your healthcare provider can be done anytime, preferably when you are younger and still healthy. Once completed, it should be revisited on a regular basis – every five years or after any potentially life- changing event, such as marriage, divorce, death of a spouse, or the onset of a life-threatening disease.

Advance care planning usually produces an **Advance Directive**, which is a written document that helps to summarize the plans you made for future care. These documents take several forms, such as **Living Will** and a **Durable Power of Attorney for Health Care**. While they can be completed without the Involvement of your healthcare provider, it is much preferred to do this together. The future usefulness of these documents is better assured if your healthcare Professional has been part of the planning process.

Please Check **one** of the statements and sign below.

_____ I have an Advance Directive in effect and agree to provide a copy for my medical record

_____ I do **NOT** have an Advance Directive in effect currently. I have read and understand the above information on Advance Directives.

Signature_____ Date_____

OFFICE FINANCIAL POLICY FORM

Geriatric Specialties of Arizona (Internal Medicine AZ), the office of Kenneth I. Levy, M.D., Stanley L. Combs, M.D., Morton Dubnow, M.D., and Saul Amber, M.D. expects your payment of your care at the time of service. However, with all verifiable insurance information, you will inly be expected to pay the deductible, co-payment, co-insurance, or those services not covered or allowed by your insurance.

It is our policy to bill your insurance carrier as a courtesy to you, although you are ultimately responsible for the entire charge when services are rendered. If your insurance carrier does not remit payment within 45 days from the dare of service, the balance will be due in full from you. Since we may not be a party to the agreement with your insurance carrier, it is not our policy to contract carriers to establish why they have not paid or why they paid less than originally indicated. Furthermore, your insurance company may have developed a reasonable and customary fee schedule for medical services. There schedules are internal to your insurance company, and they may or may not cover all the charges incurred during your treatment. These fee schedules often do not reflect standard charges and or the difference remaining following the payment by your insurance company. Exceptions, if your insurance company is on that (Geriatric Specialties of Arizona/ Internal Medicine AZ) participates or holds a contract with, you are only responsible for any patient portion or non-covered service as determined by your insurance carrier.

The above statements do not apply to those who are considered **Motor Vehicle Accident (MVA) or Workers Compensation.** We do NOT bill third parties. These claims must be paid in full at the time of service and you are responsible to submitting them for re-imbursement with your lawyer, workers compensations firm, and or insurance company.

If you fail to make any payment for which you are deemed responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by **Geriatric Specialties od Arizona** (Intern Medicine AZ) you will be responsible for all costs of collecting monies owed, including but not limited to courts cost, collection agency and/ or attorney's fees.

Your signature below indicates that you have read the above information and authorize direct payment from your insurance carrier to **Geriatric Specialties of Arizona (**Internal Medicine AZ) as it relates to your account.

_____ _____

Patient or Responsible Party Date signed

I hereby authorize the release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to **Geriatric Specialties of Arizona** (Internal Medicine AZ). I understand that I am financially responsible for any balance not covered by my insurance carriers. A copy of this signature is as valid as the original.

Signature of patient or legal guardian of patient _____

6838 N. 23rd Avenue, Phoenix, AZ 85015
Phone: (602) 864-8800 Fax (602) 864-1448

3666 N. Miller Rd # 113, Scottsdale, AZ 85251
Phone: (480) 219-9934 Fax (480) 945-2166

Notices of Privacy Practices

To our patients. 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 health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information.
We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances.
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicates with you about your health and related issues om a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for a treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only a 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.

3. You have the right to inspect and obtain a copy of the health information 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 to Kenneth Levy, M.D., 6838 N. 23rd Avenue, Phoenix, AZ 85015. – (602)864-8800

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request mist be made in writing to Kenneth Levy, M.D., 6838 N. 23rd Avenue, Phoenix, AZ 85015. – (602)864-8800.

5. You must provide us with a reason that supports your request for amendment.

6. Rights to copy of this notice. You are entitled to receive a copy od this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

7. Right to file 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. To file a complaint with our practice contact Kenneth Levy, M.D., 6838 N. 23rd Avenue, Phoenix, AZ 85015. – (602)864-8800.

8. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

9. 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.

If you have any questions regarding this notice or our health information privacy policies, please contact Kenneth Levy, M.D., 6838 N. 23rd Avenue, Phoenix, AZ 85015. – (602)864-8800.

I hereby acknowledge that I have been presented with a copy of Kenneth Levy, M.D., Geriatric Specialties of Arizona (Internal Medicine AZ) Notice of Privacy Practices.

Signature: _____

Date: _____

Name of Patient: _____

CONSENT FOR DRUG SCREEN

NAME: _____ DOB: _____

_____ Initial

I give and agree to participate in a random (unscheduled) drug urine screening to Geriatric Specialties of Arizona (Internal Medicine AZ) from me via urine as a diagnostic tool to further aid in my treatment.

Urine Specimens will be sent to the designated laboratory for analysis.

I am aware that a positive screen may result in action which may include increased level of care, termination of service and if released by consent to my referral source possible legal consequences.

I have been provided with a Statement of Financial Responsibility/ Billing Policy information and understand that I am responsible for all copays and deductibles; and for amounts not covered by insurance, litigation, or third-party liability. By signing this authorization, I am authorizing Geriatric Specialties of Arizona (Internal Medicine AZ) to submit claims and acknowledging that payment (s) of authorized insurance benefits or attorney's settlements, including but not limited to Medicaid, Medicare, other benefits or payments shall be made on my behalf to Geriatric Specialties of Arizona (Internal Medicine of Arizona (Internal Medicine AZ) for the services provided to me pursuant to this consent and that I will pay for any amounts not covered by other sources.

_____
Patient Name (printed)

_____ _____
Patient Signature Date

_____ _____
Physician Signature Date