Arizona & Family Geriatric Medicine

Patient Registration

Last Name: _____ First Name: _____ M.I. __

Date of Birth: _____ Soc Sec # _____

Male: ____ Female: ____ Transgender_____ Primary Language: _____

Race: (Please check one below)
White: _____ Hispanic: ____ Asian: ____ Black African American: _____ American Indian____
Pacific Islander: _____ Other: _____ Decline to answer: _____

Ethnicity: (Please check one below)
Not Hispanic or Latino _____ Mexican/Mexican American/Chicano: _____ Hispanic_____
Puerto Rican_____ Other: _____ Decline to Answer: _____

Arizona address: _____ City: _____ State:___ Zip:_____

Telephone Number: _____E-mail: _____

Secondary address: _____ City: _____ State: ___ Zip:_____

Marital status: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about us? _____

Pharmacy: _____Cross streets: _____ Phone: _____

Insurance Name:	Secondary name:
ID#:	ID#:
Group#:	Group#:
Policy holder name:	Policy Holder name:
Policy holder DOB:	Policy holder DOB:
Policy holder Soc Sec:	Policy holder Soc Sec:
Relationship:	Relationship:

I hereby give permission to bill my insurance company(s) and accept payment from them. I understand my insurance company may assist me in paying my medical costs, but I am ultimately responsible for all medical services rendered. I authorize the release of any medical information necessary to process any claims to my insurance company.

Signature: _____ Date: _____

Arizona & Family Geriatric Medicine

ACKNOWLEDGEMENT OF OFFICE POLICIES

Thank you for choosing Arizona Family & Geriatric Medicine, PLLC, here after referred to as AZFGM, as your primary care specialist. We have provided you with the following information to assist you with any questions or concerns you may have in regards to the operations of our office. The purpose of these policies is to ensure the effective communication is implemented in order to provide quality services for our patients.

ATTENTION: Please initial each line indicating that you have read and understand it

_____ **Appointments**:

•Appointments can be scheduled by phone or in person. We ask that all patients arrive 15 minutes before their scheduled appointment or 30 minutes prior if a new patient. We do not double book so that we can make the appointment as smooth as possible with minimal wait time, as your time is as important as ours. If you do not show up to your scheduled appointment, a fee of $25 will be incurred to your account for each appointment missed. This fee is not payable by your insurance.

We reserve the right to reschedule your appointment if you are more than 15 min late.

We require you reschedule or cancel your appointment not less than 24 hours. If less than 24 hours, a $25 fee may incur on your account which is not payable by your insurance.

_____ **Prescription requests:**

•For your safety, we do not call in new prescriptions, including new prescriptions to treat an acute illness. We ask that you make an appointment so we can properly evaluate and treat you in a safe and effective manner.

•If you need a prescription refill, please contact your pharmacy directly. Please allow 48-72 hours for processing of any refill.

•If a refill is denied, you must make an appointment

•If you have not been seen in the office with a year, you must make an appointment.

_____ **Medical records**:

•Requests for medical records must submitted in writing. There is a form at the front desk you can fill out and sign.

•There is a $25 charge for medical records

•For medical records transfer requests, please allow 7-10 days to process. A release can be signed here or at the medical facility you want them sent to.

_____ **Cell Phones and other electronic devices:**

•All Cellphones and electronic devices should be silenced upon arrival. If you should need to make or receive a phone call, please step outside to do so.

•When in an exam room, please refrain from any cell phone calls, texts etc. as this impedes the productivity of the physician as well as interferes with your care.

By signing below, you indicate you have read and agree to the above office policies.

_____ Date: _____

Signature of patient
Or authorized representative

Arizona & Family Geriatric Medicine

GENERAL CONSENT TO TREATMENT AND RIGHT TO REFUSE TREATMENT

General Consent to Treatment:

Having come to see Minh Luong, MD, Priscilla Luong DNP or any other practitioner they deem appropriate for evaluation and treatment, I (or my authorized representative on my behalf) hereby consent to and authorize the healthcare providers and/or other staff members involved in their care, to administer such diagnostic procedures and/or treatment as they consider advisable to maintain my health and to assess, evaluate and treat my injury, illness or overall wellbeing. I understand that the provider responsible for my care has the responsibility to explain to me the purpose, e and the most common risks involved in the diagnostic and treatment for me, as well as any alternatives available for treatment. I understand I have the right to refuse any suggested examination, test(s) or treatment.

Right to Refuse Treatment:

In giving my general consent, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended by the individual treating healthcare provider(s). I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as of the results of my evaluation and/or treatment.

Name: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Arizona & Family Geriatric Medicine

AUTHORIZATION FORM TO RELEASE PROTECTED HEALTH INFORMATION (PHI) TO SPOUSE/FAMILY/SIGNIFICANT OTHER

This authorization grants permission to my whomever I deem necessary, as listed below, to make, change or confirm appointments, have access to my complete medical record, have access to telephone communication and answering machine messages as well as other common means of communication; pick up medications, be made aware of my test results, diagnosis, prognosis and have complete access to my medical and financial medical records.

Patient Name: _____ DOB: _____

Name	Relationship

The patient MUST read and initial the following statement:

1. I understand that this authorization will (Please check one below)
    - Expire 1 (one) year from the date signed
    - Be effective the for the lifetime of the patient unless revoked
2. I understand that I may revoke this authorization at any time by notifying Arizona Family & Geriatric Medicine, PLLC in writing; however, If I do revoke the authorization, it will not have any effect on any actions taken by Arizona Family & Geriatric Medicine, PLLC prior to the receipt of the revocation

Patient Signature: _____ Date:_____

Arizona & Family Geriatric Medicine

MEDICAL HISTORY

List any injury/illness/surgery & reason IE: Diabetes, Heart disease, thyroid problems, appendectomy, knee surgery etc	Hospitalized? Yes or No	Date if known or Year

List All Medications both prescription and over the counter you are CURRENTLY taking:
****You may attach a separate list if needed**

Name	Dosage	Direction

Arizona & Family Geriatric Medicine

MEDICAL HISTORY

List all medications you are allergic to and reaction you had (I.E., rash, hives, swelling , etc)

- Have you ever smoked cigarettes? Yes___ No ___ Do you smoke now? Yes __ No ___ #packs per day _____ Start year _____ End Year _____
- Do you use smokeless or chewing tobacco Yes___ No ____
  - If so how much _____
- Do you drink alcohol Daily ____ Weekly____ Occasionally _____ Socially_____
  - If so how much _____
  -
- Do you use Marijuana? No___ Medical_____ Social_____
  - If so how much?
- Do you currently or have you ever used any illegal narcotics? Yes_____ No_____
  Explain: _____

Family Medical History

	Deceased?/Age	Cause of death	Illnesses
Father			
Mother			
Siblings			

Any other information provider should be aware of? _____

_____

Signature: _____ Date: _____

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- All Cellphones and electronic devices should be silenced upon arrival. If you should need to make or receive a phone call, please step outside to do so.
- When in an exam room, please refrain from any cell phone calls, texts etc. as this impedes the productivity of the physician as well as interferes with your care. All Electronic devices should be turned OFF once placed in an exam room.

By signing below, you indicate you have read and agree to the above office policies.

_____ Date: _____

Signature of patient Or authorized representative

Arizona & Family Geriatric Medicine

PATIENT PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

Arizona Family & Geriatric Medicine, PLLC, is required by law to maintain the privacy and confidentiality of your protected information and to provide our patients with notice of our legal duties and privacy practices with respect to your healthcare information.

DISCLOSURE OF YOUR HEALTCARE INFORMATION

- We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare options.
- We may disclose your healthcare information to your insurance provider for the purpose of payment or healthcare options.
- We may disclose you healthcare information as necessary to comply with States Worker's Compensation laws (only if they apply to your care)
- We may disclose your healthcare information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or death.
- As required by law, we may disclose your healthcare information to the public health authorities for purpose related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products or reaction to medications and reporting disease or infection exposure.
- We may disclose your healthcare information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, subpoena or other law enforcement purposes.
- We may disclose your healthcare information to coroners or medical examiner.
- We may disclose your healthcare information to organizations involved in procuring, banking, or transplanting of organs and tissues.
- We may disclose your healthcare information to researchers conducting research that has been approved by an Institutional Review Board.
- It may be necessary to disclose your healthcare information to appropriate persons in order to prevent or lessen a serious and imminent threat or safety of a particular person or to the general public.
- We may disclose your healthcare information for military, national security, prisoner and government benefits purposes.
- In the even that AZFGM is sold or merged with another organization, your healthcare information/medical records will become property of the new owner.
- You have the right to request restrictions on certain uses and disclosures of your healthcare information. This must be requested in writing. Please be advised, however, AZFGM is not required to agree to your request.
- You have the right to have your healthcare information received or communicated through and alternative method or sent to an alternative location other than the usual methods of communication or delivery, upon your written request.
- You have to right to inspect your healthcare information.
- You have the right to request that AZFGM amend your protected healthcare information by doing so in writing. Please be advised, however, AZFGM is not required to amend your protected health information. If your request to amend your healthcare information has been denied, you will be provided with an explanation of our denial reason(s) and information how you can disagree with the denial
- You have the right to receive an accounting of disclosures of your protected healthcare information made by AZFGM.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request

Arizona & Family Geriatric Medicine

•AZFGM reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, AZFGM is required by law to comply with this notice.
•AZFGM is required by law to maintain the privacy of your healthcare information and to provide you with notices of legal duties and privacy practices with respect to your healthcare information. If you have any questions about any part of this notice or if you want more information about your privacy rights please contact the Office Manager at 480-854-9004.
•This notice is effective as of today's date listed on the privacy acknowledgement form

Arizona & Family Geriatric Medicine

ACKNOWLEDGEMENT OF RECEPIT OF PRIVACY NOTICE

ORIGINAL TO BE MAINTAINED IN THE PATIENTS MEDICAL RECORDS

I acknowledge that I have received a copy of the offices Notice of Privacy practices.

Patient name: _____

Signature: _____ Date: _____

_____ _____

Printed name if signed on behalf of patient Relationship

Arizona & Family Geriatric Medicine

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ DOB: _____

Please release the following information ONLY as indicated below:

_____ last 2 office visits _____recent lab reports ____ Recent Radiology reports

_____ Recent cardiac testing (echo, stress test, EKG, Cath report)

Specific listed: _____

I hereby authorize Arizona Family & Geriatric Medicine, PLLC to
_____ Release to _____ Receive from:

Physician/Entity name: _____

Phone: _____ Fax: _____

I understand that I may revoke this authorization at any time. This consent will expire automatically one year from the date it is signed. Records released under this authorization shall not be considered part of the records of the receiving facility. Any further disclosure of medical records information by the recipient is not authorized without specific written consent of the person it pertains to.

_____ _____
Patient Signature Date

_____ _____
Witness Date

********DO NOT FAX IF MORE THEN 20 PAGES***********