Family Practice Specialists

Our family caring for yours

Patient Name: _____
Date of Birth: _____/_____/_____

Patient Registration and Authorization

****This packet must be completed before medical treatment can be rendered ****

Section A: Authorization for Treatment - Acknowledgment of Privacy Practices - Advanced Directives/ Living Will

Authorization for Medical Treatment

This release and consent gives Family Practice Specialists, Ltd permission to preform reasonable and necessary medical examinations, testing and treatment to my child or myself. In case of an emergency, if I cannot be reached, I hereby give Family Practice Specialists, Ltd permission to act on my behalf in providing medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my child's health, safety and welfare. I release Family Practice Specialists, Ltd and all medical providers from liability in acting on my behalf in this regard in rendering such medical treatment.

SIGN HERE

Signature: _____ Date: _____

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices. I understand that Family Practice Specialists, Ltd may at its discretion, change the terms and conditions of this notice. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon request.

Please check one option and sign below.

_____ I received a copy of the HIPPA packet
_____ I declined a copy of the HIPPA packet

SIGN HERE

Signature: _____ Date: _____

Advances Directives / Living Will

****Advanced Directives and Living Will forms are available upon request****

To comply with Medicare, managed health care plans, and hospital admission requirements, we are required to make available to you information about Federal and State laws that allow you to accept or refuse treatment to formulate advance directives. Advance directives are documents that enable you to give directions about your future medical care. Before making any decision about advance directives, please talk to your family, physicians, and/or attorney if you need assistance with your plans. If you already have an advance directive or decide to develop one, please give copies to your family, friends, and your physician so they will be aware of your wishes.

We would like to assure you that this is not a mandatory process and that you may elect to not have advance directives, but in the event of a medical emergency, all measures, including life support, will be afforded to those who do not sign advance directives. Advanced Directives and Living Will forms are not intended to provide you legal advice, but merely to provide information only. I am signing that Advanced Directives and Living Will forms have been made available to me. Your signature does not signify any decision on your advance directives, but merely shows that you have been offered the information. Thank you.

SIGN HERE

Signature: _____ ***Date:*** _____

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Patient Name: _____
Date of Birth: _____/_____/_____

Section B: Patient Information

Name (Last, First, MI, Suffix): _____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ SSN: _____

Address: _____City_____ State_____ Zip_____

Home (_____)_____-_____ Mobile (_____)_____-_____ Work (_____)_____-_____

E-mail for Patient Portal: _____

Contact Preference: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Patient Portal ☐ Mail

Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ White ☐ African American ☐ Native American ☐ Asian ☐ Jamaican ☐ Other ☐ Decline

Ethnicity: ☐ Central American ☐Cuban ☐ Dominican ☐ Puerto Rican ☐ Hispanic or Latino/Spanish
☐ Mexican ☐ Not Hispanic or Latino ☐ South American ☐ Spaniard ☐ Decline

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partner ☐ Other

How did you hear about us? _____

Preferred Pharmacy: _____ Phone: (_____)_____-_____

Guardian Name (Last, First, MI, Suffix): _____

Emergency Contact (Last, First, MI, Suffix): _____

Emergency Contact Relation: _____ Phone: (_____)_____-_____

Employer Name: _____ Occupation: _____ Phone: (_____)_____-_____

Section C: Guarantor Information (the guarantor is the person responsible for paying your medical bill)

Patients Relationship to Guarantor:

☐ Spouse ☐ Child ☐ Other_____ ☐ Self (If you are your own guarantor please skip to **Section D**)

Name (Last, First, MI, Suffix):_____Date of Birth:_____/_____/_____

SSN: _____ Phone Number: (_____)_____-_____ Employer:_____

Address: ☐ Same as Patient's **OR** _____

City_____ State_____ Zip_____

Section D: Health Insurance Information

Does the patient have current health insurance coverage? ☐ YES ☐ NO

If you marked "YES" please complete this section. If you marked "NO" please skip to **Section E**.

Patients *PRIMARY* Health Insurance Information

Policy Holder Information- Patient's relationship to the primary policy holder:

☐ Self ☐ Guarantor ☐ Other: _____

Name: _____

Date of Birth: _____/_____/_____ SSN: _____

Insurance Name: _____

Insurance Policy/ID Number: _____ Group Number: _____

Co-Pay: $_____ Deductible: $_____ Assigned Primary Care Physician: _____

Current insurance card for this policy provided to Family Practice Specialists: ☐ YES ☐ NO

Patient Name: _____
Date of Birth: _____/_____/_____

Do you have additional health insurance policies? ☐ YES ☐ NO
If you marked "NO" Please skip to **Section E**.

Patients *SECONDARY* Health Insurance Information
Policy Holder Information Patient's relationship to the primary policy holder:

☐ Self ☐ Guarantor ☐ Other: _____
Name: _____
Date of Birth: _____/_____/_____ SSN: _____

Insurance Name: _____
Insurance Policy/ID Number: _____ Group Number: _____
Co-Pay: $_____ Deductible: $_____ Assigned Primary Care Physician: _____
Current insurance card for this policy provided to Family Practice Specialists: ☐ YES ☐ NO

Section E: Authorization - Health Insurance

I understand that I am responsible for providing current and accurate insurance information including my insurance card. I understand although Family Practice Specialists, Ltd. submits my claim for services rendered, my health insurance company determines how the claim will be processed and I will be responsible for any claim issues that may arise. I also understand that Family Practice Specialist Ltd is required by law and contract to collect from me, ON THE DATE OF SERVICE, any present co-payment amount required by my insurance contract.

I understand that it is my responsibility to know if Family Practice Specialist Ltd. is an authorized and in-network provider according to my insurance contract. I understand that I am responsible to know which lab and outside facilities my insurance company utilizes for all lab work, diagnostic testing and specialists' appointments. If required by my insurance contract, I realize that it is my responsibility to request referrals and authorizations from my primary care provider. Failure to do so may result in my insurance company denying payment for services and I will be responsible for the associated charges. I understand that I am responsible for payment of all charges or fees not covered by my insurance contract.

Please be aware that some, and perhaps all, of the services you request and are provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or your medical insurance. This does not relieve you of the responsibility of payment for those services. Your insurance policy is a contract between you and your insurance company, we are not a party to that contract.

If at the time of completing these forms I do not have current health insurance coverage, I understand that I am required to pay all charges in full at the time of service. I understand that in the event that I obtain health insurance I am responsible for notifying Family Practice Specialist, Ltd. and providing the required policy details and insurance card copy.

By signing below, you are indicating that (1) you have read and understand **Section E** and (2) you are providing authorization for your health insurance company to pay all benefits directly to Family Practice Specialists, Ltd and thereby agree to the release of relevant medical information to the insurance carrier.

SIGN HERE

Signature: _____ ***Date:*** _____

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Patient Name: _____
Date of Birth: _____/_____/_____

Section F: Financial Policy

Thank you for choosing FPS as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment agreement. The following is a statement of our Financial Policy, which we require you read and sign prior to treatment. This policy is subject to change, a current copy of the policy will be provided upon request.

In addition to any co-payment amount determined by your insurance contract, all patients with a deductible are required to provide a down payment for services rendered at the time of service. Down payment rates are determined by the procedures and level of services provided. The down payment does not relieve you of any remaining/additional patient balance returned by your health insurance once your claim has been processed. Any/all remaining outstanding balances are due upon receipt of invoice and are expected to be resolved promptly.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any non-contracted insurance company's arbitrary determination of usual and customary.

Minor Patients

The accompanying adult and the parent(s)/guardian of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to the approved credit plan, credit card, or payment by cash or check at the time service has been verified.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for the missed appointment at the following rates: standard appointment (Monday – Friday) $50.00, all Saturday appointments $100, dermatology and OMT appointments $75. Please help us serve you better by keeping scheduled appointments and by giving us as much advance notice of cancellation as possible.

Check Policy

We accept checks under these conditions: “When you pay by check, you expressly authorize this merchant, if your check is dishonored or returned for any reason to electronically debit your account for the amount of the check plus processing fee of $30.00 (or the maximum allowed by law) plus any applicable sales tax. Your choice to use a check for payment is your acknowledgment and acceptance of this policy and its terms.”

Administration Fee

In an effort to provide the most up-to-date services under one roof, you will be charged an annual administration fee of $49.00. This administration fee is not covered by insurance and does not cover standard healthcare services provided. However, this fee does cover complete personalized access to your electronic medical records and complete online access to: our office, records, test results, appointment schedule, bill payment, and financial account review. Additionally, this fee allows you to have your blood drawn at our office and to participate more fully in advanced medical research and patient care models.

Collection Fee

In the event your account becomes delinquent and is turned over to a collection agency, you will be subject to a collection fee up to 40% based upon the balance of your account.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.
I have read, understand, and agree to this Financial Policy.

SIGN HERE

Signature: _____ ***Date:*** _____

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Patient Name: _____
Date of Birth: _____/_____/_____

Section G: Authorization to Release Medical Information

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of Family Practice Specialists, Ltd to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

Please check one option and sign below.

_____ **I DO NOT** authorize Family Practice Specialists, Ltd to release any or all information concerning my medical care to any individual except as set forth above.

_____ I **AUTHORIZE** Family Practice Specialists, Ltd to verbally release any or all information concerning my medical care, appointments, and billing information to the following individuals.

_____ _____
Name (Last, First, MI, Suffix) Relationship to Patient

_____ _____
Name (Last, First, MI, Suffix) Relationship to Patient

_____ _____
Name (Last, First, MI, Suffix) Relationship to Patient

SIGN HERE

Signature: _____ ***Date:*** _____

Authorization to Leave Messages

Please check one option and sign below.

_____**I AUTHORIZE** Family Practice Specialists, Ltd Medical providers and staff to leave voice messages pertaining to appointment reminders, clinical and or business related issues at the following phone numbers if there is "NO" answer:

☐ Home (_____)_____-_____ ☐ Mobile (_____)_____-_____ ☐ Work (_____)_____-_____

_____**I AUTHORIZE** Family Practice Specialists, Ltd to call me at the phone numbers listed below, but **DO NOT** leave a message.

☐ Home (_____)_____-_____ ☐ Mobile (_____)_____-_____ ☐ Work (_____)_____-_____

_____**I DO NOT** authorize Family Practice Specialists, Ltd to call me

Please be aware that for a message to be left with an individual at any of the above listed phone numbers they must be listed as an authorized individual in the "Authorization to Release Medical Information" section of this form.

SIGN HERE

Signature: _____ ***Date:*** _____

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Patient Name: _____

Date of Birth: _____/_____/_____

Medical History Questionnaire

Problems: **Please list any serious illness, injuries, and hospitalizations (hypertension, hyperlipidemia, diabetes, etc.)**

Problem	Date of Onset	Problem	Date of Onset

Medications: **Please list all current medications and non-prescription medications / supplements.**

Medication	Dosage / Frequency	Medication	Dosage / Frequency

Preferred Pharmacy: _____ Phone: (_____)_____-_____

Allergies: **Please include medications, foods, latex, adhesive tape, etc.**

Allergen	Reaction	**Severity** (Mild / Moderate / Severe / Fatal)

Social History:

How long have you lived in AZ? _____

Have you traveled outside of the country lately? □ YES □ NO Where? _____

Exercise Level: □ None □ Occasional □ Moderate □ Heavy Please Describe: _____

Alcohol Intake: □ None □ Occasional □ Moderate □ Heavy Drinks per Day: _____ Drinks per Week: _____

Caffeine Intake: □ None □ Occasional □ Moderate □ Heavy Please Describe: _____

Smoking Status: □ Never □ Former □ Current Daily □ Current Occasional _____# packs/Day _____# Years

When did you stop smoking? _____

Have you ever used recreational drugs?(i.e. marijuana, cocaine, etc.) □ YES □ NO Type:_____ When?_____

Family Medical History:

Relation	Medical Problem	Onset Age	Current Health Status	Age at Death/Cause of Death

Past Medical History: **Please provide the date of your most current evaluation.**

Bone Density: _____/_____/_____ Colonoscopy: _____/_____/_____

Complete Physical: _____/_____/_____ Eye Exam (Retinal): _____/_____/_____

PSA: _____/_____/_____ Last EGD: _____/_____/_____

Surgical History: **Please list any surgeries that you have had.**

Surgery	Date	Surgery	Date

Vaccines: **Please provide the date of your last immunization or test.**

Flu Shot: _____/_____/_____ Gardisil (HPV): _____/_____/_____ Pneumonia: _____/_____/_____

TB Skin Test_____/_____/_____ Tetanus: _____/_____/_____ Zostavax (Shingles): _____/_____/_____