Family Practice Specialists
Our family caring for yours

Patient Name:_____

Patient Date of Birth: _____/_____/_____

Patient Registration & Authorization

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

Authorization for Medical Treatment
This release and consent gives Family Practice Specialists, Ltd permission to perform 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.

Acknowledgment of Notice of Privacy Practices - **HIPPA packet available upon request**
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.

Advances Directives / Living Will - **Forms 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:*** _____

Section B: 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.

I **AUTHORIZE** Family Practice Specialists, Ltd to 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

SIGN HERE

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

Family Practice Specialists

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Patient Name:_____

Patient Date of Birth: _____/_____/_____

Section C: Patient Information

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

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

Assigned sex at birth: ☐ Male ☐ Female Gender Identity: _____

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

Primary 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

Address: _____City_____ State_____ Zip_____

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

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 Phone ☐ Mobile Phone ☐ Work Phone

E-mail for Patient Portal: _____

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

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

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

Employer Name: _____ Occupation: _____

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

Patients Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

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

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

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

City_____ State_____ Zip_____

Pharmacy & Location: _____ Phone: (_____)_____-_____

How did you hear about us? _____

SIGN HERE

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

Family Practice Specialists
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Patient Name:_____

Patient Date of Birth: _____/_____/_____

Section D: Medical Insurance Information & Authorization

PRIMARY Medical Insurance Information

Insurance Name: _____

Insurance Policy/ID Number: _____ Group Number: _____

Policy Holder Information- Name: _____

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

Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

SECONDARY Medical Insurance Information

Insurance Name: _____

Insurance Policy/ID Number: _____ Group Number: _____

Policy Holder Information- Name: _____

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

Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Authorization – Medical Insurance

I understand that I am responsible for providing current and accurate medical insurance information including my insurance card. I understand although Family Practice Specialists, Ltd. submits my claim for services rendered, my medical 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 medical 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 medical 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 D** and (2) you are providing authorization for your medical 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 Date of Birth: _____/_____/_____

Section E: 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.

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.

Deductible Policies

High deductible insurance plans create larger patient financial responsibility. In order to adapt to this new environment, Family Practice Specialists (FPS) requires a $75 payment toward the cost of services at the time services are performed until the deductible is met. You will be billed for the cost of services exceeding $75 that are the patient’s responsibility once the claim is processed. If the cost of services is less than $75 the difference will be applied to any balance you may have with FPS or returned to you.

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 Date of Birth: _____/_____/_____

Medical History Questionnaire

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

Condition	Date of Onset	Condition	Date of Onset

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

Medication	Dosage / Frequency	Medication	Dosage / Frequency

Pharmacy & Location: _____ Phone: (_____)_____-_____

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

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

Social History:

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

How long have you lived in AZ? _____ Occupation: _____

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: **Please include any chronic conditions, cancer diagnosis, serious illnesses, etc.**

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.**

Colonoscopy: _____/_____/_____ Complete Physical: _____/_____/_____

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

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Gynecological History

Date of last Pap Smear: _____/_____/_____

Have you ever had an abnormal pap smear? □ YES □ NO

If "YES" what abnormality was found? _____

If "YES" what procedure was performed? Colposcopy / Biopsy / Surgery / Cryotherapy

Have you had a hysterectomy? □ YES □ NO Year: _____

If "YES" were your Ovaries also removed? □ YES □ NO

Have you ever had a sexually transmitted disease? □ YES □ NO

If "YES" please indicate type: Trichomanas / HPV or Genital Warts / Genital Herpes / Chlamydia / Gonorrhea / Syphilis / Hepatitis B / HIV

Are you interested in STD testing? □ YES □ NO

Would you like to be tested for HIV? □ YES □ NO

Do you have bleeding or pain with intercourse? □ YES □ NO

Do you have more than one sexual partner? □ YES □ NO

Menstrual History:

Age when first period occurred: _____

- **If You Are Still Menstruating:**

Date last period started: _____/_____/_____

Are your periods regular? □ YES □ NO

If "NO" please describe: _____

How many days does you period last? _____

How many days between cycles? _____

Are your periods painful? □ YES □ NO

How many pads/tampons soaked per day? _____

- **If You Are Through Menopause or Over Age 50:**

Age at Menopause: _____

Do you struggle with menopause symptoms? □ YES □ NO

Have you had any breakthrough bleeding? □ YES □ NO

Obstetrical History

How many pregnancies have you had? _____

How many children have you delivered? _____

Are you planning pregnancy in the next year? □ YES □ NO

What form of birth control are you currently using? _____

Breast Health

Date of most recent Mammogram: _____/_____/_____

Have you ever had an abnormal mammogram? □ YES □ NO

If "YES" please describe treatment: Biopsy?_____ Surgery?_____ Other?_____

Bone Health

Date of most recent Bone Density test: _____/_____/_____

Have you ever broken any bones? □ YES □ NO Year: _____ Site: _____ How:_____

Do you ever have back pain? □ YES □ NO

If "YES" symptoms are: Mild / Severe Dull / Sharp Intermittent / Constant