



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.



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



Signature: _____ **Date:** _____



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? _____



Signature: _____ **Date:** _____



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.



Signature: _____ **Date:** _____



Patient Name: _____

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.



Signature: _____ Date: _____



Patient Name: _____

Patient Date of Birth: ____/____/____

Medical History Questionnaire

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

Table with 4 columns: Condition, Date of Onset, Condition, Date of Onset. Includes 4 rows of blank lines for data entry.

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

Table with 4 columns: Medication, Dosage / Frequency, Medication, Dosage / Frequency. Includes 3 rows of blank lines for data entry.

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

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

Table with 3 columns: Allergen, Reaction, Severity (Mild / Moderate / Severe / Fatal). Includes 3 rows of blank lines for data entry.

Social History:

Marital Status: [] Single [] Married [] Separated [] Divorced [] Widowed [] Partner [] Other
Number of Children: _____ 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.

Table with 5 columns: Relation, Medical Problem, Onset Age, Current Health Status, Age at Death/Cause of Death. Includes 5 rows of blank lines for data entry.

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.

Table with 4 columns: Surgery, Date, Surgery, Date. Includes 3 rows of blank lines for data entry.

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

Flu Shot: ____/____/____ Gardasil (HPV): ____/____/____ Pneumonia: ____/____/____
TB Skin Test ____/____/____ Tetanus: ____/____/____ Zostavax (Shingles): ____/____/____