



Patient Registration and Authorization

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

Section A: Authorization for Treatment/ Acknowledgment of Privacy Practices

Authorization for Medical Treatment

This release and consent gives Family Practice Specialists, Ltd permission to administer medical treatment to my child or myself. I understand that every effort will be made to contact the caregiver. However, 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.



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



Signature: _____ Date: _____



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: () -
Next of Kin (Last, First, MI, Suffix):
Next of Kin 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:
Policy Type: PPO HMO POS Other
Insurance Company: Policy Name:
Insurance Policy/ID Number: Group Number:
Claims Address: Phone Number: () -
Co-Pay: \$ Deductible: \$ Assigned Primary Care Physician:

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: _____

Policy Type: PPO HMO POS Other _____

Insurance Company: _____ Policy Name: _____

Insurance Policy/ID Number: _____ Group Number: _____

Claims Address: _____ Phone Number:(____)____-____

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

Patients TERTIARY Health Insurance Information

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

Self Guarantor Other: _____

Name: _____

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

Policy Type: PPO HMO POS Other _____

Insurance Company: _____ Policy Name: _____

Insurance Policy/ID Number: _____ Group Number: _____

Claims Address: _____ Phone Number:(____)____-____

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

Section E: Authorization - Health Insurance

I understand that I am responsible for providing complete and accurate insurance information as well as my current insurance card. I realize I am responsible for any claim issues that may arise. I understand that Family Practice Specialists, Ltd. submits my claim for services rendered to my health insurance; however, my health insurance company determines how the claim will be processed. 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. If for any reason my insurance contract is not valid or any fees are not covered by my insurance contract, I am responsible for payment of all charges. I understand that if my insurance is non-contracted or out of network I will be required to pay all charges in full at the time of service and I will be provided with a walk out statement that I may submit to my insurance.

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 prior authorizations are required by my insurance contract for diagnostic testing and specialists' appointments, I realize that it is my responsibility to request a referral authorization 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 services performed.



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 other 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. In the event that you would be unable to satisfy your charges in full at the time of service, we would require pre-approval on an extended payment plan.

I authorize my 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.



Signature: _____ Date: _____

Self-pay Patients

At the time of completing these forms I do not have current health insurance coverage. I understand that I will be 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 will be required to complete all insurance and authorization forms prior to my health insurance being billed. By signing I am acknowledging that I have read and understand **Section E**.



Signature: _____ Date: _____

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.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, AND MASTERCARD. WE DO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

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 adult accompanying a minor and the parents (or 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 rate of \$50.00. 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 charged a 40% collection fee 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.



Signature: _____ **Date:** _____

Section G: Authorization to Release Medical Information

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), 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



Signature: _____ **Date:** _____



Authorization to Leave Messages

Please check one option and sign below.

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

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

_____ **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 (____)_____-_____

Please be aware that in order 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 previous section of this form.



Signature: _____ **Date:** _____

Section H: 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.



Signature: _____ **Date:** _____



Medical History Questionnaire

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

Table with 4 columns: Problem, Date of Onset, Problem, Date of Onset

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

Table with 4 columns: Surgery, Date, Surgery, Date

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

Table with 4 columns: Medication, Dosage / Frequency, Medication, Dosage / Frequency

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

Flu Shot: ___/___/___ Gardisil (HPV): ___/___/___ Pneumonia: ___/___/___
TB Skin Test ___/___/___ Tetanus: ___/___/___ Zostavax (Shingles): ___/___/___

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

Table with 3 columns: Allergen, Reaction, Severity (Mild / Moderate / Severe / Fatal)

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

Bone Density: ___/___/___ Colonoscopy: ___/___/___
Complete Physical: ___/___/___ Eye Exam (Retinal): ___/___/___
PSA: ___/___/___ Last EGD: ___/___/___

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:

Table with 5 columns: Relation, Medical Problem, Onset Age, Current Health Status, Age at Death/Cause of Death