Ahwatukee Family Medical Center — Patient Information

New Patient: ( ) Update: ( ) Date: ________________________

Patient Name: ____ M ( ) F ( )
LAST FIRST MI

Mailing Address: ______________________ ____________________ City: ______________ State: _____ Zip:_____

Home Phone: (_____)________________ Work Phone: (_____)________________EMAIL:______________________________

Date of Birth: _____/______/______SS# ________________________ Marital Status: Single ( ) Married ( ) Divorced ( ) Other ( )

Employer: ____________________________________ Occupation: ____________________________________

Employer Address: ____City:__________________State:_____Zip:_______

Pharmacy used: ___________________________________ City: ____________________ Phone: (____)______________

How did you hear about our office? ____

SPOUSE/PARENT/GUARDIAN INFORMATION

Name: _________________________________ Phone(_____)________________ Relationship______________________

DOB: ______/_______/_______

Address: ____City:______________________ State: ______ Zip:________

Employer: ______________________________ Work Phone: (____)______________ Occupation:_____________________

Employer Address: ____________________________________City:______________________State:_______ Zip: _______

EMERGENCY CONTACT: ______________________________Phone (____)_______________Relationship:______________

INSURANCE INFORMATION (Please present insurance ID)

Primary Insurance Name: ______________________________

Insurance Address: ______________________________

Name of insured: ______________________ DOB: __/__/___

Group# ______________________________

Employer Name: ______________________________

Employer Address: ______________________________

Phone: (_____)______________________________

Relationship of patient to insured: ______________________

Secondary Insurance Name: ______________________________

Insurance Address: ______________________________

Name of insured: ______________________DOB: __/__/_____

Group # ______________________________

Employer Name: ______________________________

Employer Address: ______________________________

Phone: (_____)______________________________

Relationship of patient to insured: ______________________

I hereby authorize the undersigned physician to release any information acquired in the course of my examination for treatment to referring physician or insurance carrier listed above.

Signature: ______________________________ Date: ______________ Witness: ______________________________

Do we have your permission to leave a message on your answering machine at home? Yes ( ) No ( )

Do we have your permission to leave a message at your place of employment? Yes ( ) No ( )

Patient History

Name: ____ DOB: ____________________

PAST MEDICAL HISTORY

Disorder	Year	Disorder	Year	Disorder	Year
Anemia		Hepatitis		Heart DS/Attack	
Bronchitis/Pneumonia		Pancreatitis		Depression	
Hypertension		Gastritis		Neurological Ds.	
Diabetes Mellitus		Peptic Ulcer Disease		OTHER	
Gall Bladder Disease		Injuries/Fractures		OTHER	
Asthma		Kidney Disease		OTHER	

Please describe any of the above: ____

____

Medications presently taking: ____

Past surgical history: ____

____

FAMILY HISTORY

Relationship -	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcoholism						
Drug Abuse						
Asthma						
Cancer						
High Blood Pressure						
Diabetes						
Heart/Lung Disease						
Stomach/Intestinal						
Depression						
Cause of Death						
Date of Death						

Are you allergic to any medications? Yes ( ) No ( ) If yes,

Name of Medication: ____________________ What happens? ____________________

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Name of Medication: ____________________ What happens? ____________________

Do you smoke? Yes ( ) No ( ) If yes, how many packs per day? ______________ For how long? __________ Years

Do you use alcohol? Yes ( ) No ( ) If yes, what kind? __________ How much/week?________ For how long? _____Years

Method of birth control ______________ #pregnancies: ______ # living children: ________ # miscarriages: ______

HEALTH SCREENING	Normal	Abnormal		Normal	Abnormal
Date of last blood cholesterol			Date of last eye exam		
Date of last PAP exam			Date of last dental exam		
Date of last mammogram			Date of last tetanus shot		
Date of last prostate exam			Date of last flu shot		

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

And AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ____ **Date of Birth:** ________________

I acknowledge that I have received a copy of the
NOTICE OF PRIVACY PRACTICES for Ahwatukee Family Medical Center.

____ ________________________
Signature of Patient or representative **Date**

______________________________________ ______________________________________
Printed Name (if representative) **Relationship to Patient**

Please list the names and phone numbers of those individuals involved in your care or with whom you will allow us to share your health and treatment information.

____ (_______)________________________
Name (please print) Phone
____ (_______)________________________
Relationship Second phone number, if applicable

____ (_______)________________________
Name (please print) Phone
____ (_______)________________________
Relationship Second phone number, if applicable

____ (_______)________________________
Name (please print) Phone
____ (_______)________________________
Relationship Second phone number, if applicable

____ ________________________
Signature of Patient or representative **Date**

______________________________________ ______________________________________
Printed Name (if representative) **Relationship to Patient**

FOR OFFICE USE ONLY

COMMENTS:
____
____
____

____ ________________________
Signature Date

AHWATUKEE FAMILY MEDICAL CENTER

AHWATUKEE FAMILY MEDICAL CENTER FINANCIAL POLICY

YOUR RESPONSIBILITY - You are financially responsible for the services we provide you. As a courtesy to you we will file insurance claims on your behalf, when supplied with current and precise insurance information. If you present without this information please be prepared to either pay cash or reschedule your visit. It is your sole responsibility to know the individual coverage and benefits of your insurance plan. It is your responsibility to ensure our practice is a contracted provider with your plan.

PATIENTS WITHOUT INSURANCE - It is our pleasure to provide services to patients that do not have insurance. However, you will be expected to pay for your services at the time of the visit. We do not bill self pay accounts.

MEDICARE PATIENTS - AFMC accepts Medicare assignment. We will bill your secondary insurance if you provide us with the proper insurance information. You are, however, solely responsible for any coinsurance, deductibles or any charges for non-covered services. You will be required to sign an advanced beneficiary notice for any services rendered at the time of service.

PRIVATE INSURANCE PATIENTS - AFMC accepts assignment for most major insurances. It is the patients responsibility to verify if that our office is contracted with your specific insurance plan. You will be required to pay any applicable copayments, coinsurance, deductibles and/or any non-covered services rendered at the time of service.

HMO PATIENTS - It is the patient's responsibility to ensure our practice is a contracted provider and that Dr. Nichols is designated as your Primary Care Physician with your plan. If your plan requires referrals to a specialty physician, you must adhere to our office referral policy. If you seek care without prior authorization, you will be financially responsible for the specialist visit(s).

WE DO NOT FILE THIRD PARTY LIABILITY INSURANCE CLAIMS - We will provide medical care for you in accident cases, but we will only file with your medical insurance or accept cash at the time of the visit.

METHODS OFPAYMENT - We accept cash, checks, and all major credit cards. We accept checks only when billed balances are satisfied by mail. A $25.00 charge will be assessed for any returned (NSF) checks.

PRIOR BALANCES - Patients with an account showing a prior balance will be asked to pay their balance in full before being seen. If the balance cannot be paid in full, you may be asked to meet with our billing department to arrange for payment.

NO SHOW/NO CALL -Please notify our office at 480-759-5151 twenty-four hours in advance if you must cancel or reschedule your appointment. This allows us time to serve another patient in that appointment time. Patients with consecutive no show/no call appointments will be billed a $25 charge.

FORM CHARGES - There will be a charge assessed for the completion of any forms. These charges are not covered by insurance carriers and are due at the time of service, in addition to any applicable office visit fees. FEE SCHEDULE - FMLA form - $100, Temporary Disability form -$100, Wellness Exam Forms - $25 per page, Custom Letters - $450 per hour

INFORMATION CHANGE – Please advise us of any address, phone number, email, and/or insurance promptly. You will be asked at least once a year to fill out demographic information, or to initial that what is on file is current and correct.

COLLECTION PROCEDURES – Prompt payment for services rendered is expected in full. Failure to reply to communications from our office may result in your account being turned over to an outside collection agency and discharge from our practice. If your account is turned over to collections there will be an additional fee of 10% added to account balance for all collection fee costs. If your insurance company has not paid your account in full within 45 days, you will be billed the balance. Balances on accounts that are not paid 15 days from receipt of statement a "final notice" letter will be mailed out for prompt payment. If still not satisfied within 30 days, the account will be turned over to an outside collection agency at that time.

I HAVE READ AND AGREE TO THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OFSERVICES RENDERED BY AFMC. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OFCLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO AFMC. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

SIGNATURE ____ **DATE** __________________________

PARENT SIGNATURE (IF MINOR) ____

CREDIT CARD AUTHORIZATION FORM (MUST BE FILLED OUT COMPLETELY FOR FAMILY)

VISA___________ OR MASTERCARD ___________

CREDIT CARD NUMBER ____

EXPIRATION DATE ____

3 DIGIT SECURITY CODE ____

CARD HOLDERS NAME ____

LIST ALL FAMILY MEMBERS AND BIRTHDATES: ____

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UPON PROVIDING CREDIT CARD INFORMATION, ONE STATEMENT WILL BE SENT, I AUTHORIZE ANY AND ALL OUTSTANDING BALANCE DUE WILL BE CHARGED TO CREDIT CARD IF NOT PAID WITHIN 15 DAYS OF RECEIVING STATEMENT.
IF YOU CHOOSE NOT TO PROVIDE CREDIT CARD INFORMATION, AFTER ONE STATEMENT, A FINAL COLLECTION NOTICE WILL BE ISSUED IF NOT PAID WITHIN 15 DAYS OF RECEIVING STATEMENT.

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AUTHORIZED SIGNATURE

TODAY'S DATE____________________________

FOR OFFICE USE ONLY: PATIENT ACCT#______________________