# Ahwatukee Family Medical Center — Patient Information

Date: _____

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

Mailing Address: _____ City: _____ State: _____ Zip:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____

EMAIL:_____

Date of Birth: _____/_____/_____SS# _____ Marital Status: Single ☐ Married ☐ Divorced ☐ Other ☐

Employer: _____ Occupation: _____

Pharmacy:_____ Cross-Streets: _____ City:_____

Pharmacy Phone: _____

**SPOUSE/PARENT/GUARDIAN INFORMATION**

Name: _____ Phone(_____)_____ Relationship_____

Address: _____City:_____ State: _____ Zip:_____

**EMERGENCY CONTACT:** _____**Phone (____)**_____**Relationship:**_____

**INSURANCE INFORMATION** (Please present insurance ID)

Primary Insurance Name: _____

ID # : _____

Group #: _____

Secondary Insurance Name _____

ID #: _____

Group #: _____

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. I consent to email, text, and voice communication regarding my services with Ahwatukee Family Medical Center.

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

# Patient History

**Name:** **DOB:**

**PAST MEDICAL HISTORY**

| Disorder | Year | Disorder | Year | Disorder | Year |
|---|---|---|---|---|---|
| Anxiety | | Diabetes | | Melanoma | |
| Atrial Fibrillation | | Heart Attack | | Parkinsons | |
| Cancer - type: | | High Cholesterol | | Stroke | |
| COPD | | Hypertension | | Tremors | |
| Dementia | | Hypothyroidism | | OTHER | |
| Depression | | Insomnia | | OTHER | |

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? _____

Do you smoke? Yes ☐ No ☐

Do you use alcohol? Yes ☐ No ☐ How much/week?_____ For how long? _____Years

| HEALTH SCREENING | Normal | Abnormal | | | |
|---|---|---|---|---|---|
| Date of last PAP exam | | | Date of last tetanus (TDAP) | | |
| Date of last mammogram | | | Date of last flu vaccine | | |
| Date of last prostate exam | | | Date of last covid vaccine | | |
| PSA Result | | | Date of last pneumonia vaccine | | |
| Date of last colonoscopy/Cologuard | | | | | |

# 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**

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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**

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**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.

**PRIVATE INSURANCE PATIENTS** - AFMC accepts assignment for most major insurances. 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 OF PAYMENT**- We accept cash, checks, and all major credit cards. A $35.00 charge will be assessed for any returned (NSF) checks.

**BILLING STATEMENTS** - Patient statements are sent out monthly via email and text.

**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. No show/no call appointments will be billed $50 and $100 for each subsequent no show appointment.

**FORM CHARGES** - There will be a charge assessed for the completion of any forms. These charges are not covered by insurance and are due at the time of service, in addition to any applicable office visit fees. FEE SCHEDULE - FMLA form - $125, Temporary Disability form -$125, 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 change promptly. You will be asked at least once a year to fill out demographic informatio to verify 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 insurance company has not paid your account in full within 120 days, you will be billed the balance. Balances on accounts that are not paid after three billing cycles (90 days)will be sent a "final notice" letter. 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)

CREDIT CARD NUMBER _____

EXPIRATION DATE _____

3 DIGIT SECURITY CODE _____

CARD HOLDERS NAME _____

LIST ALL FAMILY MEMBERS AND BIRTHDATES: _____

_____

**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#_____