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**

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 provided. 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 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 a prior balance will be asked to pay in full before being seen. If the balance cannot be paid in full, you may be asked to reschedule your appointment.

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. 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 annually to verify your demographic information.

COLLECTION PROCEDURES - Prompt payment for services rendered is expected in full. Failure to reply to communications from our office may result in the account being turned over to a 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 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 collections and a 25% surcharge will be added to your account.

I HAVE READ AND AGREE TO THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY AHWATUKEE FAMILY MEDICAL CENTER.

I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO AHWATUKEE FAMILY MEDICAL CENTER. 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.

AUTHORIZED SIGNATURE

TODAY'S DATE _____

FOR OFFICE USE ONLY: PATIENT ACCT#_____