MEDICAL HISTORY & REVIEW OF SYSTEMS		1. Today's Date:
2. Name of Patient (Last, First, Middle)	3. Age	4. Date of Birth
5. What health concerns did you schedule your appointment for today?		

I REVIEW OF SYSTEMS

Symptoms you are **currently** experiencing

Check Each Item	Yes	No	Check Each Item	Yes	No	Check Each Item	Yes	No
Weakness			Wheezing			New/Change in mole		
Fatigue			Recent breast injury			Rash		
Don't feel well			Breast pain			Itching of the skin		
Fever			Breast Lump			Blisters		
Eye pain			Discharge from nipple(s)			Change in skin		
Recent eye injury			Enlargement of breast(s)			Ingrown nails		
Eye inflammation			Abdominal pain			Brittle nails		
Glasses/Contacts			Difficulty swallowing			Abnormal hair loss		
Visual disturbance			Nausea			Swollen glands		
Ear pain			Vomiting			Bleeding		
Ringing of the ear(s)			Heartburn			Excessive thirst		
Vertigo			Constipation			Change in hand/feet size		
Nasal congestion			Diarrhea			Unintentional weight change		
Runny nose			Abdominal cramps			Sexual difficulty / low desire		
Mouth pain			Hemorrhoids			Hearing disturbance		
Tongue pain			Rectal pain			Walking disturbance		
Sores in mouth			Blood in urine			Numbness		
Tooth pain			Pain with urination			Headaches		
Sore throat			Other urination problems			Speech disturbance		
Voice changes			Discharge from genitals			Smell disturbance		
Chest pain			Back pain			Loss of motor skills		
Leg pain with walking			Shoulder pain			Involuntary movements		
Cold extremities			Knee pain			Incontinence urine/stool		
Shortness of breath			Hip pain			Significant memory loss		
Swelling in legs/feet			Foot/ankle pain			Anxiety		
Light headedness			Other joint pain			Depression		
Cough			Recent injury			High level of stress		
Coughing up blood			Night cramps			Suicidal thoughts		
			Insomnia			Hallucinations		

II PERSONAL MEDICAL HISTORY (Not Family History)

Check Each Item	Yes	No	Check Each Item	Yes	No	Check Each Item	Yes	No
Heart attack			Thyroid problem			Other kidney problem		
Other heart disease			Cancer			Stomach ulcer		
High blood pressure			Bleeding disorder			Colon problems		
Asthma			Blood transfusion			Gout		
Other lung problems			Depression/Anxiety			Arthritis		
Seizure disorder			Suicide attempt			High cholesterol		
Migraine			Alcoholism			Learning disability		
Stroke			Hepatitis			Mental disability		
TMJ			Other liver problems			Physical disability		
Glaucoma			Kidney stone			Diabetes		

III FEMALES ONLY (Males go to IV)

Last menstrual period?	Number of pregnancies?	Number of live births?

IV SURGICAL HISTORY & HOSPITAL HISTORY

Surgery	Date	Surgery	Date	Surgery	Date
Eyes		Thyroid		Back	
Ears		Hysterectomy		Other	
Tonsils		Knee(s)			

Circle answers below:

V SOCIAL HISTORY

Do you use tobacco? No Yes Quit (date) If you smoke how many packs per day? How many years?
Type: Cigarettes Cigars Chew/snuff

Do you drink alcohol? No Yes Number of drinks per week? Is alcohol a concern to you or others?

Do you use recreational drugs? No Yes Type: Have you used needles?

Caffeine intake? None Coffee Tea Soda Indicate the daily amount for each

Are you sexually active? No Yes Not currently Current sexual partner(s) is/are male female

Have you ever had any sexually transmitted diseased? No Yes Are you interested in being screened for STD's? No Yes

Patient's occupation? Ethnicity?

VI FAMILY HISTORY

Family Member	Alive	Deceased	Age: now or at death	Asthma	Bleeding disorder	Cancer	Heart attack	Depression	High Cholesterol	High blood pressure	Osteoporosis	Stroke	Thyroid disorder	Other
Father														
Mother														
Brother(s)														
Sister(s)														
Daughter(s)														
Son(s)														

VII ALLERGIES/REACTIONS TO MEDICATIONS/ Check circle if no allergies to medications O

Medication Name	Reaction	Medication Name	Reaction

VIII MEDICATION/ Check circle if not taking medications O

Medication Name	Strength per pill	Number of pills taken at one time?	Number of doses each day?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Printed Name of patient:

Signature: Date:

ADDITIONAL DEMOGRAPHIC INFORMATION

Email: _____ Pharmacy name and Cross streets: _____

Marital Status: _____ SSN: _____ Race: _____ Ethnicity: _____

Emergency Contact Name: _____ Relationship: _____ Phone #: _____

HIPAA CONSENT PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PHI WITH CONDITIONS

Patient Name: _____ DOB: _____

I hereby authorize the use or disclosure of my personal health information as described below. I understand the information I authorize a person or entity to receive may be re-disclosed and is no longer protected by federal regulations.

1. Persons within the physician's practice authorized to use or make disclosure of the information: **ALL EMPLOYEES OF PHOENICIAN MEDICAL CENTER GROUP OF COMPANIES**
2. Persons or organizations authorized to receive the information:
   Spouse Yes No If yes, list person (s) name: _____
   Parent Yes No If yes, list person (s) name: _____
   Other individual, i.e., boyfriend/girlfriend, brother, sister, etc. Yes No
   If yes, please list name (s) and relation: _____
3. Specific description of information that may be used or disclosed: e.g.: **Contact information Tests results, referrals, prescriptions, paperwork, pertinent medical record**
4. The information will be used/disclosed for the following purposes:
   A. To inform me of my medical condition (s) by phone, mail, email or in person.
   B. To give information/referrals/medical records/prescription, paperwork, and or test results to you or the person (s) named on this form, by phone, mail email or in person.
   C. For treatment, payment and health care operations.
5. This authorization expires on: _____. I understand that I may revoke this authorization at any time by notifying the physician's office providing the information in writing. However, the revocation will not be valid, if:
   A. The physician has taken action in reliance of this authorization, or
   B. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

❑ I acknowledge that I have been offered a copy of Phoenician Medical Center dba Phoenician Primary Care Notice of Privacy Practices. I also know I can go to pmchealth.care/website to read or print the notice online.

❑ I acknowledge that I declined a copy of Phoenician Medical Center dba Phoenician Primary Care Notice of privacy Practices offered to me today.

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Patient's Representatives: _____

Rights of the Patient: *Effective 5.1.2016 / Reviewed 1.2022*

You have the right to be treated with dignity, respect and consideration and you will not be subjected to:

* ABUSE * NEGLECT * EXPLOITATION * COERCION * MANIPULATION * SEXUAL Abuse or Assault
* RESTRAINT OR SECLUTION (except as allowed in R9-10-1012(B).
* RETAILIATION for submitting a complaint to our office, The AZDHS or any other entity.
* Misappropriation of personal or private property by a staff member, volunteer or student

You or your representative:

- Except in an emergency, either consents to or refuses treatment
- May refuse or withdraw consent for treatment before treatment is initiated
- Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of proposed psychotropic medication or surgical procedure
- Is informed of our policy on Healthcare directives
- Is informed on the patient complaint process. (See “License Posting Notice”)
- To consent to a photograph before being photographed.
- Except as otherwise permitted by law, provides written consent to the release of information in the patient’s medical record or financial records.

You have the right:

- Not to be discriminated against based on Race, National origin, Religion, Gender, Sexual orientation, Age, Disability, Marital Status or Diagnosis
- To receive treatment that supports & respects your individuality, choices, strengths and abilities
- To receive privacy in treatment and care for personal needs
- To review upon written request, your own medical record according to A.R.S 12-2293, 12-2294 & 12-2294.01
- To receive a referral to another healthcare institution if our office is not authorized or not able to provide care needed by you the patient.
- To participate or have your representative participate in the development of or decisions concerning treatment
- To participate or refuse to participate in research or experimental treatment
- To receive assistance from a family member, your representative or other individual in understanding, protecting or exercising your rights.

Responsibilities of the Patient:

- To provide accurate and complete information concerning your present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
- To report perceived risks in your care and unexpected changes in you condition to your provider
- To ask questions if you do not understand what you have been told about your care or what you are expected to do
- To follow the treatment plan established by your provider, including the instructions of support staff as they carry out the providers orders
- To keep appointments and for notifying the office when you are unable to do so.
- For your actions should you refuse treatment or not follow your providers orders.
- To assure that the financial obligations of your medical care are fulfilled as promptly as possible.
- For being considerate of the rights of other patients and office staff & respectful of your personal property and that of other persons in the office.
- To have a surrogate decision maker identified if you are unable to make decisions about care, treatment or services.
- To involve the family in care, treatment and services with permission from you or your surrogate decision maker.

_____

Signature Date

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please see the receptionist to request a copy.

Understanding Your Health Record/Information

Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- tool in educating health professionals
- source of data for medical research
- source of information for public health officials charged with improving the health of the nation
- source of data for facility planning and marketing
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to

- ensure its accuracy
- better understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- notify you of a breach of "unsecured" protected health information

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your written authorization, except as described in this notice.

To Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at this office.

If you believe your privacy rights have been violated, you can file a complaint with this office or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations

Treatment: Information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide subsequent healthcare providers with copies of various reports that should assist them in treating you.

Payment: A bill may be sent to you or a third-party payer. This information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

Health Operations:

1. **Risk Management** - Members of the medical staff or the risk or quality improvement staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
2. **Business Associates** - There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory, copy services, transcription services, billing services, etc. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
3. **Notification –** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition.
4. **Communication With Family** - Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
5. **Research** - We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
6. **Funeral Directors –** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
7. **Organ Procurement Organizations** – Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.
8. **Marketing –** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
9. **Food and Drug Administration (FDA) –** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, recalls, repairs or replacement.
10. **Workers' Compensation –** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.
11. **Public Health –** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
12. **Law Enforcement –** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

This notice is effective as of 1/1/2010 and will remain in effect until revised.

X _____

Phoenician Medical Center
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PHOENICIAN PRIMARY CARE

FINANCIAL POLICIES AND ARRANGEMENTS

We recognize the need for understanding the areas of payment arrangements and insurance filings. This sheet has been put together to address some of these areas for you.

INSURANCE, FILING/BENEFITS/PAYMENT

There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to meet a deductible or make a co-payment. If you are covered by one of these plans, please show us your card. Be prepared to make your co-payment, or pay for your office visit if your deductible has not been met at the time of service. We accept cash, checks, Visa, and MasterCard. With plans that we are not contracted with, you will be asked to pay at the time service is rendered.
If we are billing your insurance for you, it is extremely important that you furnish us with accurate and updated information so your claim can be filed. It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover different types of services. Contraception, immunizations, and other services, may not be covered on your particular plan. Services provided that are not a covered benefit are your responsibility and payment is due at the time services are rendered. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card). We will set aside the portion of the balance estimated to be paid by your insurance carrier for 45 days. If your carrier does not remit payment within 45 days, you will be responsible for the full balance. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim, you will continue to receive statements until the account is paid in full.

PAYMENT ARRANGEMENTS

Payment is expected at the time of service. If you do not have your co-pay at the time of service, your visit may be rescheduled. Also, we recognize the need to set up payment plans for patients who require extensive treatment. Our business office will be happy to help you with these arrangements.

DELINQUENT ACCOUNTS

Bills that are delinquent for more than ninety (90) days may be transferred to an outside collection agency unless prior arrangements have been made. If you have questions or think an error has been made, please discuss them with us prior to the 90 days in order to help us resolve this.

RETURNED CHECKS

There is a $25.00 service fee for checks returned for insufficient funds. We belong to the Maricopa County Attorney's Check Enforcement Bureau. We request a copy of your driver's license or ID card as identification.

CANCELLATION OF APPOINTMENTS/ NO-SHOW APPOINTMENTS

We ask that you give us 24 hours notice to cancel an appointment. If you do not cancel an appointment, you can be charged $25.00 as this will be considered a no-show. Three no-show appointments are grounds for dismissal from the office.

ADVANCED BENEFICIARY AGREEMENT

Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If payment is denied for services or tests, (i.e. routine exam/lab work, vaccinations, contraception, procedures, and non-related diagnoses for the services provided), then the patient is personally and fully responsible for payment.

CONSENT FOR TREATMENT

I consent to evaluation and treatment of the condition for which I, or my child or dependant, have come to Phoenician Primary Care (PPC) and authorize the physicians and other health care providers affiliated with Phoenician Primary Care & Phoenician Medical Center Group of Companies to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by PPC. I authorize PPC to examine, use, store and dispose of all tissue, fluids, or specimens removed from my body. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at PPC.

CONSENT FOR SHARED ELECTRONIC MEDICAL RECORDS

I understand PPC shares an electronic medical record system (MDSynergy/Althea) with Phoenician Medical Center Group of Companies. I also understand only the minimum necessary will be viewed by staff members and only for continuation of patient care.

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. **It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.**

I have read and agree to the above policy of Phoenician Primary Care. I understand the contents and by signing below accept the aforementioned financial responsibilities.

Patient/Guardian's Signature: _____ Date: _____

Prescription Medical Refill Policy

PPC never wants you to be without your prescribed medications. Our refill policy is to protect your health and to reduce complications and errors on medications. It also will allow our medical staff to respond and focus on your clinical questions and needs quickly and efficiently. Our prescription medication refill policy states: Medication refills will be given at your regularly scheduled appointment by your provider. If you are low on medications, we will schedule you an appointment and make sure you have enough medications to last until we can get you in for an office visit, normally 1-2 week supply. We will not call in antibiotics or controlled medications under any circumstance, **nor do we authorize any refills by fax or pharmacy calls.**

Please bring a list of your current medications to your appointment as well as how many refills you have available. This way we can ensure you have enough medications to last until your next scheduled appointment. Thank you for your understanding and cooperation. By signing below I understand and agree to this policy.

_____ _____

Patient Name Date

PHOENICIAN VEIN AND VASCULAR

VASCULAR HEALTH QUESTIONNAIRE

Date **Patient Name (print please)** **DOB**

Todays appointment is with (provider) **Your Insurance Provider (Cigna, etc.)**

Check if you had ANY of these symptoms in the PAST or PRESENT.

Arterial

❒ Yes	❒ No	Have you had a Transient ischemic attack? (TIA) (A brief stroke-like attack)
❒ Yes	❒ No	Have you had a Cerebrovascular accident? (Prior stroke)
❒ Yes	❒ No	Do you have severe dizziness?
❒ Yes	❒ No	Do you have left arm pain or numbness?
❒ Yes	❒ No	Do you have abdominal pain after meals?
❒ Yes	❒ No	Do you have high blood pressure resistant to medication?
❒ Yes	❒ No	Does your family have a history of abdominal aortic aneurysm?
❒ Yes	❒ No	Do you have buttock or hip pain when walking?
❒ Yes	❒ No	Do you have leg pain limiting your walking?
❒ Yes	❒ No	Do you have a non-healing ulcer foot or ankle?

Venous

❒ Yes	❒ No	Do you or any members of your family have a Venous Disease? (Varicose or Spider Veins)
❒ Yes	❒ No	Do you have bleeding from varicose veins?
❒ Yes	❒ No	Do your legs hurt, ache, cramp or feel heavy?
❒ Yes	❒ No	Do you have leg or foot swelling, numbness or burning sensation?
❒ Yes	❒ No	Do you have restless leg syndrome or symptoms?
❒ Yes	❒ No	Do you sit or stand for long periods of time?
❒ Yes	❒ No	Do you have skin discoloration below your knees?
❒ Yes	❒ No	Have you had a blood clot in your legs or Pulmonary Embolism?

The results of this form will be reviewed by your PCP. If they find it medically necessary, they may forward this form to Phoenician Vein & Vascular to set up your screening consultation.

Phoenician Medical Center
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DENTAL SCREENING FORM

PATIENT NAME: _____ DOB: _____

INSURANCE PROVIDER: _____

DATE OF LAST DENTAL VISIT: _____

DATE OF LAST DENTAL CLEANING: _____

ARE YOU DIABETIC? Y / N

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

BAD BREATH Y / N

BLEEDING GUMS Y / N

MISSING TEETH Y / N

DENTAL PAIN Y / N

GRINDING YOUR TEETH Y / N

CLENCHING YOUR JAW Y / N

JAW PAIN Y / N

ARE YOU INTERESTED IN STRAIGHTER TEETH? Y / N

ARE YOU INTERESTED IN WHITENING YOUR TEETH? Y / N

DO YOU OR A FAMILY MEMBER WANT INFORMATION ABOUT OUR DENTAL CLINIC? Y / N