ADULT PATIENT INFORMATION

Last Name: _____ First Name:_____M.I._____
Birth Date:____/____/____Gender:_____SSN:_____
Marital Status (please circle): single married divorced widowed other
Home address:_____Apt:_____
City:_____State:_____Zip Code:_____
Home number:_____Cell:_____Work number:_____
Preferred Daytime Phone (please circle): home cell work other_____
Student (please circle): Yes No Full Time Part Time
Employer:_____Occupation:_____

WE ARE REQUIRED TO ASK FOR THE FOLLOWING INFORMATION PER THE NEW INSURANCE/FEDERAL REPORTING REQUIREMENTS.

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other
Ethnicity: ☐ Hispanic/Latino ☐ Non Hispanic/Latino
Preferred Language: ☐ English ☐ Spanish ☐ Other_____ ☐ I prefer not to answer

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Friend:_____ ☐ Internet ☐ Insurance plan ☐ Healow ☐ Other

EMERGENCY CONTACT

Name:_____Phone Number:_____
Relationship to patient: _____

PREFERRED PHARMACY

Name:_____Phone Number:_____
Location:_____
Do you have a living will? ☐ Yes ☐ No
If no, would you like information about regarding a Living Will? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

Insurance Company:_____
Policy Holder's Name:_____
Policy Holder's Birth Date:__/__/____Gender:_____SSN:_____
Member ID Number:_____Group Number:_____
Policy holder's Relationship to Patient (please Circle): Self Parent Spouse Other_____
Policyholder's Employer:_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____
Policy Holder's Name:_____
Policy Holder's Birth Date:__/__/____Gender:_____SSN:_____
Member ID Number:_____Group Number:_____
Policy holder's Relationship to Patient (please Circle): Self Parent Spouse Other_____
Policyholder's Employer:_____

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT

Responsible Party Name:_____
Home address:_____Apt:_____
City:_____State:_____Zip Code:_____
Home number:_____Cell:_____Work number:_____
Birth Date:____/__/____Gender:_____SSN:_____
Relationship to patient: _____

BENEFIT ASSIGNMENT/ACKNOWLEDEMENT OF PRIVACY PRACTICES

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plan payment to Healthy Life Family Medicine. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, including but not limited to co-payments and annual deductibles. I hereby authorize said assignee to release any information required to secure the payment.

_____ _____

Signature of patient or responsible party **Date**

PAST MEDICAL HISTORY

Medical History (Please list any medical condition you have been diagnosed with and the date of onset): Examples: hypertension 2009, depression 2010, diabetes 1999

Surgical History (Please list all surgeries and include the date of surgery):

Current Medications (Please list ALL medications, prescribed, over the counter, herbs, or supplements):

Drug	Strength	How Often	Length of time taken
Example: Lisinopril	**10mg**	**1 tab a day**	**3 years**

Allergies to medications (Please list ALL allergies to medications only and the type of reaction to each):

PAST MEDICAL HISTORY CONTINUED

Tobacco Use:

Do you currently use any type of tobacco products? ☐ Yes ☐ No
If yes, please list type and quantity per day: _____
Any prior use of tobacco? ☐ Yes ☐No

Alcohol/Caffeine Use:

How many drinks of alcohol do you consume per day? _____ Week?_____
How many cups of coffee/tea do you consume per day?_____ Week?_____
How many glasses of soda do you consume per day?_____ Week?_____

Drug Abuse:

Any history of drug abuse? ☐**Yes** ☐**No**
If yes, please specify substance and length of use_____

OB/GYN History (female patients):

Number of pregnancies? _____ Date of last menstrual cycle?_____
Number of miscarriages? _____ Date of last pap?_____
Number of abortions? _____ Date of last mammogram?_____
Number of living children? ___
Have you ever had an abnormal pap? ☐Yes ☐ No
If yes, what was the diagnosis?_____

FAMILY HISTORY

Father:	Alive Deceased	age_____ age of death_____	Major medical problems: Cause of death:
Mother:	Alive Deceased	age_____ age of death_____	Major medical problems: Cause of death:
Siblings:	Alive Deceased	age_____ age of death_____	Major medical problems: Caused of death:
Siblings:	Alive Deceased	age _____ age of death_____	Major medical problems: Caused of death:
Siblings:	Alive Deceased	age_____ age of death_____	Major medical problems: Caused of death:
Siblings:	Alive Deceased	age_____ age of death_____	Major medical problems: Caused of death:
Children:	Alive Deceased	age_____ age of death_____	Major medical problems: Caused of death:
Children:	Alive Deceased	age_____ age of death_____	Major medical problems: Cause of death:
Children:	Alive Deceased	age_____ age of death_____	Major medical problems: Caused of death:
Children:	Alive Deceased	age_____ age of death_____	Major medical problems: Caused of death:

PREVENTATIVE MEDICAL HISTORY

Please indicate the date of last exam or vaccine:

Colonoscopy _____
Dexa Scan (bone scan)_____
Prostate exam_____
Flu Vaccine_____

T-Dap (tetanus)_____
Pneumonia vaccine_____
Shingles vaccine_____

Patient name:_____

Healthy Life Family Medicine

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Patient's Current Address: _____

Patient's Current Phone Number: _____ Email: _____

Previous/ Other Provider: _____

Address: _____

Office Phone: _____ Office Fax: _____

Release the Medical Records (PHI) to:

Healthy Life Family Medicine
750 N. Estrella Parkway Suite 40
Goodyear, AZ 85338

P: (623)889-3477
F: (623)889-3478

Description of Information to Be Disclosed: ( ) Physician Notes ( ) Complete Records ( ) Other: _____

Reason for requested information is continuity of medical care for the patient listed above.

Please Read and Sign Below

I understand the following:

1. I authorize the release of medical records to Healthy Life Family Medicine
2. I may revoke the authorization at any time by writing a written notice to the practice.
3. I may not be able to revoke this authorization if the practice has already acted utilizing this authorization, or if the authorization was obtained as a condition of obtaining insurance coverage.
4. The practice will not condition treatment or payment based on my signing this authorization.
5. I am signing this authorization freely; no one has pressured or coerced me to sign this authorization.
6. The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law or state law.
7. I am aware that I had an opportunity to review this authorization and understand its content.
8. I understand that I am entitled to a copy of this authorization at the time of its execution. If I declare a copy, I will make my request known.
9. I understand that the information may include information relating to sexually transmitted diseases, AIDS, HIV, Behavioral or Mental Services, treatment for alcohol and/or drug abuse.

_____ _____ _____

Patient/Guardian Signature **Relationship to Patient** **Date**

Healthy Life Family Medicine

Family Medical Release

I give consent to the family member and/or friend listed below for the following:

1. I give consent for anyone listed to be able to receive any messages regarding test results, consults, and/or prescription refills if I am unable to be reached.
2. I give consent for anyone listed to be able to discuss any billing issues and/or statements.
3. I give consent for anyone listed to be able to pick up any medical records and/or prescriptions that have been requested or ready for me.
4. I give consent for anyone listed (over the age of 18) to be able to bring in patient (if a minor) for their appointment and make medical decisions if necessary.
5. I have the right to deny anyone who is listed to obtain any information for me after signing off on this consent. I understand that I must contact Healthy Life Family Medicine, so this right will be in effect immediately.

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient/Guardian Signature **Date:**

Healthy Life Family Medicine Payment Policy

Thank you for choosing Healthy Life Family Medicine as your primary care provider. We are committed to providing you with quality and affordable health care. Our practice financial policy is as follows:

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is required at each visit. Knowing your insurance benefits is your responsibility. Contact your insurance company directly for any questions regarding your coverage. By signing this form you authorize Healthy Life Family Medicine to release the necessary information in order to complete and process your insurance claims.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company.

3. **Non-covered services.** I understand that some, and perhaps all, of the services I received may not be covered by my insurance or not considered reasonable or necessary by Medicare or other insurers. I agree to pay for any services which have been determined by my insurance plan to be "non-covered". Payment in full for these services is generally due at each visit.

4. **Updates.** Our staff will ask you to verify you're billing information at each and every visit. Current information is essential in order for us to contact you regarding your treatment and for obtaining timely payment from your insurance company.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. **Coverage changes.** If your insurance changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.

7. **Missed appointments.** You will be charged a $25.00 fee for any missed appointments if you do not notify us at least 12 hours prior to your scheduled appointment time. Help us to serve you better by keeping your regularly scheduled appointment.

8. **Returned checks (NSF).** You will be charged a $15.00 processing fee for any personal check returned for nonpayment.

9. **Form Completion**- Please note that any completion of forms for insurance purposes, short term disability, and FMLA leave require an appointment with one of our providers in order to be completed. There will be a $25.00 fee for any Short term disability or FMLA paperwork.

I have read and understand Healthy Life Family Medicine's payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Healthy Life Family Medicine Office Policies

Welcome to Healthy Life Family Medicine. Please take a moment to read our office policies in its entirety. If you require additional clarification or have questions about these policies, please contact our office at (623) 889-3477 and we will be happy to assist you.

Hours of operation- Our office is open Monday through Thursday 7am-7pm. Friday 7am-12pm. Saturday 8am -12 pm.

Phones- Phones are answered Monday through Thursday 7am-5pm. Friday 8 am-12 pm. Saturday 8am-12pm. Phones are forwarded to answering service M-T 12pm through 1pm for lunch.

Emergencies- For life threatening emergencies please call 911. Our practice has limited coverage for patient emergencies that may occur after hours. If a problem arises between 5:00 pm and 7:00 am on weekdays and anytime after 12pm Saturday through 7am Monday, please call our answering service at (602) 230-4836 and the answering service will contact the physician on call. Your call will be returned in a timely manner during these hours. **Please note that prescription refills and referrals are not considered emergencies and will not be done after hours.**

Test Results- Any laboratory or imaging testing done through our practice, you will be notified of the results as soon as they are available. All results **must first** be reviewed by the ordering physician.

Prescriptions- All prescription refills should be called into your pharmacy. Your pharmacy should then notify us of your request. For any routine medications this should be called in at least 2 weeks before running out. We do not refill antibiotics or controlled medications without a follow up appointment. Your provider reserves the right to refuse prescribing any treatment that is against our company policy, community standard of care, medical or state guidelines, or ethical concerns. Please allow 7 business days for your request to be processed. If a prior authorization is needed please know that it can take your insurance up to 14 business days to come to a decision.

Medical Records- It takes our office 30 business days to process medical records requests. Medical records will be released to any physician upon your written request and authorization.

Form Completion- Please note that any completion of forms for insurance purposes, short term disability, and FMLA leave require an appointment with one of our providers in order to be completed. There will be a $25.00 fee for any short-term disability or FMLA paperwork.

Referrals/Authorizations- Routine referrals may take up to 14 business days to be completed. If a specialist referred is not convenient, we will issue a second referral as a courtesy to our patient. Referrals needing a prior authorization from your insurance can take up to 14 business days from date of submission. If you're insurance requires a paper referral this requires you to come in to your PCP office so a referral can be issued. Please note that every situation is different, and we will try our best to make the process as easy as we can.

Account Balances- Account balances are to be paid in full, unless acceptable payment arrangements have been established with our billing office. Payments made to satisfy the account balance(s) will always be applied to oldest date(s) of service. It may be necessary for our business office to contact you regarding your bill. Phone calls are made to the phone number(s) that you provide on the patient registration form.

Dismissal- If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us as your provider(s). You will have to find a doctor in another practice.

Common Reasons for Dismissal

1. Failure to keep appointments and/or frequent no-shows
2. Non-compliance, which means you will not follow physician's instructions about an important health issue.
3. Abusive behavior towards the HLFM staff.
4. Failure to pay your bill.

Dismissal Process- We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on the letter, we offer you care. After, you **must** find another doctor. We will forward a copy of your medical records to your new doctor after you let us know who it is and sign a medical records release form.

I have read and understand HLFM office policies and agree to abide by their guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

I give consent to be contacted by Healthy Life Family Medicine through

☐ Email ☐ Text ☐ Phone

to remind me of any upcoming appointments, laboratory or imaging test results.

Healthy Life Family Medicine Health Portal

healow
Health And Online Wellness

Healow app can be accessed through your desktop computer as well as your mobile device. Provide our staff with an email address to sign you up for our health portal.

- View your medical history, labs, referrals and imaging reports.
- Request Refills
- Send direct messages to your provider

Email: _____

Please sign below acknowledging the email above is correct and that we may use it to activate your health portal account.

_____ _____

Patient signature **Date**

_____

Printed Name