



NEW PATIENT REGISTRATION FORM

Please complete thoroughly and accurately! All fields with (*) are REQUIRED. Any paperwork that is incompleated may cause delays in registration and response time and a registration representative may ask you to redo this form!

Patient Information

Last Name*: _____ First Name*: _____ MI: _____

Date of Birth*: _____ SSN*: _____ Sex: M ☐ F ☐

Phone #: _____ Email*: _____

Community Name(if not at home): _____ APT/RM# _____

Address*: _____ City*: _____ State: _____ ZIP: _____

Community Contact: _____ Phone #: _____

Emergency Contact

Responsible Party: Yes No

Last*: _____ First*: _____ Relationship: _____

Address*: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Cell #: _____ Work: _____

Email *: _____ POA: ☐ Yes(Attach) ☐ No

Secondary Emergency Contact (Not Residing with Patient)

Last: _____ First: _____ Relationship: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Cell #: _____ Work: _____

Email *: _____ POA: ☐ Yes(Attach) ☐ No

Primary Insurance Policy*

Name of Insurance: _____

Policy / Subscriber #: _____ Group#: _____

Claims Address/ Phone: _____

Secondary Insurance Policy

Name of Insurance: _____

Policy / Subscriber #: _____ Group#: _____

Claims Address/Phone: _____

Tertiary Insurance Policy

Name of Insurance: _____

Policy / Subscriber #: _____ Group#: _____

Claims Address/Phone: _____

Billing Information

Person Responsible for bill*: _____

Relationship to Patient: _____ Phone: _____

Email: _____ Billing Address: _____

Preferred Pharmacy*: _____ Preferred Home Health: _____

Last admission to hospital or SNF If YES, which Hospital/SNF? _____

in 30 days? YES/ NO Discharge Date? _____

Services Needed PCP Podiatry Psych Urgent ONLY TCM

AVC Med Representative:



CONSENT FORM

CONSENT FOR TREATMENT:

I recognize that I need medical services. I voluntarily consent to treatment by the medical staff of the practice, as deemed necessary in their judgment. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments, or tests. I understand that if major diagnostic studies or treatment procedures (such as surgery) are required, I will be asked to give specific consent for those events.

USE OF MEDICAL INFORMATION AND NOTICE OF PRIVACY PRACTICES:

I understand that, consistent with Arizona state and federal laws, Angels Valley Community Health Care Center PLLC (DBA 'AVC Med'), successors and assigns, (referred to as "Provider" from here on) will share all medical information as necessary for continuation of care and with any other institution or person as permitted by law. As an example, I understand that Provider does not have an in-house laboratory and uses an outsourced medical lab, and my lab work and personal information is shared to accomplish testing as required or requested. In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Provider will keep all of your health information confidential. Note that for the purposes of medical treatment (e.g. prescriptions, discussing your case with a consulting physician), payment (e.g. insurance paperwork which shows your diagnosis and corresponding diagnostic codes), health care operations (e.g. self auditing our medical records, quality improvement), and medico-legal considerations (e.g. medical examiners, law enforcement officials, public health authorities), your health information may be obtained or disclosed by telephone, e-mail, mail, or facsimile. The Practice may incorporate the limited summary of my health record it receives through State Health Information Exchange - HealthCurrent into the Practice's own clinical record. From then on the Practice may further disclose such information only in accordance with the rules that apply to it as a covered provider under HIPAA and 42 CFR Part 2.

I acknowledge that I have been provided with Provider* Notice of Privacy Practices. A copy of the Notice is available on our website; www.avcmed.com

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to Provider. I have read and fully understand, to my satisfaction, this entire document consisting of consent to treat and use of medical information. I may be asked to update my signatures and personal information annually or not less than once every three years. I am capable of signing this document on my own.

ATTESTATION:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Provider or insurance company to release any information required to process my claims.

CONSENT FOR PAYMENT:

I hereby authorize payment of medical benefits billed to my insurance to Provider Physicians; I have listed all health insurance plans from which I may receive benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all copayments, coinsurance, and deductibles at the time services are rendered. I also accept responsibility for fees that exceed the payment made by my insurance, if Provider Physicians does not participate with my insurance. I hereby authorize Provider physicians to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operation.

MEDICAL AND MEDICATION RECORD RELEASE AUTHORIZATION:

I hereby authorize the release of my medical records to Provider. The Provider requests only the following pertinent and succinct medical record information to be forwarded from other medical and health care providers: 1. Problem Lists, 2. Vaccination History, 3. Past and Current Medical History, 4. Past Surgical History, 5. Current Medications and Past Pertinent Medications, 6. Social History, 7. Allergic History, 8. Recent Physical Exam, 10. Pertinent and Recent Laboratory and Radiology Tests, 11. Additional pertinent information at the health care provider's discretion.

I understand that while this consent is voluntary, if I refuse to sign this consent. Provider can refuse to treat me. I understand the authorization can only be revoked in writing, if I revoke my consent, such revocation will not affect any action that Provider takes before receiving my revocation.

ATTESTATION:

I AM _____ responsible for Patient Name: _____

that will be informed of all medical decisions and visits:

POA NAME

Cellphone Number

Email Address

Address

Current/ Former PCP Name*

Current/ Former PCP Phone Number*

NOTE:

We require the patient's legal Power of Attorney to sign all new patient consent forms prior to treatment. In urgent cases we will attempt to contact the patient's POA by phone and fax documents if necessary; however we must have an original, hand written signature on file. Please sign this form and return the original to:

AVC Med 6739 W Cactus Rd Peoria, AZ 85345, USA. Or Return By Fax to 480-712-0799

PATIENT / Patient's Representative, or Patient's POA if applicable:

Signature*:

Printed Name:

Date:



INFORMED CONSENT FOR BEHAVIORAL HEALTH PROGRAM

Treatment Agreement.

I consent to receive mental health services by Angels Valley Community Health Care Center PLLC, including any or a combination of the following: evaluation, individual therapy, group therapy, psychological or neuropsychological testing, and medications. It's important that we develop a mutual treatment plan so that both parties know what we are working on and with whom we are working. Usually our first three sessions are understood as assessment sessions during which time we mutually decide on how we are going to work together. We need to decide what is the issue or diagnosis we are working with and what kind of interventions or treatment modalities will be best for you. If necessary we will refer you to our licensed clinical social workers for additional support, internal neuropsychologists for testing, or psychiatrists for medications.

You are expected to take an active role in therapy, which includes regular feedback to your therapist as to your progress, and also some assignments outside of the therapy hour. These might include journaling, thought and behavior tracking logs, practicing stress reduction techniques, practicing assertive communication skills or attending various support groups. The outside assignments are essential aspects of your treatment and failure to follow through may seriously impair my ability to be helpful to you. We will then have to reassess our treatment plan and decide if I can still be helpful to you. If you believe therapy is not working, please inform your personal psychologist and AVC Med. We will arrange to give you the service that works best for you. You are entitled to receive information about the methods of therapy, the techniques used, the duration of therapy, if known, and the fee structure. You may seek a second opinion from another therapist or terminate therapy at any time. Nevertheless, we recommend you give a two-week notice for termination.

During the course of treatment, you will either be seeing a psychologist, or a psychology doctoral intern. Please note that all interns are supervised by the supervising psychologist, and you may ask to meet the supervising psychologist should any issues arise.

Since openness is vital to successful therapy, we encourage you to discuss with these policies with us, prior to or during your treatment. Whenever you have a concern about any aspect of your treatment, please inform your personal psychotherapist and AVC Med. When you choose to participate in the Vibrant Living Program, various energy psychology modalities are used and will be explained as provided. It is always your right to refuse a modality. Treatment surveys will be provided for feedback.

Confidentiality.

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include:

1. Suspected abuse or neglect of a child, elderly person or a disabled person.
2. When we believe you are in danger of harming yourself or another person or you are unable to care for yourself.
3. If you report that you intend to physically injure someone, the law requires us to inform that person as well as the legal authorities. If we are ordered by a court to release information as part of a legal involvement.
4. When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc. In natural disasters whereby protected records may become exposed.
5. As required by the Patriot Act or when otherwise required by law.

When you registered with AVC Med, you should have signed a Release of Information so that we may speak with other healthcare professionals (such as your primary care physicians) or to family members to discuss about your health.

Record Keeping.

A clinical chart is maintained describing your counseling goals and progress, dates of and fees for sessions, and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the Confidentiality section above.

Fees & Payments.

When you registered with **AVC Med**, you should have read and signed a notice of billing and payments to any of your services offered by **AVC Med**.

Consultations via Telemedicine.

Sometimes, having a face-to-face meeting is not always possible. As such, with enough advance notice, we can and will facilitate a counseling session with you via telemedicine technology, equipped with both video and audio. The charge for this is the same as it would be for House Call or Clinic visit.

Cancellations and Missed Appointments.

Please reach out to our Scheduling Department at **623-322-6921** in case you want to adjust the scheduled appointments. Our therapists will only wait 15 minutes past our start time if you do not show up.

Cancellations and Missed Appointments.

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please contact your current therapist immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also call our line at **(833) 242-0100**, so our internal departments can help you.

PATIENT / Patient's Representative, or Patient's POA if applicable:

Signature*:

Printed Name:

Date:



CHRONIC CARE MANAGEMENT CONSENT FORM (CCM)

By signing this Agreement you consent to Angels Valley Community Health Care Center PLLC (DBA "AVC Med"), successors and assigns, (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.

When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights.

You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally (by calling (833) 242-0100) or in writing to 6739 W Cactus Rd Peoria, AZ 85345, USA. Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

PATIENT / Patient's Representative, or Patient's POA if applicable:

Signature*:

Printed Name:

Date:



TELEMEDICINE PROGRAM TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. **[Note:** The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all of my medical information may be used for teaching or educational purposes.

I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. **DECLINE _____ (initials of patient)**

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes. **DECLINE _____ (initials of patient)**

FOR DEMONSTRATIONS ONLY: I agree to permit other persons who are not involved in my medical care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation.

DECLINE _____ (initials of patient)

Signature of patient (or parent/guardian): _____ Date: _____

Please print the above name: _____

Signature of witness: _____ Date: _____



Consent for Remote Patient Monitoring Program

I hereby confirm that I am voluntarily seeking medical care and treatment from AVC Med, through its Remote Patient Monitoring program. I likewise confirm that I give voluntary permission to the medical and health staff of AVC Med to examine me, make diagnoses, and provide treatment (collectively, "healthcare services") to me in accordance with the information, explanations and recommendations they provided me. I further confirm that I freely agreed to avail of the remote patient monitoring (RPM) services of AVC Med and the use of the device for such service.

Patient Responsibilities Include:

- Provide complete and accurate information about your health, including present condition, past illnesses, hospitalizations, medications, natural products and vitamins, and any other matters that pertain to your health or work injury care plan
- Advising the physician of any pain you may be experiencing or continue to experience during your treatment. Actively participating in your treatment process, including but not limited to asking questions when you do not understand explanations about your care or services
- Respecting the rights of other patients and OTC personnel.
- Being responsible for your actions if you refuse treatment or do not follow the provider's instruction
- Provide complete and accurate information including your full name, address, telephone number, date of birth, Social Security number, insurance information and/or payment information, and employer when it is necessary. Provide us with a copy of your advance directive if you have one and want it to be part of our medical record. Abide by all clinic rules and regulations including NO SMOKING and No WEAPONS on the premises policy.
- Be considerate of the rights and comfort of all patients such as noise levels, privacy, and safety.
- Ask questions of your insurance company or our billing departments if there is a financial issue that you do not understand.

Patients have the following Rights:

- Not to be discriminated against because of race, religion, age, national origin, gender, sexual preferences, disability, marital status, or diagnosis.
- To receive treatment that supports and respects the patient's individuality, choices, strengths and abilities
- To personal privacy in treatment and care for personal needs;
- To have a safe and clean environment during your visit
- To review, upon written request, your own medical record per Arizona Revised Statutes 12-2293, 12-2294 and 12-2294.01.
- To know the name and professional status of caregivers providing services to you,
- To have your complaints reviewed and, when possible, resolved
- To receive a referral to another health care institution or provider if the OTC is unable to provide the health care services you need.
- To participate or to refuse care that involves research, experimental treatments, or educational projects
- To participate or have your representative participate in the development of, or decisions about your treatment. To receive assistance from a family member, representative or other individual in understanding, protecting or exercising your rights as a patient.

Patient or Patient Representative

Date

OTC Representative

Date

NEW PATIENT HEALTH INFORMATION

Name:		Date of Birth:		Today's Date:	
Prescriptions, Over the Counter Medications, and Supplements Include name, strength, number of pills and how often taken. Example: Ibuprofen, 200mg, 2 tablets, 2 times a day					
1.		8.			
2.		9.			
3.		10.			
4.		11.			
5.		12.			
6.		13.			
7.		14.			
Medical History (previous health problems)					
1.		7.			
2.		8.			
3.		9.			
4.		10.			
5.		11.			
6.		12.			
Drug Allergies or Intolerances: Yes / No Include medications you have tried in the past, which did not work for you. Example: Lisinopril: did not help lower blood pressure.					
1.	Reaction:	5.	Reaction:		
2.	Reaction:	6.	Reaction:		
3.	Reaction:	7.	Reaction:		
4.	Reaction:	8.	Reaction:		
Surgical History Please also list any implants you may have had, such as pins, plates, stents, pacemakers, augmentations.					
1.		5.			
2.		6.			
3.		7.			
4.		8.			
Hospitalizations Please include the name of the hospital, reason and duration of stay.					
1.		5.			
2.		6.			
3.		7.			
4.		8.			

NEW PATIENT HEALTH INFORMATION

Name:		Today's Date:	
General Health History			
Last Colonoscopy and Dr. Name:		Last Test for Hidden Blood in Stool:	
Last Dental Exam and Dr. Name:		Last ECHO:	
Last Eye Exam and Dr. Name:		Last EKG:	
Last Physical:		Last Foot Exam:	
Vaccine History			
Last Tetanus:			
Did the Tetanus vaccine include Whooping Cough/Pertussis: Yes / No			
Last Pneumovax:		Last Prevnar 13:	
Last Flu Vaccine:		Last TB Test:	
Last Shingles Vaccine:		Last Tdap:	
Please list names and dates of any other vaccines you may have had (e.g. Hepatitis B):			
Other information?			