Fountains Family Care
Dr. Richard Le D.O.
Phone: (480)-726-6632
Fax: (480)-726-3868

3930 S Alma School Rd Ste #1
Chandler, AZ 85248

2015 N Dobson Rd Ste #11
Chandler, AZ 85224

Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: □ Married □ Single □ Child Sex: _____ Age: _____

DOB: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Work Address: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Parent/Guardian Information (If under the age of 18)

Parent/Guardian Name: _____

Relationship to child: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: __ Age: _____ DOB: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Work Address: _____

Do You have an Advanced Directive? (Living Will)
□ Yes □ No If yes, please give name: _____
Relationship: _____

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Insurance Information

Primary Insurance (subscriber): _____

Insurance company: _____

Relationship to patient: _____ DOB: _____

Subscriber ID #: _____

Subscriber Employer or Plan Sponsor: _____

Group #: _____

Additional Insurance:

Relationship to Patient: _____ DOB: _____

Subscriber ID:_____

Subscriber Employer or Plan Sponsor: _____

Group #: _____

Secondary Insured (Subscriber): _____

Insurance Company: _____

Pharmacy:
Name: _____ Cross Streets: _____

Authorization and Release
I authorize my insurance company to pay Fountains Family Care P.C. all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. Fountains Family Care P.C. may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits for related services, as pertaining to the HIPPA guidelines.

Name: _____ Signature: _____ Date: _____

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Notice of Privacy Practices Forms

Dear Patient,

Physicians have always protected the confidentiality of health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This privacy rule protects health information that is managed by physicians, hospitals, other health care providers and health plans. As of April 14, 2003 we are compliant with the privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital and health plan will need to consider the privacy rule. All health information including paper records, oral communications and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. In addition we will be taking even more precautions in our office to safeguard your health information, such as training our employees and employing computer security measures. Please feel free to ask you physician or our privacy contact (Office Manager) about exercising your rights of how your health information is protected in our office.

This document contains very important information about how your protected health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our privacy officers (Office Manager) at (480)726-6632 to discuss any questions you may have.

Sincerely,

Dr. Richard Le D.O.

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Acknowledgement of Receipt of Our Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Fountains Family Care P.C. Notice of Privacy Practices. I have therefore been advised of how heath information about me may be used and disclosed by Fountains Family Care P.C. I have also been informed how I may obtain access to and control this information.

Print Name of Patient or Personal Representative: _____

Signature of Patient or Personal Representative: _____

Date: _____

- Please list who you want to have access to your pertinent medical information.
  (i.e. family member, spouse, significant other)
  - _____
  - _____
  - _____
  - _____

- May we leave a message on your answering machine? □ Yes □ No

- Preferred method of contact: □ Home □ Cell □ Work

  - Phone Numbers:
    - Home: _____
    - Cell: _____
    - Work: _____

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Financial Policy

Patient Name: _____ DOB: _____

Thank you for choosing Fountains Family Care P.C. as your health care provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.
All patients must read and sign this form prior to receiving services.

- It is your responsibility to provide us with your most current insurance information
- If you fail to provide accurate insurance information in a timely manor, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We must emphasize that as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level the level of services covered by your insurance company.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provide may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
- Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment however, is due in full at the time of service.
- We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- Co-payments, co insurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we received from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have pain your claim-regardless of our estimation.
- **It is your responsibility to provide us with your most current billing information.**
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe, If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement.
- **Payment in full is due upon receipt of the statement.** Patient balances not pain in full within in 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
- If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Fountains Family Care P.C. Failure to accept this certified letter (and/or pick it up at the post office) serves as notice of termination of services.
- In the event you submit payment by check and the bank returns the check unpaid for any reasons, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Arizona law.
- We may charge you're a "No Show" fee of $25.00 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment
- **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

Full payment is due at the time of service. We accept cash, checks and credit cards. By signing this, I attest that I have read and understood this Financial Policy.

Printed Name of Responsible Party: _____ Date: _____
Signature of Responsible Party: _____

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Authorization to Release Medical Information

To: _____

Address: _____

City/State/Zip: _____

Office Phone: _____ Fax: _____

I authorize _____ to release medical
(Name of place we are requesting records from)

information to Fountains Family Care P.C.

This information will be used for the purpose of:

□ Legal Reasons
□ Insurance
□ Personal Use
□ Continued Care
□ Workman's Compensation
□ Other: _____

Please send all medical records, lab results, x-rays, imaging and consultation reports.

I understand that I have a right to revoke the authorization at any time. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date: _____

If I fail to specify an expiration date, this authorization will expire in one year.

Patient name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

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Patient Intake Form

Name _____ Gender _____ Age _____ DOB _____

Reason for Visit: _____

_____

_____

Current Medications: (use back of page if needed)

Name	Dose	Frequency

Allergies:

Name	Reaction

Past Medical History:

□ Cancer
□ Diabetes
□ Heart disease
□ Hepatitis A, B, C
□ High Blood Pressure
□ High Cholesterol
□ Other _____

Hospitalizations/Surgeries:

Reason _____ Date _____
Reason _____ Date _____
Reason _____ Date _____

Family History:

□ Cancer
□ Diabetes
□ Heart Disease
□ Hepatitis
□ Other _____

Women Only:

# of Pregnancies _____ # Living children _____

Last Pap Smear _____ Last Mammogram _____

Social History:

- Are you sexually active? □ Yes □ No # of partners in last year: _____
- Do you wish to be checked for STDs? □ Yes □ No
- What is your occupation? □Work □ Student Type of work: _____
- Have you ever smoked? □ Yes □ No # of Years _____ #Packs per day: _____
- Do you smoke now? □ Yes □ No #Packs per day: _____
- Do you use recreational drugs? □ Yes □ No
- How much alcohol do you drink in one week? _____
- How much caffeine do you drink in one day? _____
- How often do you exercise? _____