Centra Internal Medicine

Manish Sahni, MD
13000 N 103rd AVE.
STE 59- Sun City, AZ 85351
P: (623) 594-4126 F: (623) 594-4127

Name: ________________________________ **Date of Birth:** ____________

Address:________________________________ City/Zip: ______________

Home phone:____________________ Cell:________________

Social Security Number:______________ Email Address: ____________________
Gender: Female Male
Marital Status: Married Single Widowed Divorced

Race: Caucasian Hispanic African American Asian American Indian/Alaskan
Native Hawaiian/Other Other: ______________ Refused by Patient
Ethnicity: Hispanic Origin Not of Hispanic Origin Refused by Patient

Preferred Language: ____________________
Retired Employee Employer ____________________
Work phone: ________________

Do you have an advanced directive (living will)? YES, NO
Preferred Pharmacy (Phone number and cross streets/ address):

____

Emergency Contact
Name:______________ Relationship:____________ Telephone:__________

How did you hear about us? ______________________________

Primary: Insurance Company : ______________________________

ID#____________ Group#____________ Policy Holder Name: ______________

DOB : __________ Relationship to Insured: ______________
Secondary: Insurance Company: ______________________________

ID# ___Group#______ Policy Holder Name:__________________
DOB: __________ Relationship to Insured: ____________________

INSURANCE PAYMENT/FINANCIAL RESPONSIBILTY RELEASE

I request that payment of authorized Medicare benefits, or any other insurance benefits be made to either me or on my behalf to Centra Internal Medicine for any services furnished to me by the Physician/Provider. I authorize any holder of medical information concerning me to be released to my insurance carrier or health care financing, its agents, any information needed to determine these benefits or the benefits payable for related services. A photocopy of this authorization shall be considered effective and valid as the original.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY.

Signature: ____________________ Date: ____________

Notice of Privacy

To *Our Patients:* This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

- € We realize that these laws are complicated, but we must provide you with the following Important information
- € Our practice Is dedicated to maintaining the privacy of your health Information. We are required by law to maintain the confidentiality of your health information.

Use and disclosure of your health Informatlon in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required by a law enforcement official.

4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For workers Compensation and similar programs.

Your rights regarding your health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests

2. You can request a restriction of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health Information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to Inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.

4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing.

5. Right to copy this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You

may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator.Allcomplaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy

Signature ____________________ Print Name: ________________ Date: ________

Notice to Patients:

- ALL insurance copays are due at the time of service.

Please List Medications Below

Medication day or 90-day supply)	Dose Directions	Quantity (30

Allergies

Please list anything that you are allergic to (Medications, food, Bee Stings, Etc.) and how it affects you.

Allergies and Reactions **Reaction**

1. ______________________________
2. ______________________________
3. ______________________________
4. NO KNOWN DRUG ALLERGI E

PERSONAL MEDICAL HISTORY

GENERAL MEDICAL HISTORY

☐Yes ☐No Alcoholism
☐Yes ☐No Allergies/Hay fever
☐Yes ☐No Anemia
☐Yes ☐No Anxiety
☐Yes ☐No Asthma
☐Yes ☐No Atrial Fibrillation
☐Yes ☐No Blood Transfusions
☐Yes ☐No CAD
☐Yes ☐No Cancer
☐Yes ☐No Cardiac Pacer
☐Yes ☐No Cardiovascular Disease
☐Yes ☐No CHF
☐Yes ☐No Cirrhosis
☐Yes ☐No Colitis
☐Yes ☐No COPD
☐Yes ☐No CRF
☐Yes ☐No Crohn's Disease
☐Yes ☐No CVA
☐Yes ☐No DVT
☐Yes ☐No Depression
☐Yes ☐No Diabetes Type 1
☐Yes ☐No Diabetes Type 2
☐Yes ☐No Epilepsy
☐Yes ☐No Fracture
☐Yes ☐No Gastric Ulcer
☐Yes ☐No Gastrointestinal Disease
☐Yes ☐No GERD
☐Yes ☐No Gestational Diabetes
☐Yes ☐No Glaucoma
☐Yes ☐No Heart Murmur
☐Yes ☐No Hepatitis
☐Yes ☐No High Cholesterol
☐Yes ☐No Hyperlipidemia
☐Yes ☐No Hypertension
☐Yes ☐No Hyperthyroidism
☐Yes ☐No Hypothyroidism
☐Yes ☐No Insulin Pump
☐Yes ☐No Joint Pain
☐Yes ☐No Kidney Infections
☐Yes ☐No Kidney Stone
☐Yes ☐No Migraine
☐Yes ☐No Multiple Sclerosis
☐Yes ☐No Obesity
☐Yes ☐No Old MI
☐Yes ☐No Osteoarthritis
☐Yes ☐No Osteoporosis
☐Yes ☐No Pneumonia
☐Yes ☐No Progressive Neurological Disorder
☐Yes ☐No Pulmonary Disease
☐Yes ☐No Rheumatic Fever
☐Yes ☐No Rheumatoid Arthritis
☐Yes ☐No STD
☐Yes ☐No Terminal Illness
☐Yes ☐No Thyroid Disease
☐Yes ☐No TIA
☐Yes ☐No Tuberculosis
☐Yes ☐No Valvular Problems

HOSPITALIZATIONS

____

____

Social History

Smoking Status (Circle below)

1. Current Every day Smoker
2. Former Smoker
3. Heavy tobacco Smoker
4. Light tobacco Smoker
5. Smoker current status unknown
6. Unknown if ever smoked.
7. Never smoked

☐Yes ☐No counseling on tobacco cessation ☐Yes ☐No Tobacco User

☐Yes ☐No RX therapy for tobacco cessation

# of packs per days/ for how many years______________
Smoked for how long____________
Date Quit Smoking___________

Alcohol use

1. Non-Drinker
2. Occasional
3. Social Drinker
4. Moderate alcohol consumption
5. Heavy alcohol consumption
6. Recovering alcoholic
7. Beer drinker
8. Wine drinker
9. Never Drank
10. Alcohol Discontinued

Caffeine Use: servings per day (circle one) 0 1 2 3 4+ occasional

Drug use: Type ______________________________________ **Status:** 1.Ocassional 2. Daily 3. Prior use

SURGICAL / PROCEDURES

- ☐ No prior surgical history
- ☐ Appendectomy
- ☐ Breast Lumpectomy
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Cone Biopsy
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Gall Bladder
- ☐ Heart Surgery
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Joint Replacement
- ☐ Laparoscopy
- ☐ Mastectomy
- ☐ Myomectomy
- ☐ Oophorectomy
- ☐ Ostomy
- ☐ Splenectomy
- ☐ Tonsil/ Adenoidectomy
- ☐ Tubal Ligation

Other Surgical History ______________________________

____

HISTORY OF MOTHER

☐ Living ☐ Deceased ☐ Age _____ ☐ In good health
☐ Adopted

- ☐Yes ☐No Alcoholism
- ☐Yes ☐No Anemia
- ☐Yes ☐No Anxiety
- ☐Yes ☐No Asthma
- ☐Yes ☐No Birth Defects
- ☐Yes ☐No CAD
- ☐Yes ☐No Cardiovascular Disease
- ☐Yes ☐No CHF
- ☐Yes ☐No Cancer
- ☐Yes ☐No Congenital Anomaly
- ☐Yes ☐No COPD
- ☐Yes ☐No Crohn's Disease
- ☐Yes ☐No Depression
- ☐Yes ☐No Diabetes
- ☐Yes ☐No Epilepsy
- ☐Yes ☐No GERD
- ☐Yes ☐No High Cholesterol
- ☐Yes ☐No Hyperlipidemia
- ☐Yes ☐No Hypertension
- ☐Yes ☐No Hypothyroidism
- ☐Yes ☐No Kidney Disease
- ☐Yes ☐No Liver Disease
- ☐Yes ☐No Multiple Births
- ☐Yes ☐No Osteoarthritis
- ☐Yes ☐No Osteoporosis
- ☐Yes ☐No Pulmonary Disease
- ☐Yes ☐No Stroke

Type of Cancer ______________________________
Other Conditions ______________________________

FAMILY HISTORY OF FATHER

☐ Living ☐ Deceased ☐ Age _____ ☐ In good health
☐ Adopted

- ☐Yes ☐No Alcoholism
- ☐Yes ☐No Anemia
- ☐Yes ☐No Anxiety
- ☐Yes ☐No Asthma
- ☐Yes ☐No Birth Defects
- ☐Yes ☐No CAD
- ☐Yes ☐No Cardiovascular Disease
- ☐Yes ☐No CHF
- ☐Yes ☐No Cancer
- ☐Yes ☐No Congenital Anomaly
- ☐Yes ☐No COPD
- ☐Yes ☐No Crohn's Disease
- ☐Yes ☐No Depression
- ☐Yes ☐No Diabetes
- ☐Yes ☐No Epilepsy
- ☐Yes ☐No GERD
- ☐Yes ☐No High Cholesterol
- ☐Yes ☐No Hyperlipidemia
- ☐Yes ☐No Hypertension
- ☐Yes ☐No Hypothyroidism
- ☐Yes ☐No Kidney Disease
- ☐Yes ☐No Liver Disease
- ☐Yes ☐No Multiple Births
- ☐Yes ☐No Osteoarthritis
- ☐Yes ☐No Osteoporosis
- ☐Yes ☐No Pulmonary Disease
- ☐Yes ☐No Stroke

Type of Cancer ______________________________
Other Conditions ______________________________

Centra Internal Medicine

13000 N 103rd AVE.
STE 59- Sun City, AZ 85351
P: (623) 594-4126 F: (623) 594-4127

FINANCIAL POLICY CENTRA INTERNAL MEDICINE

At Centra Internal Medicine we believe in delivering exceptional patient care. However, our professional services are rendered to you, not your insurance company; therefore, payment for treatment is your responsibility. We are committed to navigating with you to get you your best allowed coverage.

Please notify us of any change in your insurance, address, place of employment, phone number, etc. when you arrive and before you see your physician or have any testing. Failure to notify us of these changes will result in you being responsible for the bill.

You may use cash, check, Master Card, Visa, Discover to charge current services or any outstanding balance on your account.

Payment Responsibility:The patient or his legal representative is ultimately responsible for all charges incurred. We do not have a contract with your insurance company. It is your responsibility to know and understand your insurance. We will do the best job we can to help you understand or direct you to the information, however we are not responsible for verifying that your insurance is an "in-network "participant.

Self-Pay Patients: For patients that do not have insurance, payment in full is due at the time of service. We offer discount for all self-pay patients who pay at the time of service.

Co-Pays/Patient Balance: Your balance and co-pay is due at time of service. You may be asked to reschedule your appointments if you are not prepared to pay your co-pay.

Physicals: We recommend that you have a physical once a year, but it is your responsibility to clarify with your insurance if these services are covered with your health plan.

Non-covered Services: Payment for all charges which are not covered by insurance is due and payable at the time ofservice

Prior Unpaid Accounts: Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements be approved by the Practice Administrator.

Collection Agency:Accounts which cannot be collected by Centra Internal Medicine after normal in-house collection Procedures may be referred to a collection agency, for further collection action. Any fees incurred will be patient's responsibility. If your account has been sent to collection, we will not be able to see you in the office until your balance is paid in full.
Forms: There will be a $10.00 fee due, at the time of request, associated with simple/one page forms that need to be completed by the physician or office staff. For longer/complex forms, the fee charged will be $25 and will be due at the time of request. Allow 5-7 business days for the forms to be completed. All forms will be filled at the discretion of the provider

Lab Orders: It is your responsibility to check with your insurance company to confirm the coverage for your lab work. Physicians will order lab work but not guarantee that your insurance company will cover

them.

Auto Insurance: We will bill your Attorney for auto-accident or other liability or lawsuit related case. You are responsible for payment if you do not have any of the above stated coverage. We will need all information associated with the claim to bill your carrier.

Worker's Compensation: If your injury is work related, we will need the case number and carrier name prior to your visits in order to bill the Worker's compensation insurance company.

Patient Acknowledgement: I have read, understand and agree to the above financial policy.

Patient Signature: ______________________________ Date: ______________

Consent for release of Protected Health Information

Centra Internal Medicine

Name of person or individual: ____________DOB:________________

Social Security Number ________________________________

I consent to the release of protected health information that is required to carry out treatment, or for payment of healthcare operations on my behalf.

I have received a copy of the Notice of Privacy practices and am aware of the following:

- I have the right to place restrictions on the way my PHI is used or disclosed.
- I understand that once Centra Internal Medicine agrees to my restrictions; it must comply with these restrictions.
- I have a right to revoke my consent for use and disclosure of my PHI at any time. I understand that, if I chose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Centra Internal Medicine must immediately comply with my request to revoke consent, except to the extent that it has already taken some action based on my original consent.
- Centra Internal Medicine has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the notice accordingly; and we will inform you, placing the amendment date at the bottom of the posted notice.

I understand that on occasion Centra Internal Medicine may need to contact me concerning health matters. On these occasions I give permission to speak to another Authorized party.

YES ☐ NO ☐

Name of Authorized Entity or Person(s) to Receive

________________________ ____

Information: Name Date of Birth

________________________ ____

Name Date of Birth

____

Name of patient or Personal Representative (Type/Print)

____ ______________________

Signature of Patient or Personal Representative Date

____

Description of Personal Representative 's Authority