3075 N Windsong Dr Ste B1
Prescott Valley, AZ 86314

FAMILY 1ST PRIMARY CARE

p: 928-350-8780
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www.family1stcc.com

Please complete form in its entirety

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Date of Birth:

Mailing Address: Apt #

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Email Address: Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Sex: ☐ Male ☐ Female ☐ Transgender

Social Security #:

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____

Employer Name:

Emergency Contact Name and Phone:

Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip:

Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Race (please select):

☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Member ID & Group #:	Member ID & Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Name: _____ **Allergies** _____

Please list ALL medications you are currently taking, prescribed and or over the counter. Please try and be as specific as possible.

Medication	Dosage	Route	Frequency

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

SOCIAL / CULTURAL HISTORY:

Are there any vision problems that affect your communication? ☐ Yes ☐ No

Are there any hearing problems that affect your communication? ☐ Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐Never Type:_____Amount/day:_____Number of Years: _____

Alcohol: ☐Current ☐Past ☐Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature _____

ALLERGY INTAKE FORM

Name_____ Date of Visit: _____

Do you have any of the following symptoms?

SNEEZING ITCHY AND/OR WATERYEYES SCRATCHYTHROAT CONGESTION CHRONIC COUGH
FATIGUE RESTLESSNESS POST NASAL DRIP JOINT PAIN ITCHYDRY SKIN HIVES RUNNY NOSE
OTHER_____
_____

How long have you had these symptoms? _____

Do you frequently get sinus infections, colds, flu or a runny nose? _____

Have you been diagnosed with Asthma? If yes, is it controlled? YES NO

Are you interested in discussing an allergy test with your provider? YES NO

Patient Name: _____Date: _____

Patient Signature: _____

****Consent to Treat Including Telemed****

I do hereby agree and give my consent to the physician at Family 1st Primary Care to furnish medical care, examination, routine testing and or treatment considered necessary and proper in diagnosing or treating my medical condition as the providers of the practice deem necessary. I understand my physician may utilize a nurse/Medical assistant to assist with my plan of care.

****TELEHEALTH****

Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Client health records
- Live two-way audio and video
- Output data from health devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by enabling a client to remain in his/her provider's office (or at a remote site) while the providers obtains test results and consults from practitioners at distant/other sites.
- More efficient client evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;
- In rare cases, a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

**** ACKNOWLEDGMENTS OF CONSENT TO TREAT AND THE USE OF TELEHEALTH ****

I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

By signing below; you the patient or your representative, acknowledge that you have received a copy of your CONSENT TO TREAT AND THE USE OF TELEHEALTH from Family 1st Primary Care at time of service.

Print Name:_____

Signature: _____DATE: _____

Patient Rights

R9-10-1008. Patient Rights

1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:

a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:

1. A patient is treated with dignity, respect, and consideration;
2. A patient as not subjected to:

a. Abuse;
b. Neglect;
c. Exploitation;
d. Coercion;
e. Manipulation;
f. Sexual abuse;
g. Sexual assault;
h. Except as allowed in R9-10-1012(B), restraint or seclusion;
i. Retaliation for submitting a complaint to the Department or another entity; or
j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and

3. A patient or the patient's representative:

a. Except in an emergency, either consents to or refuses treatment;
b. May refuse or withdraw consent for treatment before treatment is initiated;
c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
d. Is informed of the following:
i. The outpatient treatment center's policy on health care directives, and
ii. The patient complaint process;
e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
i. Medical record, or
ii. Financial records.

C. A patient has the following rights:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;

3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

****ACKNOWLEDGMENTS OF PATIENTS RIGHTS & RESONSIBILITIES****

By signing below; you the patient or your representative, acknowledge that you have received a copy of your patient rights from Family 1st Primary Care at time of service.

Print Name:_____

Signature:_____Date:_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14th, 2003. Many of the policies have been in our practice for years. This form is a friendly version. A more complex text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as a patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. HHS.gov. We have adopted the following policies:

1. Patient information will be kept confidential: except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies as patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily. In administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records. PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, US mail, or by any means convenient for the practice and or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws. 8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. We have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI, however, we are not obligated to alter internal policies to conform to your request. I on (date) do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

10. I acknowledge receipt & have read and understand health information practices regarding my providers participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

I (print name)_____ on (date)_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____ Date:_____

Family 1" Primary Care Financial Policy & No-Show Fee

Thank you for choosing Family 1" Primary Care. We are committed to providing our patients with the highest quality primary care. This financial policy is an important part of your healthcare. Due to increased insurance company demands, we ask you to read and agree to the following:

We make every attempt to accept a wide range of insurance plans. For the patient's convenience, we file your claim(s) with insurance plans with which we have an agreement, as long as valid Insurance information is provided to us. However, all policies have different benefits, and we cannot know the specific details of each individual policy. It is the patient's responsibility to know their Individual policy and to verify all benefits and coverage Information prior to having any services rendered. **Also, the patient is responsible for notifying us of any changes to his or her insurance plan or policy prior to his or her visit.** If you are working with an attorney for a personal injury case, please be notified that you will be required to sign lien paperwork and this will be filed with the County Clerk's office. If you filed a worker's comp claim you must provide Family 1" Primary Care this Information before any services can be provided, failure to do so will result in you getting a bill for services.
Co-pays and Deductibles: Insurance policies are an agreement between the patient and his or her insurance company. Contracting with health insurance companies requires us to collect co-pays and deductibles. The patient must pay this amount prior to having services provided.

Additional Fees: If the patient does not have medical insurance or if Family 1? Primary Care is not a contracted provider with his or her insurance carrier, all charges will be due and payable at time of service. A $35.00 charge will be applied to all checks returned. Additionally, **if a patient no-show an appointment or fails to cancel their appointment within 24 hours of their scheduled appointment time it will result in the patient being charged a $35.00 no-show fee.** Regardless of the type of insurance you have, this fee will be accessed to your account if you fail to provide us with 24-hour notice when cancelling or rescheduling your appointment.

Timely payment: If for any reason the patient incurs an account balance, we will mail a statement. Payment is due from the patient upon receipt of the first statement from our office. If the balance is not paid in full, Family 15 Primary Care reserves the right to send the patients account to collections and an additional 35% collection fee will be added. Please be aware that any delinquent account balance may prohibit the patient from scheduling future appointments.

Payment plans: If for any reason you require a payment plan, we require 1/2 of your estimated balance to be paid up front and then your monthly payments will be auto debited from the debit/credit card of your choice on the date that you delegate us to process your payment. If you fail to honor your scheduled payment the entire balance will be come due and expected to be paid within 10 days. Your card information will be stored in our secured credit card system that cannot be duplicated or used in any fraudulent manner. Family 1st Primary Care adheres to all federal compliance regulations as part of our merchant agreement with the bank.

Your cooperation with this agreement will help us contribute to overall lowering the cost of medical care in our community.

I have read and understand the Family 1" Primary Care financial policy. I understand the financial policy is retroactive for any and all services provided to patients by Family 1" Primary Care prior to the date this policy was signed. I authorize Family 1" Primary Care to obtain and/or release medical information necessary for filing insurance claims on my behalf. I assign all benefits to which the patient or insured is entitled for my services provided to me to be paid directly to Family 1? Primary care. Should Insurance payment be made directly to the insured, I agree to immediately pay these funds to Family 1? Primary Care.

Patient Name_____
(Please print)
Signature: _____ Date: _____

BILLING CONSENT

As a courtesy to you, we will submit your health care services to your insurance company using the benefit explanation provided to our office during our verification process. However, benefits quoted to our office are not a guarantee of payment; therefore, if your insurance carrier does not pay, you will be responsible for the payment of your account.

If your insurance has not paid the submitted charges within 60 days from the date of service, it then becomes your responsibility to pay your account in full. It is your responsibility to contact your insurance company regarding the status of your claim.

I authorize Family 1st Primary Care to release my records or other information necessary to process my claims. I authorize direct payment of my medical benefits to Family 1st Primary Care.

I, _____ attest by my signature below that I
(Print name)
understand and accept the policy of Family 1st Primary Care.

Patient/Guardian Signature:_____Date:_____