WELCOME TO PALO VERDE INTERNAL MEDICINE

PATIENT INFORMATION AND RELEASE INFORMATION

PATIENT INFORMATION (Please Print Clearly)

Full Name (First, Middle Initial, Last):	
Local Address:	Birth Date: / / / Sex: M F
City/State/Zip:	SS#:
Mailing Address: _____	Home Phone: ( ) _____
_____	Cell Phone: ( ) _____
Patients Employer:	Work Phone: ( ) _____
Employment Address:	Drivers License #
Spouse Name:	Birth Date: / / / Sex: M F
Occupation/Employer:	Work Phone#:
Emergency Contact (other than spouse)	Relation:
Address:	Phone #

INSURANCE INFORMATION

Is Medicare Your Primary Ins.? ◯ Yes ◯ No	Do you have an HMO? ◯ Yes ◯ No
Primary Ins.:	Secondary Ins.:
Name of Insured (if other than Patient):	Relation to Patient:
Birth Date of Insured: / / /	SS# of Insured:

ALL PATIENTS: If you have insurance that we are contracted with, we will file your claims for our reimbursement; if we do not have a contract with your insurance we will file the claim for your reimbursement. We will than wait 45 days for the insurance company to remit payment, IF it is not paid within this time, you will need to contact your insurance company to expedite payment and make regular payments until such time as the claim is paid in full. In case of financial hardship, please make arrangements with our billing office prior to seeing the doctor.

WE WILL NOT FILE INSURANCE CLAIMS UNLESS WE HAVE A COPY OF YOUR INSURANCE CARD WITH THE COMPLETE ADDRESS, PHONE NUMBER AND ID NUMBER.

WE DO NOT FILE SUPLEMENTAL CLAIMS UNLESS IT IS AN INSURANCE COMPANY THAT WE PARTICIPATE WITH.

Please initial: _____

Thank you! We appreciate your patronage and your patience. Please make sure you have completed all questions on the first page. This will enable this office to file your insurance claims with correct information. Incorrect information will result in a denied claim. It will than become your responsibility to re-file with your insurance company and your responsibility to pay.

PERSONAL HEALTH HISTORY

PATIENT NAME: _____ **DATE:** _____

REASON FOR YOUR VISIT TODAY:

_____

_____

_____

PAST HISTORY

Have you had any of the following illnesses?

	YES	NO		YES	NO		YES	NO
Coronary Artery Disease	( )	( )	Osteoporosis	( )	( )	Lung Cancer	( )	( )
Myocardial Infarction	( )	( )	Osteopenia	( )	( )	Breast Cancer	( )	( )
Atrial Fibrillation	( )	( )	Osteoarthritis	( )	( )	Melanoma	( )	( )
Aortic Stenosis	( )	( )	Rheumatoid Arthritis	( )	( )	Colon Cancer	( )	( )
Carotid Stenosis	( )	( )	Gout	( )	( )	Prostate Cancer	( )	( )
Hypertension	( )	( )	Asthma	( )	( )	Anemia	( )	( )
Chronic Kidney Disease	( )	( )	COPD	( )	( )	Parkinson's Disease	( )	( )
Diabetes Type I	( )	( )	Hypothyroidism	( )	( )	Other:		
Diabetes Type II	( )	( )	Seizures	( )	( )	_____		
Stroke	( )	( )				_____		

SURGERIES

Approximate Date

1.) _____
2.) _____
3.) _____
4.) _____

MEDICATIONS

Dosage

How many Per DAY

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____
6.) _____
7.) _____

Are you ALLERGIC to any medications? YES ( ) NO ( )

If YES, please list medications and the reactions you have had to them:

_____
_____
_____
_____

PATIENT NAME: _____ DOB: _____

PERSONAL HABITS

Did you ever smoke? YES ( ) NO ( )

( ) Cigarettes: Pack per day _____

( ) Pipe ( ) Cigars

How long have you been smoking? _____ yrs. When did you stop? _____

Do you drink ALCOHOL? YES ( ) NO ( ) Quantity: _____ Daily Weekly Monthly

REVIEW of SYSTEMS

GENERAL:	YES	NO
Do you usually feel tired or worn out	( )	( )
Do you feel depressed a lot of the time	( )	( )
Have you been drinking more fluids	( )	( )
Have you noticed that warm weather brothers you	( )	( )
Has there been any unusual weight gain or loss	( )	( )
SKIN:		
Have you noticed:		
Change in the color of your skin	( )	( )
Skin rashes or itching	( )	( )
Unusually dry skin	( )	( )
Growths on your skin that bother you	( )	( )
Sores or wounds that do not heal	( )	( )
Change in color or size of warts	( )	( )
ENT:		
Do you have:	( )	( )
Any trouble hearing	( )	( )
Ringing or buzzing in your ears	( )	( )
Frequent or severe nosebleeds	( )	( )
Persistent hoarseness	( )	( )
A lump in your throat	( )	( )
A sore tongue or mouth	( )	( )
Bleeding gums	( )	( )
RESPIRATORY:		
Do you have:		
A constant or bothersome cough	( )	( )
Coughing up blood	( )	( )
Difficulty breathing	( )	( )
Noticed any wheezing	( )	( )
CARDIOVASCULAR:		
Do you have pain, tightness or pressure in your chest	( )	( )
Do you have swelling in your feet	( )	( )
Does your heart ever beat fast or irregular	( )	( )
Do you have cramps in the calf muscle when you walk	( )	( )
Do you ever awaken at night with severe difficulty breathing	( )	( )

GASTROINTESTINAL:	YES	NO
Any changes in your eating habits?	( )	( )
Are there any foods that cause you to have Stomach pains, nausea etc?	( )	( )
Any trouble swallowing	( )	( )
Do you have indigestion or heartburn	( )	( )
Do you have frequent diarrhea	( )	( )
Have you ever passed blood or tarry stool	( )	( )
Any recent change in bowel movement	( )	( )
GENITOURINARY:		
Do you have:		
Burning or pain when you urinate	( )	( )
To get up to urinate at night	( )	( )
Trouble losing urine when you cough or sneeze	( )	( )
Dribbling urine	( )	( )
Have you ever passed blood in your urine	( )	( )
MEN, do you have Prostate Gland trouble	( )	( )
MUSCULOSKELETAL:		
Do you have a problem with back pain	( )	( )
Do you have joint pain or stiffness	( )	( )
Do you have trouble walking or using your hip Or knee joints	( )	( )
CENTRAL NERVOUS SYSTEM:		
Do you have frequent or severe headaches	( )	( )
Do you often have spells of dizziness or faintness	( )	( )
Have you ever seen double	( )	( )
Do you have numbness or tingling in your head, arms or legs	( )	( )
Do you have trouble remembering recent events	( )	( )
Do you consider yourself a nervous person	( )	( )
Do you cry a lot for no reason	( )	( )
WOMEN ONLY		
Are your menstrual periods irregular	( )	( )
Do you pass clots with your period	( )	( )
Have you passed menopause or the change	( )	( )
Do you have hot flashes	( )	( )
Have you had any lumps in your breasts	( )	( )

STRUCTURED FAMILY HISTORY

Check ALL that apply...

Pt. Name: _____ DOB: _____ Chart #: _____

MOTHER	FATHER	BROTHER	SISTER
Alive _____ Age _____ Deceased _____ Age: _____ Cause of Death _____ Lung CA _____ Colon CA _____ Breast CA _____ Ovarian CA _____ Heart Disease _____ Stroke _____ Diabetes _____ Hypertension _____ High Cholesterol _____ Unknown _____ Other _____	Alive: _____ Age _____ Deceased _____ Age: _____ Cause of Death _____ Lung CA _____ Colon CA _____ Prostate CA _____ Heart Disease _____ Stroke _____ Diabetes _____ Hypertension _____ High Cholesterol _____ Unknown _____ Other _____	Alive: _____ Age: _____ Deceased _____ Age: _____ Cause of Death _____ Lung CA _____ Colon CA _____ Prostate CA _____ Heart Disease _____ Stroke _____ Diabetes _____ Hypertension _____ High Cholesterol _____ Unknown _____ Other _____	Alive: _____ Age: _____ Deceased _____ Age: _____ Cause of Death _____ Lung CA _____ Colon CA _____ Breast CA _____ Ovarian CA _____ Heart Disease _____ Stroke _____ Diabetes _____ Hypertension _____ High Cholesterol _____ Unknown _____ Other _____
Paternal Grandmother (Fathers Mother) Alive _____ Age _____ Deceased _____ Age: _____ Cause of Death _____ Cancer _____ Stroke _____ Unknown _____ Paternal Grandfather (Fathers Father) Alive _____ Age _____ Deceased _____ Age: _____ Cause of Death _____ Cancer _____ Stroke _____ Unknown _____	Maternal Grandmother (Mothers Mother) Alive: _____ Age _____ Deceased _____ Age: _____ Cause of Death _____ Cancer _____ Stroke _____ Unknown _____ Maternal Grandfather (Mothers Father) Alive _____ Age _____ Deceased _____ Age: _____ Cause of Death _____ Cancer _____ Stroke _____ Unknown _____	Son(s): _____ Alive: _____ Age: _____ Deceased _____ Age: _____ Cause of Death _____ Lung CA _____ Colon CA _____ Prostate CA _____ Heart Disease _____ Stroke _____ Diabetes _____ Hypertension _____ High Cholesterol _____ Unknown _____ Other _____	Daughter(s): _____ Alive: _____ Age: _____ Deceased _____ Age: _____ Cause of Death _____ Lung CA _____ Colon CA _____ Breast CA _____ Ovarian CA _____ Heart Disease _____ Stroke _____ Diabetes _____ Hypertension _____ High Cholesterol _____ Unknown _____ Other _____

PLEASE READ CAREFULLY, SIGN and DATE WHERE APPLICABLE

AGREEMENT FOR PAYMENT and RECORDS RELEASE

I acknowledge full financial responsibility for medical services and I agree to pay in full at the time of service or make prior arrangements for payment. I acknowledge that it is my responsibility to verify that all prior authorizations have been obtained for all scheduled doctors' appointments, procedures and medications as required by my insurance plan.

If my account is placed in collections; I acknowledge responsibility for associated collection expenses (a $25.00 collection fee will be added to my balance turned over to the collection agency). Once your account has been turned over to collections you will no longer be seen at our office until the debt is satisfied. There will be a $25.00 charge for all returned checks.

I agree to the payment conditions outlined above and I understand that any overpayment will be returned to me.

Signature: _____ Date: _____

CONDITIONS FOR FILING INSURANCE and PAYMENT RESPONSIBILITY

MEDICARE PATIENTS: Palo Verde Internal Medicine accepts Medicare assignments. Medicare pays 80% of the allowable charges; you are responsible for the deductible and co-insurance amounts. Medicare has a yearly deductible starting January 1st. The co-insurance is 20% of the Medicare allowable. YOU WILL BE RESPONSIBLE FOR NON-COVERED SERVICES.

We file supplemental insurance claims for Medicare patients as a courtesy, we will file one claim with your supplemental insurance and wait 30 days for payment. At that time the arrangements can be made for regular monthly payments. Any follow-up with the Insurance companies is the responsibility of the patient.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. Other primary insurance companies, HMO'S or automobile policies. (Section 112B of the Social Security Act and 31 U.S.C. 3801 – 3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignments of benefits also apply.

Signature: _____ Date: _____

HIPAA PRIVACY PATIENT REQUEST FORM CONFIDENTIAL COMMUNICATION

I acknowledge that I have been given the opportunity to read Palo Verde Internal Medicine PLLC's Notice of Privacy Practice.

Requests for Confidential Communications: I hereby request a HIPAA-compliant alternate means or that confidential communications be sent to an alternative location.

Please list the address or method by which you would like Palo Verde Internal Medicine PLLC to communicate about all or part of your protected health information. (i.e.. US postal service, telephone, etc.).

_____ _____

Patient Full Name (Please Print) Date of Birth

_____ _____

Mailing address, City, State Zip code

_____Leave VOICE message on answering machine: YES ( ) NO ( )

Area Code/Telephone No.

Who can we leave a message with by phone? _____

PRINT NAME

Besides you, are there any parties that you will specifically allow to receive communications about all or part of your protected health information? (Provide Name and Relationship to Patient)

( ) Spouse: _____ _____

( ) Caregiver: _____ _____

( ) Other: _____ _____

( ) Other: _____ _____

I understand that Palo Verde Internal Medicine may approve or not approve some of these requests as permitted under federal law, and that I will be informed by Palo Verde Internal Medicine concerning the granting or denying of this request. Please consult this Organization's "Notice of Privacy Practices" which is available to you upon request, for more details about your rights under HIPAA.

_____ / _____ / _____

Signature PATIENT OR Personal *Representative* *Date* *Date of Expiration*

Living Will

DECLARATION

This declaration is made this _____ day of _____(month, year).

I, _____, being of sound mind, willfully and voluntarily make know my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent expect for death delaying procedures, I direct that such procedure which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

In my absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed: _____
(Legal Signature)

City, County and State of Residence: Lake Havasu City, Mohave County, Arizona.

The declarant is personally known to me and I believe him/her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he/she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking at declarant's death, or directly financially responsible for declarant's medical care.

Witness: _____

Witness: _____

PALO VERDE INTERNAL MEDICINE
1923 McCulloch Blvd, No. #101
Lake Havasu City, Arizona 86403

MISSED APPOINTMENT POLICY

Recently **Palo Verde Internal Medicine** has put into place at **$50** fee for patients who do not show or cancel scheduled appointments. This missed appointment fee is the sole responsibility of the patient and will need to be paid before any further appointments are scheduled.

We make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of **(1) ONE DAY** in advance if you are unable to make your appointment. When we receive advanced notice of a cancellation, we are able to accommodate other patients needing care. Failure to comply with this policy will necessitate the assessment fees.

Appointment times are very important to our patients as well as our provider(s). When a patient fails to keep his/her appointment, this time goes unused. Even on a relatively short notice another patient could have made use of your appointment time. By implementing the **"NO SHOW"** fee, it is our goal to make as many appointments available to our patients as possible, by encouraging all patients to keep their appointments or to cancel in advance.

Please sign below that you have read and understood this policy.

Sign: _____
Patient Signature

Print Name: _____

Date: _____

Palo Verde Internal Medicine

Physician-Patient Email Communication Disclaimer

Risks of using email

The physician offers patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via email without understanding and accepting these risks. The risks **include,** but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have legal rights to inspect and keep email that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient.
- Email is indelible even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.
- The physician uses encryption software as a security mechanism for email communications. The patient:
    - Agrees to and will comply with the use of encryption software
    - Waives the encryption requirements, with the full understanding that such waiver increases the risk of violation of the patient's privacy.

Conditions of using email:

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct of the physician. Thus, patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- The physician may forward emails internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, health care operation, and other handling. The physician will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although the physician will endeavor to read and respond promptly to an email from the patient, **the physician cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time sensitive matters.**

- Email communication is not an appropriate substitute for clinical examination. The patient is responsible for following up on the physician's email and for scheduling appointments where warranted.
- If the patients email requires or invites a response from the physician and the patient has not received a response within a reasonable time it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental or substance abuse. Similarly, the physician will not discuss such matter over email.
- The physician is not responsible for information loss due to technical failures.

Instructions for communication by email

To communicate by email, the patient shall:

- Inform the physician of any changes in patients email address.
- Include in the email: the category of the communication in the email's subject line for routing purposes (e.g., "prescription renewal); and the name of the patient in the body of the email.
- Review the email to make sure it is clear and that all relevant information is provided before sending to the physician.
- Inform the physician that the patient received the email.
- Take precautions to preserve the confidentiality of email, such as using screen savers and safeguarding computer passwords.
- Withdrawal consent only email or written communication to the physician.
- **Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email. Rather, the patient should take other measures as appropriate (such as going to the nearest emergency department).**

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand the Physician-Patient Email Communication consent form. I understand the risks associated with the communication of email between the Physician and me, and consent to the conditions outlined herein, as well as any other instructions that the Physician may impose to communicate with patients by email. I acknowledge the Physician right, to upon the provision of written notice, withdraw the option of communication through email. Any questions I may have we answered.

Name: _____ Chart# _____ Date: _____

Patient Signature: _____

Information the patient does not want communicated via Email

I have read the email disclaimer and agree to the conditions listed above

_____ Yes, I agree _____ No, I do not agree – please do not email me

Email address: _____