ARIZONA COMMUNITY SPECIALISTS

MEDICAL HISTORY FORM

Please fill out the form in its entirety if not applicable please mark N/A

Patient's Name_____ DOB_____Age_____ **Height**_____**Weight**_____

Reason for your visit today? _____ Referring Doctor_____

Is the reason for visit accident related (provide details):_____

If needed, I consent to the transfusion of a Blood/Blood products: YES_____ NO_____

Have you ever been diagnosed with: **C-Diff** Y___N___ HIV Y___N___ **Hep B** Y____N____ **Hep C** Y____N____

Do you have an active or history of MRSA/VRE infection: YES ____ NO____ Current_____ History of_____

CURRENT MEDICAL PROBLEMS (e.g., high blood pressure, diabetes)

MEDICATIONS/SUPPLEMENTS TAKEN REGULARLY	**AND**	**REASON**

MEDICINE/FOOD ALLERGIES	**AND**	**REACTION**

PAST MEDICAL AND SURGICAL HISTORY

DISEASE/ILLNESS	YEAR DIAGNOSED	PROCEDURE/SURGERY	YEAR OF PROCEDURE

FAMILY HISTORY (e.g. cancer, heart disease, diabetes for **maternal/paternal** grandparent, parent, sibling, children)

FAMILY MEMBER	**DISEASE**

TOBACCO USE: ☐ YES ☐ NO ☐ FORMER ☐ Never

Type_____ Years used_____ Units per day_____

VAPING: ☐ YES ☐ NO ☐ Never Frequency_____

ALCOHOL USE: ☐ YES ☐ NO ☐ FORMER ☐ Never: Frequency _____

PHARMACY

NAME

CROSS STREETS

PHONE NUMBER

ARIZONA COMMUNITY SPECIALISTS

Review of Systems

Are you currently experiencing any of the following:
Please mark **YES** or **NO** for each

Patient Name: _____ DOB: _____ Date: _____

Date/Year of Last Mammogram: _____ Date/Year of Last Colonoscopy: _____

Y	N	Constitution
		Activity Change
		Appetite Change
		Chills
		Diaphoresis (excessive sweating)
		Fatigue
		Fever
		Unexpected weight change

Y	N	HENT
		Congestion
		Dental problem
		Drooling
		Ear discharge
		Ear pain
		Facial swelling
		Hearing loss
		Mouth sores
		Nosebleeds
		Postnasal drip
		Rhinorrhea (runny nose)
		Sinus Pain
		Sinus pressure
		Sneezing
		Sore throat
		Tinnitus (ringing ears)
		Trouble swallowing
		Voice change

Y	N	Eyes
		Eye discharge
		Eye itching
		Eye pain
		Eye redness
		Photophobia (light sensitivity)
		Visual disturbance

Y	N	Respiratory
		Apnea (stop breathing)
		Chest tightness
		Choking
		Cough
		Shortness of breath
		Stridor (noise when breathing)
		Wheezing

Y	N	Cardio
		Chest pain
		Leg swelling
		Palpitations

Y	N	GI
		Abdominal distention (swelling)
		Abdominal pain
		Anal bleeding
		Blood in stool
		Constipation
		Diarrhea
		Nausea
		Rectal pain
		Vomiting

Y	N	Endocrine
		Cold intolerance
		Heat intolerance
		Polydipsia (Increased thirst)
		Polyphagia (increased hunger)
		Polyuria (increased urination)

Y	N	GU
		Dysuria (difficulty urinating)
		Enuresis (involuntary urination)
		Flank pain (side pain)
		Frequency
		Genital sore
		Hematuria (blood in urine)
		Penile discharge
		Penile pain
		Penile swelling
		Scrotal swelling
		Testicular pain
		Urgency
		Urine decreased
		Dyspareunia (painful sex)
		Menstrual Problem
		Pelvic Pain
		Vaginal Bleeding
		Vaginal Discharge
		Vaginal Pain

Y	N	Musculoskeletal
		Arthralgias (stiffness)
		Back pain
		Gait problem
		Joint swelling
		Myalgias (muscle pain)
		Neck pain
		Neck stiffness

Y	N	Skin
		Color Change
		Pallor (paleness)
		Rash
		Wound

Y	N	Alleg/Immuno
		Environmental Allergies
		Food Allergies
		Immunocompromised

Y	N	Neurological
		Dizziness
		Facial asymmetry
		Headaches
		Light headedness
		Numbness
		Seizures
		Speech difficulty
		Syncope (fainting)
		Tremors
		Weakness

Y	N	Hematologic
		Adenopathy (enlarged lymph nodes)
		Bruises/bleeds easily

Y	N	Psychiatric
		Agitation
		Behavior problem
		Confusion
		Decreased Concentration
		Dysphoric mood (unease)
		Hallucinations
		Hyperactive
		Nervous/anxious
		Self-injury
		Sleep Disturbance
		Suicidal Ideas

ARIZONA COMMUNITY SPECIALISTS

Patient Registration

PATIENT INFORMATION-PLEASE MAKE SURE EVERY LINE IS COMPLETE

Patient Name: _____ Preferred Name: _____ DOB: _____

Address: _____ Zip: _____

Home phone: _____ Mobile: _____ SSN: _____

Email address: _____

Birth sex: _____ Current Gender: _____ Gender Identity: _____ Preferred Pronoun: _____

Marital Status: _____ Spouse's Name: _____

Race: _____ Ethnicity: _____

Primary Care Physician: _____ Referred By: _____

Other Providers Involved in Your Care: _____

Employer: _____ Occupation: _____

Employment status: _____ Birth state: _____

Emergency Contact: _____ Phone number: _____ Relationship: _____

Pharmacy Name: _____ Cross Streets: _____

_____(Initials) ACS providers may prescribe medications electronically. By initialing, you give ACS permission to access your prescribed medications.

INSURANCE INFORMATION-PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST

Primary Insurance: _____ ID: _____ Group: _____

Insurance Company Address: _____

Policy Holder: _____ **DOB**: _____ Relationship to patient: _____
(If other than the patient)

Secondary Insurance: _____ ID: _____ Group: _____

Policy Holder: _____ DOB: _____ Relationship to patient: _____
(If other than the patient)

Do you have AHCCCS? _____ Yes ____ No

I attest that the information provided above is true and accurate. I acknowledge that I have read, signed, and will abide by the Arizona Community Specialists, P.C. "Patient Payment and Financial Policies". I give ACS my consent to access my pharmacy/medication records.

Patient's signature: _____ Date: _____
(Parent/guardian if patient is a minor)

ARIZONA COMMUNITY SPECIALISTS

NOTICE OF PRIVACY PRACTICES

PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Omnibus Rules of 2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Arizona Community Specialists, PC ("ACS"), which contains a more complete description of the uses and disclosures of my health information. I understand that ACS has the right to change its Notice of Privacy Practices from time to time and that I may contact ACS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ACS restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations. I also understand ACS is not required to agree to my requested restrictions, but if ACS does agree then ACS is bound to abide by such restrictions.

ACS does not discriminate based on race, age, sex, sexual orientation, or ethnicity.

Patient Name: _____ **Patient DOB:** _____

Signature: _____ **Date Signed:** _____

REQUEST FOR CONFIDENTIAL COMMUNICATION

HIPAA privacy rules give a certain individuals the right to request confidential medical information. In that regard, you may select the method in which this confidential medical information is communicated. Also, ACS may need to communicate with you regarding your confidential medical information. Please select your preferred method of contact. If you would like to change your contact information in the future, please provide your request in writing to the address contained within the Privacy Practice Notice.

I give permission to disclose my confidential medical information to the following individuals:

Printed Name: _____ **Relationship:** _____

Printed Name: _____ **Relationship:** _____

Printed Name: _____ **Relationship:** _____

My **EMERGENCY** contact is: _____ **Relationship:** _____

Phone number: _____

Signature: _____ **Date Signed:** _____

ACS OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ **Employee Name:** _____

Reason: _____

ARIZONA COMMUNITY SPECIALISTS

PATIENT PAYMENT AND FINANCIAL POLICY

Arizona Community Specialists, PC (ACS) is committed to providing exceptional care and service without exception. We encourage you to understand your insurance benefits, coverage, and your financial responsibility for the care provided by our doctors and providers.

Be sure you understand the following information:

- Insurance plans and benefits vary. Verify ACS services are in-network to avoid additional charges. Call your insurance carrier to ensure you understand your financial obligation for the care you are receiving. Provide secondary insurance information, if applicable, at check-in.
- If you do not have insurance, payment is due at the time of service. Payment plans can be arranged, ask at the front desk for assistance.
- You will need to present a government issued identification (state driver's license, passport, etc.) along with your insurance card, if insured, at every visit. This protects your identity and prevents someone else from using your insurance.
- You will be asked to pay your co-payment, co-insurance, and deductible at the time of check-in. Be prepared to pay the amounts requested. If you are unable to pay at the time of your appointment, we reserve the right to reschedule non-urgent care. Payment plans can be arranged, ask at the front desk.
- Certain procedures or tests may require a higher co-payment amount. Know your benefits and be prepared to pay the required amounts. Payment is due at the time of service.
- Total out-of-pocket requirements are not always known at the time of service. You will be billed for all uncovered expenses incurred and not paid by your insurance plan.
- ACS uses a collection agency should you fail to comply with our financial policy, which will charge an 18% collection fee.
- If you have an unplanned surgical procedure, your insurance may or may not pay for all charges. ACS will contact you AFTER your surgery has been scheduled. Your signature below is your acknowledgment you are responsible to pay the balance upon receipt of the invoice post-surgery. Failure to pay within 15 days or no payment arrangement made will result in the account going to a collection agency and additional 18% in fees assessed to your account.

Medicare:

- Typically covers 80% of allowed charges.
- You are responsible to pay the 20% not covered.
- Medicare requires an Advanced Beneficiary Notice (ABN) be signed for those treatments or test that may not be covered under Medicare covered treatment or services.

Medicare Replacement Plans:

- Medicare Replacement Plans have varying degrees of coverage.
- Know your plan and your financial obligations for care, co-payments, and deductibles which are not covered and will be your responsibility to pay.

Referrals and Authorization:

- Some insurance plans require a referral and/or authorization for specialty services from your Primary Care Provider (PCP) in order to pay for the services received at ACS.
- You will be responsible to pay for services provided if appropriate referrals or authorizations is not obtained, or if the claim is denied.

ARIZONA COMMUNITY SPECIALISTS

PATIENT PAYMENT AND FINANCIAL POLICY

Worker's Compensation:

- You are responsible for providing correct billing information from your employer's industrial insurance.
- You are ultimately responsible to pay for the services received but not covered by your employer.

Personal Injury:

- You must provide the appropriate insurance company for billing. If the insurance company does not pay within 60 days, you will be billed and are responsible to pay the total amount on your account.

Motor Vehicle Accidents:

- Care related to a motor vehicle accident will be treated as "private pay". You are responsible to pay for care at the time of service.
- You will receive documentation that you can submit to your insurance company or attorney upon request.

Returned checks: There is a $35 fee for every check that is returned from the bank unpaid for any reason.
Additional fees: There is a $25 fee for completion of FMLA documents payable at the time of your request. We reserve the right to charge for other forms or letters requested on your behalf depending on the complexity of the request.
No show policy: There may be a $35 fee assessed for not providing a 24-hour notice to cancel and/or reschedule an appointment.
Assignment of Benefits: I, the patient, assign the benefits from the insurance carrier (s) to Arizona Community Specialists, PC for the medical/surgical services for which I am entitled.
Release of Information: I authorize Arizona Community Specialists, PC to release and/or request any information needed to determine benefits or benefits payable for related services.
Patient Responsibility: I understand that I am responsible for advising Arizona Community Specialists, PC of any changes to my address, phone number, insurance plan or coverage.

ALL PATIENTS MUST COMPLETE AND SIGN THIS PAYMENT POLICY, ASSIGNMENT AND RELEASE OF INFORMATION AGREEMENT WITH THE PATIENT REGISTRATION FORM PRIOR TO RECEIVING CARE BY AN ARIZONA COMMUNITY SPECIALISTS, PC PROVIDER.

Patient or Responsible Party Signature **Date**

Duplicates of this release and assignment are as valid as the original

If you have any questions about the Arizona Community Specialists, PC payment and financial policies, please call our Central Billing Office at (520) 750-7160.

ARIZONA COMMUNITY SPECIALISTS

Prescriptions for Narcotics and Other Controlled Substance

Print Patient's Name: _____ Date of Birth: _____

Narcotics, or medications containing opioids and related substances, can be used to treat severe pain. It is sometimes appropriate to use these medications for severely painful conditions or following surgery to help alleviate pain. However, these medications can be dangerous if not used properly. There is an opioid abuse epidemic in our country, and all doctors are making efforts to reduce their use in order to help prevent abuse, addiction, tolerance, complications, and deaths that result from their inappropriate use.

We would like to do our part to reduce the use and misuse of opiates and related controlled substances. This requires cooperation and good communication between our providers and you, our patients. We have established some guidelines for prescribing controlled substances from our office.

1. Your PCP is your health care manager and needs to be aware of any and all medications you are taking. As a general rule, we prefer that long-term medications be prescribed by your primary care provider.

2. After surgeries performed by one of our doctors, a reasonable amount of pain medication will be provided to you at the surgeon's discretion. This is based on the type of surgery you are having. Sometimes this is one day's worth of medication for minor surgeries, and sometimes it is provided for a longer period of time for more extensive surgeries.

3. Narcotic pain medication is not typically prescribed by our doctors for treatment of pre-operative pain. ACS providers do not provide long-term pain medication or prescribe pain medication for chronic pain. Under no circumstances will we provided long-acting narcotic pain medications such as MS Contin, Oxycontin, or Fentanyl patches, etc. Please notify us, or annotate on your intake paperwork, if you are on a "pain contract". If you under a pain contract, all of your pain medication MUST be prescribed by the provider designated on your contract.

4. If you need a refill of your pain medication following surgery, you can call the office during normal working hours and leave a message with the office staff. Your surgeon will review your situation and determine if a refill is required. Because our physicians are surgeons, they may not be in the office every day. This could take up to 48 hours, longer in some circumstances. We do not refill prescriptions for controlled substances after normal office hours or on the weekends. In those instances, you would need to call on the next office workday.

5. Arizona State law now requires that narcotics and similar medications be prescribed electronically. It cannot be "called in" by a medical assistant. A physician must personally enter the prescription on a computer. Additionally, the law limits the amount of narcotic medication and duration that can be prescribed in a single prescription.

6. We understand the importance of managing your pain and want to do everything possible to assist you with pain control. We are committed to preventing the serious problems that may result from misuse of narcotic pain medications. Your cooperation and understanding is greatly appreciated.

Patient Signature Date

ARIZONA COMMUNITY SPECIALISTS

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Patient's signature: _____ Date: _____
(Parent/guardian if patient is a minor)

_____
Patient Printed Name

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