BESTCARE INTERNAL MEDICINE

PERSONAL INFORMATION

NAME _____ (LAST) _____ (FIRST) _____ (MI)

STREET _____ Apt. # _____

CITY _____ STATE _____ ZIP _____

EMPLOYED ❑ RETIRED ❑ PART TIME STUDENT ❑ FULL TIME STUDENT ❑

EMPLOYER _____ SCHOOL _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____ EXT _____

DATE OF BIRTH _____

SEX _____ MARITAL STATUS _____

SOCIAL SECURITY NO. _____

E-MAIL _____

INSURED (card holder) / RESPONSIBLE PARTY (if not patient)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

POSITION _____

RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

HOME PHONE _____

WORK PHONE _____

INSURANCE INFORMATION

PRIMARY

INSURANCE COMPANY NAME _____ Please bring your id card(s)

ADDRESS _____

ID # _____ GROUP # _____

NAME OF INSURED _____

BIRTHDATE OF INSURED _____

SECONDARY

INSURANCE COMPANY NAME _____

ADDRESS _____

ID # _____ GROUP # _____

NAME OF INSURED _____

BIRTHDATE OF INSURED _____

ADDITIONAL INFORMATION

ARE YOU MEDICARE ELIGIBLE?	☐ YES	☐ NO
DID YOU SUSTAIN AN INJURY WHILE AT WORK?	☐ YES	☐ NO
ARE YOUR INJURIES ACCIDENT RELATED?	☐ YES	☐ NO
ARE YOU CURRENTLY EMPLOYED?	☐ YES	☐ NO
ARE YOU COVERED UNDER AN EMPLOYER OR UNION HEALTH PLAN ?	☐ YES	☐ NO
IS YOUR SPOUSE OR OTHER FAMILY MEMBER CURRENTLY EMPLOYED?	☐ YES	☐ NO

SPOUSE INFORMATION

NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NO. _____

WORK PHONE _____

EMERGENCY CONTACT (not living with you)

NAME _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

ALL COPAYMENTS, COINSURANCE AND DEDUCTIBLES ARE DUE AT THE TIME SERVICE IS RENDERED.
IN THE EVENT THAT PAYMENT IS NOT MADE ON THIS ACCOUNT AND IT IS PLACED WITH A LICENSED COLLECTION AGENCY, I/WE AGREE TO PAY THE FEES OF THE COLLECTION AGENCY EQUAL TO A MAXIMUM OF 50% OF OUR OUTSTANDING BALANCE AT THE TIME THE ACCOUNT IS PLACED WITH THE COLLECTION AGENCY. INTEREST OF 10% PER YEAR WILL BE ACCRUED ON THE PRINCIPAL BALANCE. SHOULD LEGAL ACTION ALSO BE NECESSARY TO COLLECT THE ACCOUNT, I/WE AGREE TO PAY ATTORNEY FEES AND COURT COSTS INCURRED FOR COLLECTION.

CONSENT GIVEN FOR MEDICATION HISTORY DOWNLOAD TO MY CHART FROM THE PHARMACY. ❑ YES ❑ NO

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

OUR FINANCIAL POLICY IS PAYMENT AT THE TIME OF SERVICE. I WILL BE PAYING TODAY BY: CASH_____ CREDIT CARD_____

PLEASE PRINT

HEALTH HISTORY

(Confidential)

NAME _____ AGE _____ DATE _____

OCCUPATION _____ BIRTH DATE _____ ☐ Single ☐ Separated ☐ Widow(er) ☐ Married ☐ Divorced ☐ Remarried

ARIZONA RESIDENT SINCE _____ BIRTH PLACE _____

WHAT IS YOUR REASON FOR VISIT? _____

SYMPTOMS Check (✓) symptoms you **currently** have or have had in the **past 12 months**.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump ☐ Penis discharge
- ☐ Erection difficulties ☐ Sore on penis
- ☐ Lump in testicles ☐ Other

Date of last exam / MEN only

PSA Test _____

Flexible Sigmoid _____

Testicular Exam _____

Hemoccult/Stool Test _____

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge ☐ Vaginal discharge
- ☐ Painful intercourse ☐ Other

Date of last / WOMEN only

Menstrual period _____

Pap Smear _____

Mammogram _____

Hemoccult/stool test _____

Are you pregnant? ☐ yes ☐ no

Number of children? _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Ulcers
- ☐ Vaginal Infection
- ☐ Venereal Disease

MEDICATIONS List medications your are currently taking	**ALLERGIES** To medications or substances

PHARMACY NAME _____ PHONE _____

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relative had any of the following Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates: _____

HEALTH HABITS Check (✓) which Substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

SERIOUS ILLNESS/INJURIES

	DATE	OUTCOME

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

IMMUNIZATION RECORD / ADULT

	DATE
Tetanus	
Flu	
Pneumococcal	
Hep B1	
Hep B2	
Hep B3	
Cocci ST	
TB ST	
Other	

IMMUNIZATION RECORD / CHILD

	DATE		DATE
DPT / OPV 1		HIB 1	
DPT / OPV 2		HIB 2	
DPT / OPV 3		HIB 3	
DPT / OPV 4		HIB 4	
DPT / OPV 5		HEP 1	
MMR		HEP 2	
Measles		HEP 3	
		Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by _____ Date _____

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ADVANCE DIRECTIVE ACKNOWLEDGEMENT

NAME: _____

SOCIAL SECURITY #:_____ DATE OF BIRTH: _____
(*optional*)

LIVING WILL/ ADVANCE DIRECTIVES YES____ NO_____
WHERE_____

MEDICAL POWER OF ATTORNEY: YES____ NO_____

NAME: _____
PHONE #_____

NON-STANDARD FORM YES_____ NO_____

OTHER HEALTHCARE PROVIDERS INVOLVED IN MY CASE:
1._____
2._____
3._____

I AUTHORIZE BESTCARE INTERNAL MEDICINE TO LEAVE A MESSAGE IN CASE THEY RECEIVE A VOICEMAIL. YES_____ NO_____.

PATIENT SIGNATURE _____ DATE: _____

Bestcare Internal Medicine Practice Policies

Please read each section carefully, initial each section and sign at the bottom.

Prescription Policy

For prescription renewals, contact your pharmacy. The turnaround time is 24 – 48 hours, so please call before you run out of your medication. For your safety, we will refuse to prescribe medications for a new problem without seeing you at the office. Depending on your medical condition we in general require that anyone on continuing medication be seen every 3 months to evaluate drug effectiveness and to detect possible adverse reactions. Prescriptions for medications are given at office appointments. If there are no refills remaining on your prescription, you will need to schedule an appointment before you run out. Before each office visit, review your medication list and make sure that you have enough refills of all your medication to last until your next office visit. **For all refill requests please call your pharmacy to send us a request**. If your pharmacy contacts our office for renewal authorization and no refill has been authorized it is because you need an appointment. **For each visit you MUST bring ALL your medication bottles with you.** _____ *initials*

Phone Policy

Our office staff can answer general questions. If you need to speak with one of the providers, please inform the front desk of the nature of your call. Except for emergencies, our first priority is to patients in the office, so the message will be reviewed after the provider is done seeing patients. If you feel very ill we advise all of our patients to call 911 or go to the emergency where you can be treated promptly**.** _____ *initials*

Referral Request Policy

Some insurance plans require a referral to see another physician or a pre-certification to have certain procedures done. In most instances your provider will have to see you before we can provide a referral for you. The nature of the referral needs to be addressed and documented in your chart during a face to face visit**,** please call our office to schedule an appointment if you need a referral or let us know during your office visit. Unless an urgent referral is required, please allow up to **14 days for your referral to be completed.**_____ *initials*

Results of Diagnostic/Lab Tests Policy

If you have a test performed, please schedule a follow up within 10 days of the test to go over results**. It is your responsibility to call and schedule an appointment to go over all results.** _____ *initials.*

Copay Policy

Any patient out-of-pocket expense is expected on the date of service. We do except Master Card, Visa, American Express and Discover. **ANY other account balances are also due at the time of service**. _____ *initials*

Special Letters & Forms Policy

Employers, insurance companies, and others sometimes ask that we prepare letters or forms containing detailed information about the medical care we provide. There are fees for these forms and some require an appointment. Such forms include, but are not limited to, completing disability forms, health questionnaires, assisted living and composing various letters. The fee varies please call our office to ask what the fee maybe for your request and if it requires an appointment. Completion time varies by form. _____ ***initials***

Missed Appointments/Late Cancellation Policy

We appreciate your consideration of the provider's schedule. When patients do not show for an appointment it hinders our ability to efficiently manage the schedule and impacts other patients**. We require 24 hour advance notice of cancellation.** A **$50.00** fee will be applied to your account for short-notice cancellations or missed appointments. If you have scheduled a first appointment of the day, you **MUST** come 20 minutes before your appointment. Patients who miss several appointments without calling may be discharged from our practice. _____ ***initials***

Same Day Appointment Policy

Our office has blocked appointment times so we are able to accommodate our patients with same day urgent appointments. Please call our office before going to an urgent care clinic or the hospital. When using an urgent care clinic or a hospital your out-of-pocket expense will be greater. _____ ***initials***

Dismissal Policy

If you are "dismissed" from our practice it means you can no longer schedule appointments, get medication refills or consider us your medical provider. *Common reasons for dismissal are failure to keep appointments (frequent no shows), noncompliance, abusive to staff, failure to pay your bill.* _____ ***initials***

MANDATORY Annual Exam/Wellness Visit Policy

An annual physical exam visit is mandatory once yearly for all of our patients under the age of 65. The annual wellness visit is mandatory of all patients over the age of 65. Questionnaire for your annual visit is available at www.bestcareaz.com. The annual visit is a designated time to review all problems, medications and ensure that all cancer screening and other preventive measures are up to date. The annual visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment and possibly a copay. Please let our scheduling staffs know if you need the providers help with a health problem, a medication refill or something else. We need to schedule a separate appointment**.** _____ ***initials***

Financial Policy

If you have no Insurance: Payment will be due at the time of service, ask the front desk for cash-pay prices.

If you have insurance: Although we are contracted with several insurance companies, it is **your** responsibility to make sure that our provider is in your plan and if you are in an HMO plan which requires an assigned primary care provider, make sure this is done before your scheduled appointment**.** *(Please note some plans take longer than others for this change to take effect).* It is also your responsibility to know your insurance benefits.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover). Payments are also accepted by phone and at www.bestcareaz.com

Auto Accident: If your injury is a result of an auto accident, you are required to pay for services and then collect from the auto carrier. We will not file your insurance but will provide you with a receipt to do so.

Liability Injury: If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance but will provide you with a receipt to do so.

Worker's Compensation: If your injury is due to an accident in your work place, please inform the front desk immediately. You will need to contact your supervisor for instructions on how to file a worker's compensation claim. We regret any inconvenience this may cause.

Billing: If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact our billing department, if you think there is a problem. If you cannot pay your entire balance, please call to make payment arrangements.

Collections: Accounts that are not paid within 30 days begin our in house collection process. If your balance becomes 90 days old, your provider will be notified and you may be subject to dismissal from the practice.

_____ ***initials***

Please note all of these polices have been created for your own safety, health and well-being as well as requirements by health insurance plans. We thank you for your cooperation and choosing Bestcare Internal Medicine as your medical provider. A COPY OF THIS FORM WILL BE PROVIDED AT YOUR REQUEST, PLEASE INFORM FRONT DESK.

SIGNATURE: _____

NAME: _____ **DOB:** _____

PRIVACY POLICY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

We may use and disclose your protected health information for purposes of treatment, payment, and health care operation as permitted by Federal law. These purposes are: billing your insurance carrier for our services, to coordinate ongoing medical care, and to provide our referring physician with the results of treatment and testing.

We may use and disclose your protected health information for purposes other than for treatment, payment, or health care operations without your consent or authorizations, as permitted or required by Federal and/or State law. These purposes are:

1. Uses and disclosures required by law
2. Uses and disclosures for public health activities
3. Uses and disclosures about victims of abuse, neglect, or **domestic** violence
4. Uses and disclosures for health oversight activities
5. Uses and disclosures for judicial and administrative proceedings
6. Uses and disclosures for law enforcement purposes
7. Uses and disclosures to avert serious health threat to health and safety
8. Uses and disclosures for specialized government functions
9. Uses and disclosures about decedents
10. Uses and disclosures for worker's compensation.

We will make other uses and disclosures only with your authorization; this authorization may be revoked.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

You have a right to access and amend your protected health information that is used to make decisions about you. You have the right to request a restriction of certain uses and disclosures of your protected health information. We are not required to grant your request. You have the right to receive confidential communication regarding your protected information. You have the right to obtain a paper copy of this notice upon request. You may exercise your rights upon your written request for specified information. The information requested must be specific and defined in your written request. We are required to answer your request within 30 days.

We are required, by law, to maintain the privacy of protected health information and to provide notice of our legal duties and privacy practices with respect to protected health information.

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

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13945 W. Grand Ave. Suite A-105
Surprise, AZ 85374

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www.bestcareinternalmedicine.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of Bestcare Internal Medicine office's Privacy Policy Notice.

PATIENT SIGNATURE _____ **DATE:** _____

PRINTED NAME _____ **RELATIONSHIP:** _____
(If signed on behalf of the patient)

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

I AUTHORIZE: _____

_____

_____

PHONE #: ( ) _____ FAX #: ( ) _____

TO RELEASE INFORMATION REGARDING MY MEDICAL RECORDS TO:

BESTCARE INTERNAL MEDICINE

13945 W. Grand Ave. Suite A-105

Surprise, 85374

Phone: (623) 546-0007 • Fax (623) 584-6915

PLEASE DISCLOSE:

- **PROGRESS NOTES**
- **LABARATORY REPORTS (BLOOD, HEMACOLT, PAP SMEARS)**
- **ANY RADIOLOGY REPORTS (X-RAYS, MRI, CT SCANS, DEXA, MAMMO)**
- **HIV OR ANY OTHER CONFIDENTIAL TEST(S)**
- **OTHER**

I understand that this authorization can be used for up to six months after the date is signed. I understand I may revoke this authorization at any time by providing written notice of revocation. However, I may not revoke authorization retroactively for any information released.

PATIENT SIGNATURE _____ **DATE:** _____

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CONSENT TO LEAVE PHONE MESSAGES

Beginning on April 14, 2003 new government Health Insurance Portability Accountability Act (HIPAA) privacy regulations will take effect. Without your written consent any of your health information cannot be given to family members or even left on your home answering machine. All test results or answers to any questions will need to be discussed on a follow-up appointment. If you still want us to leave results or messages on telephone answering machines, voice mails, family members, friends, etc. You can still do so. However you need to give us consent in writing. This consent can be revoked at anytime.

I give the staff of Bestcare Internal Medicine consent to leave my healthcare information on my answering machine or voice mail: **YES____** **NO_____**

I give the staff of Bestcare Internal Medicine consent to leave my healthcare information with the following people:

Name	**Relationship**	**Phone #**
_____	_____	( ) _____
_____	_____	( ) _____
_____	_____	( ) _____

PATIENT SIGNATURE _____ **DATE:** _____

PATIENT'S CURRENT MEDICATION LIST AS OF _____

Last Name	First Name	Date of Birth

MEDICATION	DOSAGE	HOW MANY TIMES DO YOU TAKE IT?

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