Vasanta Weiss, MD

ARIZONA COMMUNITY PHYSICIANS

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Aria Internal Medicine

An Affiliate of Arizona Community Physicians

Thank you for your interest in becoming a new patient at Aria Internal Medicine. As a primary care physician, I felt it was necessary to make a proactive change to allow adequate time to accommodate the broader health care needs of all patients. Arizona has implemented changes to the prescription drug monitoring program, affecting the time and resources required to comply. **Due to this change, I will not be prescribing any long-term opioids, benzodiazepines, stimulants, sedatives, or testosterone to new patients. I will be referring patients out should there be a need for pain management, and psychiatric care.** If you already see pain management or psychiatry, I ask that you provide the name and phone number so we may coordinate care if needed.
I appreciate your time and attention to this matter.

Vasanta Weiss, MD

By signing below, I hereby acknowledge that I have completely read, fully understand, and agree to this document.

_____ _____

PATIENT NAME (PRINTED **PATIENT SIGNATURE**

_____ _____

LEGAL REPRESENTATIVE NAME (PRINTED **LEGAL REPRESENATIVE SIGNATURE**

(if applicable, documentation needed for records – i.e. POA)

_____

DATE OF ABOVE SIGNATURES

Aria Internal Medicine **Catalina Endocrinology**

Affiliates of Arizona Community Physicians

Patient Name: _____ DOB: _____ MRN: _____

Office Policies and Procedures

Our providers and staff members are trained to assist you in obtaining the best care possible, and to do so with courtesy and compassion. We strive to provide the best professional care possible. In turn, we expect our patients to treat our staff with courtesy and respect. Disrespectful or aggressive behavior towards our staff and providers will not be tolerated and will result in the termination of your care at Ars Nova Internal Medicine.

1. All patients should arrive for appointments at their appointed check-in times. This policy is in place so the necessary intake efforts can be made and so that you can be roomed in a timely manner. Patients who arrive late create an inconvenience for our providers as well as other patients. Our practitioners reserve the right to ask you to reschedule if you are late. Please do not wear perfume or cologne as a courtesy to other patients that have fragrance sensitivities.

2. If there is a need to cancel your appointment, please do so at least 24 hours in advance. **There is a $50.00 fee if you do not show for your appointment or if you do not give 24 hours' notice when canceling an appointment.** There is a cancellation line for after hour needs. Please remember, reminder calls are a courtesy, not mandatory. If you do not show up to your scheduled appointment and do not cancel it in advance, we reserve the right to release you from our practice.

3. Co-pays and deductibles are due at the time of service as dictated by your insurance. We do not bill co-pays. We will accept cash, check, Visa, Mastercard, Discover and American Express. You will also be asked to present your insurance card at each visit.

4. To assist us in providing optimal medical care, please bring in an updated list of medications, including the strength and directions, to each visit. If we are managing your diabetes or hypertension, please bring in your glucose and/or blood pressure readings.

5. Nurse visits for lab draws and injections are generally scheduled between 7:15AM-10:45AM and 1:30PM-3:15PM. An appointment is necessary.

6. Please provide us with at least two phone numbers that we can contact you at regarding your healthcare. If you use a PO Box, please provide us with a physical address to use only in the event of an emergency.

7. **Insurance/disability paperwork usually requires an office visit to fill them out. There will be a $50.00 charge for filling out these forms whether or not an appointment is needed.** The price is based on the amount of time required to complete the forms. This fee may be increased for extensive letters and reports. Please allow up to 10 days to complete forms. An additional $50.00 will be charged if forms are requested to be "Expedited" (five days or less turnaround time). There is no charge for filling out MVD handicap forms.

8. Please allow 72 hours for refills on prescriptions. Our on-call doctors will not send in controlled medications – opioids, benzos, etc. If you are in need of such a prescription after hours or on the weekend, you will be referred to the emergency room. Please call your pharmacy for routine refills of medications.

9. Referrals may take up to 14 days depending on your insurance carrier. Some procedures require a prior-authorization, delaying the completion of your referral.

_____

Signature of Patient/Legal Representative **Date**

Arizona Community Physicians

Patient Information

FIRST NAME | MIDDLE | LAST NAME | ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE# | EMERGENCY CONTACT NAME / RELATION

DOB (/ /) | SEX | MARITAL STATUS | EMAIL | RACE (optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | PREVIOUS NAME

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE

Billing Information
(If different than patient)

FIRST NAME | MI | LAST NAME | ADDRESS | CITY | STATE/ZIP | PHONE

Primary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

SELF | SPOUSE | CHILD | OTHER

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH (/ /) | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

Secondary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

SELF | SPOUSE | CHILD | OTHER

GROUP ID# | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH (/ /) | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

PERSON GIVING CONSENT | RELATIONSHIP IF NOT THE PATIENT | DATE

Patient Registration

Patient Name: MRN:

Date of Birth: Date:

Please Circle Most Appropriate Response

Employment Status

Full Time Part Time

Employer:_____

Work Phone Number:_____Ext:_____

Not Employed

Retired

Disabled

On Active Military Duty

Student – Full Time Part Time

Unknown

Marital Status

Married	Single
Divorced	Legally Separated
Widowed	Significant Other
Other	

Preferred Language: _____

Written Language: _____

Interpreter Needed: Yes No

Race

American Indian or Alaska Native	
Asian Indian	
Black or African American	
Chinese	Samoan
Filipino	Vietnamese
Guamanian or Charnorro	White
Japanese	Other
Korean	Unknown
Native Hawaiian	Decline to Answer
Other Asian	
Other Pacific Islander	

Veteran Status

No, Never Served

No, Currently Serving - Branch_____

Yes - Branch_____

Yes, Combat Veteran - Branch_____

Emergency Contact

Name:_____Relation:_____

Best Contact Phone Number:_____

Name:_____Relation:_____

Best Contact Phone Number:_____

Ethnicity

Cuban

Decline to Answer

Mexican, Mexican American, or Chicano/a

Not Hispanic, Latino/a, or Spanish origin

Other Hispanic, Latino/a, or Spanish origin

Puerto Rican

Unknown

Email: _____

MyChart

Do you want to sign up for MyChart - Yes No

Patient portal - access to your medical records

Patient/Guardian Signature:_____

Date:_____

MRN _____
Name _____
Date of Birth _____
Phone _____

General Information: Date: _____

Gender: _____
How long have you lived in Arizona? _____Where did you live before?_____
What is your occupation/former occupation? _____
Relationship Status: ☐Married/Partner ☐Single ☐Divorced ☐Widowed
Are you sexually active? ☐Yes ☐ No Preferred Partner: ☐Male ☐Female ☐Both
Do you have any children? ☐Yes ☐ No How many? _____
Who lives at home with you? _____
Do you follow any type of diet, if yes what? _____
Do you exercise? _____ How often? _____
Do you drink alcohol? _____
If yes, how many drinks? _____ /day _____ /week _____ /month
Do you use tobacco? ☐Now ☐Past ☐Never
If so, what? _____ How much?_____ For how long & year quit?_____
Do you use illicit drugs? ☐Now ☐Past ☐Never
If so, what? _____ How much? _____ For how long? _____
Do you use Cannabis? ☐Now ☐Past ☐Never
Do you vape? ☐Now ☐Past ☐Never

Over the past two weeks have you felt (check the answer that applies the most to you):

Little interest or pleasure in doing things?	☐No days (0)	☐Several days (1)	☐More than half the days (2)	☐Nearly every day (3)
Feeling down, depressed, or hopeless?	☐No days (0)	☐Several days (1)	☐More than half the days (2)	☐Nearly every day (3)

MRN ______________________________
Name ______________________________
Date of Birth ________________________
Phone ______________________________

Allergies / Adverse Reactions to Medications and/or Products

What	Reaction

Medications and Supplements

Name	Dose	Frequency	Reason

MRN _____
Name _____
Date of Birth _____
Phone _____

Self/Family History

Adopted _____ Unknown family history: _____

Condition	Self	Mother	Father	Sister	Brother	Child/ren	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alive (age)										
Deceased (age)	—									
Alcohol abuse										
Arthritis										
Asthma										
Diabetes										
Heart disease										
High blood pressure										
Elevated cholesterol										
Kidney stones										
Depression										
Anxiety										
Other mental illness										
Stroke										
Cancer										
-Type of cancer										

Surgical History

Type	Date

Specialists You See

Name	Condition

MRN _____
Name _____
Date of Birth _____
Phone _____

Health Maintenance/Prevention

Please check if you have received the following and when they were received:

☐ Influenza	Date: _____		
☐ Tetanus (Td/Tdap)	Date: _____	☐ HPV/Gardasil	Date: _____
☐ Hepatitis A	Date: _____	☐ Prevnar 13	Date: _____
☐ Hepatitis B	Date: _____	☐ Pneumococcal	Date: _____
☐ Varicella	Date: _____	☐ Shingles	Date: _____
☐ Covid	Date: _____		
☐ RSV	Date: _____		

Screenings

☐ Eye exam	Date: _____	☐ Pap smear	Date: _____
☐ Dental exam	Date: _____	☐ Hepatitis C test	Date: _____
☐ Mammogram	Date: _____	☐ HIV test	Date: _____
☐ DEXA	Date: _____	☐ PSA test	Date: _____

☐ Colon cancer screening (circle type): iFOBT Cologuard Colonoscopy
Date last done: _____

Name:_____ Date:_____

DOB:_____ MRN:_____

Review of Systems

Constitutional (affecting general well being)

____ No symptoms
____ Activity change
____ Appetite change
____ Chills
____ Diaphoresis (unusual perspiration/sweating)
____ Fatigue
____ Fever
____ Unexpected weight change

Hent (Head, Ears, Nose, Throat)

____ No symptoms
____ Congestion
____ Dental problem
____ Drooling
____ Ear discharge
____ Ear pain
____ Facial swelling
____ Hearing loss
____ Mouth sores
____ Nosebleeds
____ Postnasal drip
____ Rhinorrhea (runny nose)
____ Sinus pain
____ Sneezing
____ Sore throat
____ Tinnitus (ringing in the ears)
____ Trouble swallowing
____ Voice change

Eyes

____ No symptoms
____ Eye itching
____ Eye pain
____ Eye redness
____ Photophobia (painful oversensitivity to light)
____ Visual disturbance

Respiratory

____ No symptoms
____ Apnea
____ Chest tightness
____ Choking
____ Cough
____ Shortness of breath
____ Stridor (high-pitched/musical breathing sound)
____ Wheezing

Cardio

____ No symptoms
____ Chest pain
____ Leg swelling
____ Palpitations

Gastroenterology

____ No symptoms
____ Abdominal distention
____ Abdominal pain
____ Anal bleeding
____ Blood in stool
____ Constipation
____ Diarrhea
____ Nausea
____ Rectal pain
____ Vomiting

Endocrine

____ No symptoms
____ Cold intolerance
____ Heat intolerance
____ Polydipsia (extreme thirstiness)
____ Polyphagia (excessive appetite/eating)
____ Polyuria (excessive urination)

Name:_____ Date:_____

DOB:_____ MRN:_____

Review of Systems

GU (Genitourinary)

____ No symptoms
____ Difficulty urinating
____ Dyspareunia (painful intercourse)
____ Dysuria (pain, discomfort or burning with urination)
____ Enuresis (involuntary urinary incontinence)
____ Flank pain
____ Frequency
____ Genital sore
____ Hematuria (blood in urine)
____ Menstrual problem
____ Pelvic pain
____ Urgency
____ Urine decreased
____ Vaginal bleeding
____ Vaginal discharge
____ Vaginal pain

Musculoskeletal

____ No symptoms
____ Arthralgias (joint pain/stiffness)
____ Back pain
____ Gait problem (walking balance/coordination)
____ Joint swelling
____ Myalgias (muscle pain)
____ Neck pain
____ Neck stiffness

Skin

____ No symptoms
____ Color change
____ Pallor (pale color of skin)
____ Rash
____ Wound

Allergy/Immunologic

____ No symptoms
____ Environmental allergies
____ Food allergies
____ Immunocompromised

Neurological

____ No symptoms
____ Dizziness
____ Facial asymmetry
____ Headaches
____ Light-headedness
____ Numbness
____ Seizures
____ Speech difficulty
____ Syncope (fainting or passing out)
____ Tremors
____ Weakness

Hematologic

____ No symptoms
____ Adenopathy (enlargement of lymph nodes)
____ Bruises/bleeds easily

Psychiatric

____ No symptoms
____ Agitation
____ Behavior problem
____ Confusion
____ Decreased concentration
____ Dysphoric mood (feeling uneasy)
____ Hallucinations
____ Hyperactive
____ Nervous/anxious
____ Self-injury
____ Sleep disturbance
____ Suicidal ideas

Aria Internal Medicine

Arizona Community Physicians, P.C.

Release of Information Form

MRN_____

Patient Name_____**DOB**_____**Date**_____

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

By providing the below phone number(s) you are giving permission to leave voicemails regarding appointment information and/or detailed health information (i.e. lab results, radiology results or any other imperative information regarding your health).

Home:_____ Cell:_____ Work:_____ Other:_____

DO NOT RELEASE Information to the following people:_____

_____

I acknowledge that either I or the physician may withdraw the releasing of test information at any time, upon written notice. Any questions I had have been answered.

SIGNATURE OF THE PATIENT/LEGAL GUARDIAN_____

The information provided on this form will stay in effect until updated by the patient

Arizona Community Physicians
5055 E. Broadway, Suite A-100
Tucson, AZ 85711
520-327-0460

HIPAA

NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact Arizona Community Physicians Business Office by mail or phone. Our contact information is listed above.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is **NOT** an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS

We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Arizona Community Physicians
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520-327-0460

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information:

You have the right to inspect and have a copy of your protected health information (fees may apply). Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Patient Requesting Medical Record Copies. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees.

You have the right to request a restriction of your protected health information – You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications – You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

You have the right to request an amendment to your protected health information – You may ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.

You have the right to receive an accounting of certain disclosures — You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request.

You have the right to receive notice of a breach - We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Patient Printed Name:_____ Patient Signature:_____

Relationship (if not patient):_____ Date:_____

Arizona Community Physicians P.C.
Authorization to Release Medical Information

PATIENT INFORMATION

Patient Name_____ Former Name_____ Account #_____

Daytime Telephone_____ Birth Date_____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____

Street Address _____

City/State/Zip_____

Phone # _____Fax#_____

To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization _____

Street Address _____

City/State/Zip_____

Phone # _____Fax#_____

Requested format ☐Paper ☐Disc (PDF format) ☐Email*_____

***Email option only available for medical records processed by CIOX.**

PURPOSE FOR THIS REQUEST **(Please check a box)**

☐At request of Patient ☐ Other* (specify) _____

***The standard charge for copying medical records is $6.50 for a disc and $0.07 per page for paper. However, there may be additional charges for shipping and handling. Please do not submit payment with this request, you will receive a billing invoice.**

TYPE OF INFORMATION TO BE RELEASED **(No information will be released unless a box is checked)**

General Release DATES OF TREATMENT

☐ Medical Records/**Excluding Protected Records**

(This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated) From_____ To_____

☐ Other Records (specify) _____ From_____ To_____

Information Protected by State/Federal Law

☐ All of my records including: From_____ To_____

AIDS/HIV and Other Communicable Disease Information,

Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

Signature of Patient or Personal Representative who may request Release of Medical Information: I understand authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____ _____

Signature of Patient OR Legal Representative **Date** **Please Print Name of Signing Party**