

**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# MEDICARE ONLY**                      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# MEDICARE ONLY**                      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

ARIZONA COMMUNITY PHYSICIANS  
REGISTRATION ADDENDUM

Patient Name: \_\_\_\_\_

Account Number: \_\_\_\_\_

Due to a governmental mandate that all healthcare is provided fairly, without regard to race or ethnicity, we have added new fields to our patient registration form. This information will be kept confidential.

Race (check one)

- Black, African American (01)
- Asian (02)
- Caucasian (White) (03)
- American Indian, Alaskan Native (08)
- Native Hawaiian/Other Pacific Islander (09)
- Unknown (98)
- Declined (99)

Ethnicity (check one)

- Hispanic
- Non- Hispanic
- Unknown

E-mail

\_\_\_\_\_

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Parent/Guardian Signature

Preferred Language (check one)

- English (EN)
- Spanish (SPA)
- Arabic (AR)
- Chinese (all types) (ZH)
- French (FR)
- German (DE)
- Greek (EL)
- Italian (IT)
- Japanese (JA)
- Korean (KO)
- Navajo (NV)
- Polish (PL)
- Russian (RU)
- Tagalog' (TL)
- Ukrainian (UK)
- Vietnamese (VI)
- Other \_\_\_\_\_  
(Specify)

\_\_\_\_\_

Patient declined filling out the form. Staff signature required

Name: \_\_\_\_\_ Date: \_\_\_\_\_ MRN #: \_\_\_\_\_

**Arizona Community Physicians, P.C.  
Release of Information Form**

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or close friend needs access to your health information, or to the health information of someone under your care.

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

Spouse's Name \_\_\_\_\_ Contact Number \_\_\_\_\_

Child's Name \_\_\_\_\_ Contact Number \_\_\_\_\_

\_\_\_\_\_ Contact Number \_\_\_\_\_

Parent's Name \_\_\_\_\_ Contact Number \_\_\_\_\_

\_\_\_\_\_ Contact Number \_\_\_\_\_

Other's Name \_\_\_\_\_ Contact Number \_\_\_\_\_

**DO NOT RELEASE** information to the following people:

\_\_\_\_\_

Can we leave detailed lab results, radiological test results or any other imperative information on your mobile phone voice mail? \_\_\_\_\_ On your home voice mail? \_\_\_\_\_

Please check if applicable for patients under 15 years old:

\_\_\_\_\_ I give permission for my child (of >15 years old) to be seen without the presence of an adult.

\_\_\_\_\_ I give permission for my child (of >15 years old) to have minor procedures or immunizations without the presence of an adult.

\_\_\_\_\_ I give permission for my child to be taken to medical appointments  
by: \_\_\_\_\_

\_\_\_\_\_

Patient/Parent/Guardian Contact Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_

**Signature of the Patient or their Parent/Legal Guardian**

**Date** \_\_\_\_\_

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

Arizona Community Physicians  
5055 E. Broadway, Suite A-100  
Tucson, AZ 85711  
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: \_\_\_\_\_

**INITIAL EACH LINE THEN SIGN**

## Tucson Family Medicine

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

### Office Policies and Procedures

**Patient Conduct and Office Policies:** These policies are in place to ensure safe, efficient, and respectful care for all patients. Our providers and staff are committed to delivering high-quality medical care with professionalism and compassion. In return, we expect all patients to treat our team with courtesy and respect. **Disrespectful, inappropriate, threatening, or aggressive behavior toward any provider or staff member will not be tolerated and may result in immediate termination of care at Tucson Family Medicine. Please read and initial by each office policy listed below.**

**1. Arrival Time:** All patients must arrive **15 minutes prior** to their scheduled appointment to allow adequate time for check-in and intake. Patients who arrive **late for their appointment may be asked to reschedule at the providers discretion.** Late arrivals disrupt clinic flow and impact other patients. As a courtesy to patients with fragrance sensitivities, please do not wear perfume or cologne to your visit.

**2. Appointment Cancellations / No-Shows:** If you need to cancel an appointment, please provide **at least 24 hours' notice.** A **\$50 no-show or late-cancellation fee** applies if you fail to appear or cancel with less than 24 hours' notice. After-hours cancellations may be left with our after hours messaging service. Appointment reminder calls and texts are a courtesy, not a guarantee. **Repeated no-shows or late cancellations may result in dismissal from practice.**

**3. Payments:** Co pays and deductibles are due at the time of service per your insurance plan. We do not bill copays or deductibles. Accepted payments include check, Visa, Mastercard, Discover, and American Express. Please bring your insurance card to every visit.

**4. Medications and Home Readings:** Please bring an updated medication list (including doses and directions) to every appointment. If we are managing your diabetes or blood pressure, please bring your home readings to your appointment.

**5. Lab draws/INR's and Injections are by appointment only, between 7:40-11:50 AM and 1:00-3:10 PM. Our phones and lab are closed from 12:00-1:00 PM daily.**

**6. Contact Information:** Please provide at least two phone numbers where we can reach you regarding your care. If you use a PO Box, a physical address is required for emergency purposes. **We do ask all patients to sign up for and utilize My Chart.** My Chart patient portal will allow you to view future and past appointment information, labs, and will allow you to communicate with your provider through messaging. **Please note: any patient initiated health concern sent through the "My Chart" portal may be subject to an e-visit charge that will be billed to the patients insurance. If not covered, the patient will be responsible for any fees incurred. This does not include medication renewal requests, result notifications, or appointment requests.**

**7. Forms and Paperwork:** All forms/paperwork requires an office visit. Patients are required to obtain the forms needed and have those forms with them at their scheduled appointment for the provider to fill out at that visit. **If you do not have the forms to be filled out you may be asked to reschedule.**

**8. Prescription Refills:** Please allow **three business days** for routine prescription refills. Contact your pharmacy first for standard refill requests. **It is the on-call providers discretion as to whether they will refill or prescribe ANY controlled substances such as; opioid, benzodiazepines, etc.**

**9. Prior Authorizations:** Many referrals, medications, imaging studies, and procedures require prior authorization from your insurance company and may take several weeks to process. **Once our office submits the request, approval timelines are determined by your insurer and are outside of our control.** Repeated phone calls, demands for expedited processing, or attempts to bypass standard workflows delay care for all patients and will not be accommodated. **Disrespectful, abusive, or aggressive behavior toward staff is unacceptable and may result in dismissal from the practice.**

By signing below, you acknowledge that you have received and reviewed these policies and agree to adhere to them.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
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 Tucson Family Medicine
Street Address 7105 N La Cholla Blvd.
City/State/Zip Tucson, Arizona 85741
Phone # 520-547-0611 Fax# 520-547-0616

PURPOSE FOR THIS REQUEST (Please check a box)

At request of Patient Other (specify) \_\_\_\_\_

Requested format (if no selection is made, records will be delivered in paper): Paper\* Disc (PDF format)\*

\*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.

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:
AIDS/HIV and Other Communicable Disease Information,
Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment
From \_\_\_\_\_ To \_\_\_\_\_

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

**Medical Health History Form**

CONDITION	RELATION TO PATIENT	STATUS	AGE
	Grandmother	LIVING/DECEASED	
		LIVING/DECEASED	

**Social History**

Are you a Smoker: Current  Former  Never  Number of Years \_\_\_\_\_

Packs Per Day: \_\_\_\_\_ Other Tobacco Products Used \_\_\_\_\_

Do you drink Alcohol: Current  Former  Never  Drinks per Week: \_\_\_\_\_

Have you used illicit drugs? If so, what kind? \_\_\_\_\_

Do you exercise regularly? \_\_\_\_\_ What kind? \_\_\_\_\_ How often: \_\_\_\_\_

Please list the name and relation of ones who live with you. (Parents, Spouse, Children, Friends, Etc.)

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**IMMUNIZATIONS:**

Have you had a shot to prevent pneumonia? Yes/No  Pneumovax 23 Year? \_\_\_\_\_

Prevnar 13 Yr? \_\_\_\_\_  Prevnar 20 Year? \_\_\_\_\_

Have you had vaccines to prevent shingles? Yes/No What year? \_\_\_\_\_ Tetanus Year \_\_\_\_\_ Flu Year \_\_\_\_\_

**Please fill in as applicable:**

Last Colonoscopy: \_\_\_\_\_ Result: Normal or Abnormal

Last Prostate Exam: \_\_\_\_\_ Result: Normal or Abnormal

Last Mammogram: \_\_\_\_\_ Result: Normal or Abnormal

Last Pap: \_\_\_\_\_ Result: Normal or Abnormal

Last Dexa Scan: \_\_\_\_\_ Result: Normal or Abnormal

Last Glaucoma/Eye Exam: \_\_\_\_\_ Result: Normal or Abnormal

Are you Sexually Active: Yes  No  If yes, with a Male  Female





**Medical Health History Form**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ MRN: \_\_\_\_\_

Marital Status M [ ] S [ ] D [ ] W [ ]      Number of Children \_\_\_\_\_

Current occupation \_\_\_\_\_ If retired, previous Occupation \_\_\_\_\_

Please list any Medications you are currently taking

Medications	Dose	Frequency

Please list any medications you are allergic to and reaction:

Medication	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

Please list any Medical Problems or Surgeries you have had even as a child.

(i.e: Diabetes, high blood pressure, cancer, heart disease)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Family History**

PLEASE LIST MEDICAL CONDITION(S) FOR FAMILY MEMBERS

CONDITION	RELATION TO PATIENT	STATUS	AGE
	Mother	LIVING/DECEASED	
	Father	LIVING/DECEASED	
	Brother	LIVING/DECEASED	
	Sister	LIVING/DECEASED	
	Grandfather	LIVING/DECEASED	

