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 (o p t i o n a l)

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

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 (ES)
- ☐ 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

ARIZONA COMMUNITY PHYSICIANS

Posadas Rheumatology and Bone Health

4530 E. Camp Lowell
Tucson, Arizona 85712

(520) 202-3398
Fax: (520) 202-3399

NAME:______________________________

DATE OF BIRTH:______________________________

PLEASE TAKE A FEW MINUTES PRIOR TO YOUR VISIT FO FILL OUT THIS QUESTIONAIRE. IF YOU ARE UNSURE OF THE QUESTIONS, PLEASE LEAVE IT BLANK, THANK YOU.

PAST MEDICAL HISTORY: (PLEASE PLACE A CHECK MARK IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS)

___ HEART DISEASE
___ EMPHYSEMA
___ SEIZURES
___GASTRIC OR DUODENAL ULCERS
___THYROID DISEASE
___ KIDNEY DISEASE
___ ASTHMA
___ DIABETES
___HYPERTENSION
___ STROKE
___ LIVER DISEASE
___ HIGH CHOLESTEROL
___ CANCER (TYPE) ______________________________
___ OTHER ______________________________

PAST SURGICAL HISTORY:

___ GALL BLADDER
___ INTESTINAL
___ APPENDIX
___ CATARACT
___ HYSTERECTOMY
___ TONSILS AND ADENOIDS
___ BYPASS
___ OTHER ______________________________

ALLERGIES TO THE FOLLOWING:

MEDICATIONS:______________________________

FOODS: ______________________________

MEDICATIONS: (PLEASE INCLUDE THE DOSE AND HOW OFTEN TAKING)

____

____

____

____

____

HABITS:

TOBACCO (HOW MUCH AND HOW LONG) ______________________

ALCOHOL (HOW MUCH PER WEEK) ______________________

SOCIAL HISTORY:

MARITAL STATUS ______________________

OCCUPATION ______________________

CHILDREN ______________________

FAMILY HISTORY: (PLEASE INDICATE RELATION)

HEART DISEASE ______________________

CANCER ______________________

HIGH CHOLESTEROL ______________________

DEPRESSION ______________________

HYPERTENSION ______________________

DIABETES ______________________

THYROID DISEASE ______________________

STROKE ______________________

OTHER ______________________

SCREENING AND PROCEDURES : (PLEASE INDICATE DATES AND RESULTS)

PAP SMEAR (LATEST) ______________________

MAMMOGRAM (LATEST) ______________________

DEXA BONE DENSITY (LATEST) ______________________

PROSTATE EXAM (LATEST) ______________________

PSA (PROSTATE BLOOD TEST) ______________________

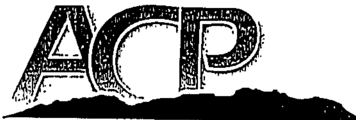
HEMOCCULT TEST (FOR BLOOD IN STOOL) ______________________

ELECTROCARDIOGRAM (LATEST) ______________________

COLONOSCOPY (SCREEN FOR COLON CANCER) ____________________
TETANUS SHOT ____________________
FLU SHOT ____________________
PNEUMOVAX ____________________
OTHER IMMUNIZATIONS ____________________

PLEASE LIST NAMES OF ALL PHYSICIANS SEEN WITHIN THE LAST TWO YEARS:

____
____
____
____
____
____



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Posadas Rheumatology and Bone Health

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Tucson, Arizona 85712

(520) 202-3398
Fax: (520) 202-3399

Refills requested from Monday thru Wednesday will be processed within 24 hours after our office has received notification.

REFILLS REQUESTED ON THURSDAY OR FRIDAY SHOULD BE EXPECTED TO BE PROCESSED ON THE FOLLOWING MONDAY OR THE NEXT DAY AFTER A WEEKEND.

Regular follow up appointments are necessary to maintain optimal care and ensure safety with medicine intake. If regular follow up appointments are not followed there may be interruption in provision of scripts for safety concerns.

Patient Signature ______________________________ Date: ________________________

No Show Policy

In our continuing efforts to provide quality medical care in a timely manner, we must more strictly enforce our cancellation policy. An unfortunate high volume of patients not complying with policies currently in place, prompts a need to provide more of a deterrent to those not playing by the rules.

Missed appointments pose a threat to delivery of efficient care, as the time slots allotted for these patients are not available to those truly needing evaluation, and result in the unfair delayed ability of these patients to be seen by the physician.

Therefore, patients who do not cancel their appointment with provision of 24 hours advance notice, or simply do not show for a scheduled appointment, will be assessed a $30.00 nonrefundable administrative fee for the first offense, with subsequent offenses necessitating escalation of charges to $60.00 per offense. We realize that emergencies occur, and if documentation of these emergencies (police documentation/hospital records/notes from other physicians) is provided, charges will be waived.

It will be left to the discretion of Dr Posadas to assess cases on an individual basis, including multiple cancellations or no-show appointments, to determine if the lack of regular follow up/assessment poses a threat to the physician/patient relationship, and necessitates individuals to seek care from another provider.

Thank you for your understanding, and we look forward to clearing up these issues so as to provide the best care for all our beloved patients.

Thus, please sign the document as below to acknowledge the change in policy as described above.

Patient Signature: ____

Date: ____

MRN______________

ARIZONA COMMUNITY PHYSICIANS, P.C.

RELEASE OF INFORMATION FORM

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 close friend needs access to your health information, or to the health information of someone under your care.

I, ______________________________ hereby give my consent for my physician's office to provide access to my medical records, or to my dependents medical records. **This information is not limited to but includes appointments, billing information and test results.**

☐ **Authorize to leave information on my Home Phone/ Voice Mail:** ______________

☐ **Authorize to leave information on my Work # /Voice Mail:** ________________

☐ **Authorize to leave information on my Cell Phone #/ Voice Mail:** ______________

Other than myself to the following:

☐ **Spouse** ______________________ **Phone #/Voice Mail** ____________________

☐ **Child** ________________________ **Phone #/Voice Mail** ____________________

☐ **Parent** _______________________ **Phone #/Voice Mail** ____________________

☐ **Other** ________________________ **Phone #Voice Mail** _____________________

DO NOT RELEASE information to the following people: ______________________________________

____

Please check if applicable:

________ 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: ____________

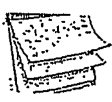
____

Patient/Parent/Guardian Contact Numbers: Home__________ Work__________ Other__________

Signature of the Patient or their Parent/Legal Guardian ______________________________

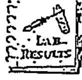
Our Office is Online!

Visit Your Doctor Online



Schedule Your Next Appointment

Refill Your Prescriptions



Get your Lab Results

Provide us with your **email address** to start managing your healthcare from the Web.

Name ______________________________

Email ______________________________

Date of Birth ______________________________

We are collecting your email address for *our* records, and will use it to issue you an invitation to enroll in our online communication service. Enrollment is optional. We will not disclose your address to others without your prior written consent.

PATIENT PORTAL IS A GREAT WAY TO COMMUNICATE WITH OUR OFFICE VIA EMAIL. YOU CAN REQUEST MEDICATION REFILLS, SCHEDULE, CONFIRM OR CHANGE YOUR APPOINTMENTS. ONCE YOU HAVE APPROVED AND RECEIVED PORTAL ACCESS WE ASK THAT YOU SEND A "TEST" MESSAGE THAT WE CAN RESPOND TO.

THANK YOU!!

Arizona Community Physicians (ACP) Online Patient Portal

Adult Proxy Authorization

Release of Information Form

This form is an authorization that will permit *ACP* and other providers affiliated with *ACP* who use the electronic health record (EHR) to release your medical information to your designated adult proxy. Anyone **age 16 and older** who would like someone other than themselves to have online access to their records must complete this form.

Proxy Name: ______________________ Relationship: ______________________
Proxy Email Address: ______________________ Proxy Phone Number: ______________________
Proxy Home Address: ______________________

I understand that:

- Authorizing proxy access will allow the person named below access to my personal health information through the *ACP Online Patient Portal.*
- This form does not authorize release of my medical records to my designated proxy by other methods or in other forms.
- If I no longer wish this individual to access my information, it is *my responsibility* to revoke their access. A written request must be made to revoke this proxy access and any actions taken or accesses made prior to that revocation were authorized as part of the initial signature and date.
- All activities within my *ACP Online Patient Portal* account may be tracked by computer audit, and entries my proxy makes may become part of my medical record.
- Access to my *ACP Online Patient Portal* account is provided as a convenience and may be revoked at any time for any reason, including unauthorized or inappropriate actions made by the proxy.
- Use of my *ACP Online Patient Portal* account is voluntary, and I am not required to use or to authorize another person (proxy) to access account.
- I authorize the use and/or disclosure of electronic protected health information (ePHI) through my *ACP Online Patient Portal* as described below. The ePHI is being disclosed for my proxy to have a more active role in my health care via the *ACP Online Patient Portal.*
- I understand that my proxy will have access to records that may include information relating to the diagnosis and/or treatment of mental illness, alcohol/drug abuse, STDs, HIV test results, developmental disabilities and genetic testing results.
- I understand that once information has been disclosed, the proxy may further disclose my ePHI and it may no longer be protected by federal health law. By signing below, I acknowledge that I have read and understand the authorization, and I agree to its terms and grant proxy access to my personal health information via the *ACP Online Patient Portal* to the individual named below.
- ACP's Online Patient Portal can give users the option of communicating securely via the Internet with our ACP offices.

Please circle one of these choices:

I do / I do not (circle one) authorize my proxy to communicate with my ACP provider and staff *electronically* through the portal regarding my health issues. I understand that these messages WILL become part of my medical record.

Patient Name: ______________________ Date of Birth: ______________________
Patient Phone Number: ______________________ MRN: ______________________
Patient Signature: ______________________ Date: ______________________

IF YOU NO LONGER WANT YOUR PROXY TO HAVE ACCESS TO YOUR ONLINE RECORDS, SIGN BELOW

Revocation of Proxy Rights

Patient Name: ______________________
Patient Signature: ______________________
Date: ______________________