



1925 W. Orange Grove Road, Suite 207
Tucson, Arizona 85704
Phone: (520) 742-0999
Fax: (520) 742-6563
www.azacp.com

Aria Internal Medicine

An Affiliate of Arizona Community Physicians

Thank you for your interest in becoming a new patient at Aria Internal and Family Medicine. To provide safe, focused primary care, and in accordance with Arizona prescription monitoring requirements, Dr. Sparkes has established the following policies for all new patients:

Dr. Sparkes does not initiate or continue long-term prescriptions for opioids, benzodiazepines, stimulants, sedatives, or testosterone. This includes narcotic pain medications, anxiety or sleep medications, ADHD stimulants, and testosterone therapy.

Patients who require ongoing management of these medications will be referred to appropriate specialists, including pain management or psychiatry, as clinically indicated. Our practice focuses on general medical care and chronic disease management.

In addition, Dr. Sparkes does not complete disability determination forms (including short-term, long-term, or permanent disability paperwork). Patients requiring disability evaluation or documentation will need to work with the appropriate specialist or a designated disability assessment provider.

If you are currently followed by pain management, psychiatry, or another specialist, please provide their contact information so we may coordinate care as needed.

Please understand that these policies are firm. Thank you for your cooperation.

Sincerely,

Stephanie Sparkes, M.D.

Acknowledgment

By signing below, I acknowledge that I have read, understand, and agree to the policies outlined above.

Patient Name (printed): _____

Signature: _____ Date: _____

Name: _____ DOB: _____ Medical record number: _____

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 Aria Internal and Family Medicine and Catalina Endocrinology.**

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 **10 minutes or more after their scheduled appointment time** may be asked to reschedule at the provider's 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 on our cancellation line. Appointment reminder calls and texts are a courtesy, not a guarantee. **Repeated no-shows or late cancellations may result in dismissal from the practice.**

3. Payments: Copays and deductibles are due at the time of service per your insurance plan. We do not bill copays. Accepted payment methods include cash, 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.

5. Lab Draws and Injections: are by appointment only, between **7:30–11:15 AM** and **1:30–3:15 PM**.

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.

7. Forms and Paperwork: Most forms require an office visit and carry a **\$50 completion fee**, depending on time required. Extensive letters or reports may incur higher fees. There is no charge for MVD handicap forms.

8. Prescription Refills: Please allow **three business days** for routine prescription refills. Contact your pharmacy first for standard refill requests. On-call providers do **not** prescribe controlled medications, including opioids, benzodiazepines, or stimulants.

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

ARIA INTERNAL AND FAMILY MEDICINE
HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: _____ **Date:** _____ **MRN:** _____
Preferred Name: _____

Marital Status: Single Married Divorced/Separated Partner Widowed

RISK ASSESSMENT / SOCIAL HISTORY

Current smoker? No Yes Packs/day: _____ Years: _____

Past smoker? No Yes Quit: _____ Packs/day: _____ Years: _____

Other nicotine/tobacco use: _____

Alcohol: Drinks/day: _____ Drinks/week: _____

Recreational drugs (past year)? No Yes

Exercise regularly? No Yes Times/week: _____

Occupation: _____

MEDICATIONS (include OTC, vitamins, supplements)

| Medication | Dose | How Many Times Per Day? |
|------------|------|-------------------------|
|------------|------|-------------------------|

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

ALLERGIES (medication, food, environmental)

Please list all allergies and reactions.

| |
|-------|
| _____ |
| _____ |
| _____ |
| _____ |

Patient Name: _____ Date: _____ MRN: _____

PAST MEDICAL HISTORY (check all that apply)

- Anemia
- Arthritis
- Asthma
- COPD/Emphysema
- Diabetes
- Drug/Alcohol Abuse
- Epilepsy/Seizure
- Heart Disease
- High Blood Pressure
- Kidney Disease/Stones
- Mental Illness
- Skin Disease
- Stroke
- Thyroid Disease
- Cancer (type): _____
- Other: _____

HOSPITALIZATIONS / SURGERIES

FAMILY HISTORY

| Condition | Father | Mother | Fathers Parents | Mothers Parents | Siblings | Children |
|----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Cancer | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> |
| HTN | <input type="checkbox"/> |
| Lung Disease | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> |
| Mental Illness | <input type="checkbox"/> |
| Alzheimer's | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> |
| Kidney Disease | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> |

SIGNATURE

Patient Signature: _____ 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 | | | |
| GROUP ID# | | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER SELF SPOUSE CHILD OTHER | | | |
| 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 | | | |
| GROUP ID# | | POLICY ID# | RELATIONSHIP OF PATIENT TO SUBSCRIBER SELF SPOUSE CHILD OTHER | | | |
| 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 |
|-----------------------|---------------------------------|------|

Name: _____ Date: _____ MRN #: _____

**ARIZONA COMMUNITY PHYSICIANS
REGISTRATION ADDENDUM**

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 or 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.

Scan under Patient forms

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

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.

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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.

| <u>TYPE OF INFORMATION TO BE RELEASED (No information will be released unless a box is checked)</u> | |
|---|---------------------------|
| General Release | DATES OF TREATMENT |
| <input type="checkbox"/> Medical Records/Excluding Protected Records (This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated) | From _____ To _____ |
| <input type="checkbox"/> Other Records (specify) _____ | From _____ To _____ |
| Information Protected by State/Federal Law | |
| <input type="checkbox"/> 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