New Patient Letter

Thank you for choosing Healthy Outlook Family Medicine, P.C.

1835 W Missouri Avenue
Phoenix, AZ 85015
602-230-0777
602-230-0008 (Fax)

Your appointment is scheduled at _________ on _____________ with ______________. Please arrive 15 minutes prior to your appointment. You will need to bring the enclosed paperwork with you on the day of your appointment. You must have your insurance card. If your card does not have one of our providers listed on it, please call your insurance company and have it corrected before your visit.

If you are scheduled for a complete physical and were told you need to fast, stop eating 12 hours before your scheduled appointment time. Do not drink anything other than plain tea, black coffee, or water. Continue taking all vitamins and ***medications*** as usual. If you are diabetic, you may call the office for fasting instructions.

If you can not make your appointment, call the office 24 hours prior to your appointment to cancel. There is a $50 charge for missed appointments. Thank you.

Remember: Co-pays are due at time of service.
We accept cash, check, Visa and MasterCard as forms of payment.

Patient Information

fill in **ALL** blanks (use same or N/A if needed)

If you were preregistered by phone, only fill in information you did not have available during preregistration.

PATIENT

Last Name ______________________ **First Name** ________________ **MI** ___ **Jr./Sr. (if used)** _____

Mailing Address ________________________________ City ______________ State ____ Zip ________

Home Phone ______________________ Cell Phone ______________________

Work Phone ______________________ ext _____

Date of Birth ___ / ___ / ______ Sex ___ ☐ Single ☐ Married ☐ Other ☐ Employed ☐ FT Student ☐ PT Student ☐ Other

Social Security Number ___________________ Email __________________________________

Race ☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ American Indian ☐ Pacific Island ☐ Other ☐ Refused

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic ☐ Refused

Language Preference ☐ English ☐ Spanish ☐ Other _____________________

If patient is a minor, fill in this section. If insurance is in another person's name, fill in this section.
If it's okay to mail your family's statements together, fill in this section.

Who are statements sent to?

Last Name _____________________ First Name _______________ Is this an established patient? ☐ Y ☐ N

Mailing Address ________________________________ City _______________ State ____ Zip _______

Home Phone ______________________ Other Phone ______________________ ext _____

Relationship _____________________________ SSN ___________________

INSURANCE

Primary Insurance Company ____________________ ID # _______________________ Group _________

Relationship to Cardholder ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

If "self" was not selected above, fill in this section.

Is cardholder a patient at this office? ☐ Y ☐ N

Cardholder's Last Name ______________________ First Name ________________ MI ___ Jr./Sr. _____

Mailing Address _________________________________ City _______________ State ____ Zip _______

Phone ______________________ Date of Birth ___ / ___ / ______ Sex ___

If insurance is through an employer, name of employer _________________________________

Secondary Insurance Company _________________ ID # _______________________ Group _________

How did you find out about our office? ☐ Family ☐ Co-Worker ☐ Friend
☐ Another Doctor ☐ Insurance ☐ Other ______________

CONTACT

State Law requires the following information for emergency contact.

If your mailing address listed above is a PO Box, you must provide your physical address.

Physical Address _______________________________ City _______________ State ____ Zip _______

Emergency Contact:

Spouse's Name ______________________ Emergency Phone ______________________

Closest relative living at a different address:

Last Name ______________________ First Name ________________ Relationship _______________

Address _________________________________ City _______________ State ____ Zip ________

Home Phone ______________________ Other Phone ______________________ ext _____

Patient or Authorized Signer _______________________________ Date ___ / ___ / ______

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Health Database

Name ____ Today's Date ___ / ___ / ______

Height ________ Weight ________ Race __________ Date of Birth ___ / ___ / ______

Past Illnesses (Circle those you have experienced)

Heart Disease	TB/Emphysema	Kidney Disease	Sexually Transmitted Disease
Hypertension	Asthma	Bleeding Tendency/Transfusions	Depression/Anxiety/Bipolar
Heart Murmur	Diabetes	Ulcers	Neurologic Disorder/Seizures
Rheum. Fever	Thyroid	Arthritis	Digestive Problems
Stroke	Cancer ________	Eye Problems	Other ___________________

List All Surgeries/Hospitalizations: ____

____

____

Social History

Relationship status _____________ Occupation _______________________

Age(s) of children __________ Vaginal or Caesarian birth(s)? ____________

If patient is a child, were there any complications during birth? ___________

Do you have a living will/advanced directives? ________________________

Do you have a religious/spiritual preference? _________________________

Use of	Circle
Tobacco	Y N
Cigarettes	Y N
Alcohol	Y N
Illegal Drugs	Y N
Caffeine	Y N
Guns in home	Y N
Pool at home	Y N

Medications

Medications you are using or have used in the past year (name, dose, frequency): ____

____

____

____

Allergic or sensitivity reactions to any medication, product, or food:
None __ List ____

Adult immunizations (Circle those done in the past 10 years – children must have their immunization records):
Tetanus Influenza Pneumonia Others: ______________

Family History

Family Member	Health Problems	Cause of Death
Father		
Mother		
Brothers		
Sisters		
Children		
Grandparents		

Is there any history of sudden unexplained death in your family? ____________________________
Is there any history of breast cancer in your family? _____________________________________

Names of other family members seen in our office ____________________________________

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Financial Agreement

Please review carefully. Fees are subject to change.

Appointment Late Cancellation (24 hour notice required, excluding weekends) $25.00
Appointment Late Arrival (cannot be seen for appointment) $25.00
Appointment No Show $50.00

Forms (complete all patient sections before submitting)

- Disability / FMLA .... $25.00 - $50.00
  - We do not complete forms for conditions being treated by a specialist. Allow 5 business days for completion or rejection. Additional visits may be required.
- Biometric Screening ....$15.00 - $25.00
- Medical Necessity Letters $50.00
- Nursing School $25.00
  - Additional visits may be required.
- Mission Physicals ....$50.00 - $75.00
- Miscellaneous Form Not Listed .... $varies
  - There may be a charge for your particular form not listed here.
- Medical Records from Patient Portal..free
- Medical Records Provided by Office .... $varies
  - Allow two weeks. Mailing fees apply.

Fees are payable when the forms are dropped off. Forms are completed at the provider's discretion.
If your form cannot be completed, the fee will be refunded or placed as a credit on your account.

Payment authorization for office visits, fees and services rendered at any time:

☐ Bill my insurance. When the amount due is determined, charge my CREDIT CARD automatically.

☐ Bill my insurance. When the amount due is determined, send me a bill. I will pay by CHECK within 15 days. I understand that $20 late fees will be added each month.

____________________________	____________________________	___ / ___ / ______
Last Name– **print neatly**	First Name	Date of Birth

I agree that calls and messages may be delivered to any phone number I provide. I authorize any provider at Healthy Outlook Family Medicine, P.C. to provide treatment. I authorize the release of all medical records or other information necessary to process claims. I authorize insurance to pay Healthy Outlook Family Medicine, P.C. directly for services rendered. Insurance is billed one time as a courtesy. However, **payment for all services is my responsibility.** Furthermore, **I agree to pay any amount denied or not covered by insurance.**

State law requires payment of medical claims within 30 days. **45 days after service has been rendered, insurance coverage is deemed to be waived and the patient is responsible for all billed charges without adjustment. $20 late fees and finance charges apply to all unpaid amounts. There is a $50 charge for missed appointments. Collection agency fees are paid by the patient.**

Patient or Authorized Signer ______________________________ Date ___ / ___ / ______

Healthy Outlook Family Medicine, P.C.

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Healthy Outlook Family Medicine, an Arizona Professional Corporation, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

_______________________ _______________________________________

Date Signature of Patient or Patient's Representative

____

Patient Name (Print)

ACKNOWLEDGEMENT OF RECEIPT
OF
STATEWIDE HEALTH INFORMATION EXCHANGE NOTICE

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_______________________ _______________________________________

Date Signature of Patient or Patient's Representative