CHOLLA MEDICAL GROUP, INC.

Documents Needed Before First Visit

Please provide all or as many of the following...

- *Complete the Insurance Verification Form, We need a Legible copy of PRIMARY & SECONDARY **INSURANCE** card front & back. We need this information to verify insurance prior to visit being scheduled. **Fax it to: 866-246-5494**
- Once Insurance has been verified, we will contact you and request the patient registration forms.
- Complete list of **MEDICATIONS** & previous physician information.
- Signed consent & demographics complete with patient's address, phone number & POA contact information.

The Insurance Verification Form does not apply to Cash Pay Patients

PLEASE SEND IN ANY OLD RECORDS THAT MIGHT ASSIST US. YOU MAY USE THE PROVIDED MEDICAL RECORD RELEASE FORM TO OBTAIN THIS INFORMATION FROM YOUR PREVIOUS PHYSICIAN OR HOSPITAL.

PLEASE FAX THIS INFORMATION TO: ***(866) 246 5494***

CONTACT US AT ***(480) 298 9951*** *FOR ANY QUESTIONS. THANK YOU!*

CHOLLA MEDICAL GROUP, INC.

MEDICATION LIST

MEDICINE	STRENGTH, QUANTITY AND DOSAGE

PLEASE LIST ANY CURRENT OR PREVIOUS SPECIALISTS OR PRIMARY CARE PROVIDERS

NAME	PHONE NUMBER	DATE OF YEAR OF LAST VISIT

6909 W Ray Rd. Suite 15, Chandler, AZ 85226 **Cmgstaff@chollamedical.com**
Office: 480-298-9951 www.chollamedicalgroup.com **Fax: 866-246-5494**

Patient Information:

Last Name _____ **First Name** _____ **MI** _____

Gender M ☐ F ☐ DOB _____Race: _____ Soc. Sec. No. _____

Address _____ Apt/Room # _____ City _____ Zip _____

Community name (if not at home) _____Martial Status: S ☐ M ☐ W ☐ D ☐

Home Phone _____ Cell Phone _____

E-mail _____ Preferred Pharmacy_____

Emergency Contact Person: Last Name _____ First Name_____MI_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ ext. _____ E-mail _____

Relationship to Patient _____ Responsible party Y ☐ N ☐ Power of Attorney Y ☐ N ☐

Credit Card Information (For Trip Fees or Insurance Co-Pays) Card Type: AmEx ☐ MC ☐ Visa ☐ Disc ☐

Credit Card Number_____ Exp. Date:_____

Name on card _____ CVC2 (3 digit code , AmEx is 4 digits) _____

Billing Address _____ City _____ State ___ Zip_____

Primary Insurance Policy Provider _____

Policy/Subscriber ID No._____ Group No._____

Claims Address (not needed for Medicare) City _____ State _____ Zip _____

Secondary Insurance Policy/Medicare Supplement _____

Policy/Subscriber ID No._____ Group No. _____

Claims Address (not needed for Medicare) City _____ State _____ Zip _____

Does Patient have Medicaid? Yes ☐ No ☐ ID#: _____

How did you find out about us? _____

CHOLLA
MEDICAL GROUP, INC.

Authorization of Treatment

PLEASE FAX TO: 866-246-5494

PATIENT: _____
(Please Print Patient's Name)

DOB: _____ SSN: _____

_____ I authorize the release of my medical records to Cholla Medical Group upon its request, including all examinations, diagnoses, laboratory and imaging studies, and treatments from the past two years.

_____ I authorize payment of my medical benefits to Cholla Medical Group for services rendered.

_____ I authorize disclosure of my medical record to Cholla Medical Group's business associates

_____ I authorize Cholla Medical Group to give my insurance company any information about services rendered to me necessary to process claims.

_____ I acknowledge that I received or was offered the practice's *Notice of Privacy Practices* describing the use and disclosure of confidential healthcare information.

_____ I understand and agree that I am financially responsible for all charges for services rendered to me, including balances owed after insurance payments.

_____ _____
Date Signature of patient or patient's Power of Attorney

(If signing as a POA, please fax a copy of your POA document as well.)

_____
(Please print name of the person signing this document)

CHOLLA MEDICAL GROUP, INC.

Advanced Beneficiary Notice (ABN)

Presented by Cholla Medical Group to _____

(Name of patient or POA)

WHAT DO YOU NEED TO KNOW: Read this notice, so you can make an informed decision about your care. Ask us any questions that you may have after you finish reading.

NOTE: Medicare does not pay for everything, even for some of the care that you or your health care provider have good reason to think you need. We do not expect Medicare to pay for services listed below:

Service		Cost	Reason
Trip fee is waved in senior communities on scheduled visit days			
Trip fee:	**Schedule Home Visits**	☐ - $50	Not a covered benefit
	Unscheduled Visits	☐ - $100	
	*This varies based on time of need and provider location and availability		
Flu Vaccine		☐ - $40	Not a covered benefit
Pneumonia Vaccine		☐ - $110	Not a covered benefit
PPD skin testing and screening		☐ - $42	Not a covered benefit.
Telephone consultation not "bundled" into an encounter		☐ - $30 per15 minutes	Not a covered benefits

OPTIONS (Choose only one!)

1) ☐ I want the services listed above when applicable to my care except those I crossed out.
I will pay for them at the time of service, but I will also fill request to Medicare for an official decision on payment, which I can appeal if payment denied. If Medicare does pay, you will refund any payment I made, less co-pays or deductible

2) ☐ I want the services listed above when applicable to my care except those I crossed out. I will pay for them at the time of service because I understand that those services are not covered by Medicare or supplemental insurances.

3) ☐ I do not want the services listed above. I will not be billed and cannot appeal to see if Medicare would pay.

Please understand the services listed on the ABN form will only be performed at your request-by filling out the form you give us the option of performing these services. Without form on file Insurance Company will not allow us to charge for specific services which are not covered under their policy.

_____ _____

Signature Date

Form CMG-R-131 (05/15) Form Approved OMB No. 0938-0566

CHOLLA
MEDICAL GROUP, INC.

Authorization for Release of Protected Health Information

I hereby authorize Cholla Medical Group to disclose Protected Health Information (HPI) as deemed below.

Patient:
Name:_____
SS #:_____
Date of Birth: _____

Requestor (If other than Patient):
Name: _____
Relationship:_____
Source of Legal Authority: _____
_____

Name and Address of who to receive health records/information:

Cholla Medical Group, Inc
6909 W. Ray Road, Suite 15
Chandler, AZ 85226
Phone # 480-298-9951
Fax # 866-246-5494

☐ I wish to have the following records copied, and I will pick them up at your facility
☐ **I request the facility copy the following records and fax/send them to the above address**

I request the release of **all** medical record created between: Date: _____and_____

Legal Authority Request:
☐ I am the Patient noted above
☐ I am the Patient's legal representative
☐ I am the Patient's Power of Attorney
☐ I am the Patient's legal Guardian
Requestor's Initials _____

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for use in medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

If signing as a POA, please include a copy of documentation, as some providers will not release records without additional documentation.

Signature:_____ Date:_____

Relationship to Patient:_____

Name of Person Completing this Form:_____

Medical History Form

Current Medical Problems:

_____
_____
_____
_____
_____
_____
_____
_____

Do you have or have you been treated for:
- ☐ DM
- ☐ Heart problem
- ☐ HTN
- ☐ Anxiety/Depression
- ☐ Alzheimer's/Dementia
- ☐ Arthritis/Joint Problems
- ☐ COPD/Breathing problems
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Acid Reflux

Current Height: ___ft ___in Weigh: ____lbs

What other past medical problems do you have: _____
_____

In the past year have you been hospitalized? if so when and for what: _____
_____

What surgeries have you had?

☐Tonsillectomy	☐Tubal/vasectomy	Other:_____
☐Appendectomy	☐Hysterectomy	_____
☐Gall Bladder	☐Joint/Orthopedic	_____
☐C-section	☐Heart	_____

Are you Allergic to any medication?: _____

Please Provide a complete list of medications, including over the counter medications and vitamins (use a separate list if needed)_____

_____

Primary pharmacy, do you use more than one, if so please list: _____
_____

Do you have any hearing problems: ___Do you have hearing aids?___
Do you where glasses? ____ or Contacts. Reading glasses only? ____

Vaccines: do you have a current…
- ☐Flu Vaccine
- ☐Pneumonia Vaccine
- ☐Shingles Vaccine

Do you have any false teeth or dentures? _____

Age and health of your:

Mother: _____Father: _____

Do you have a Family Medical History of:
Diabetes: M☐ F☐ S☐ C Heart Disease: M☐ F☐ S☐ C☐
High blood pressure: M☐ F☐ S☐ C☐ Stroke: M☐ F☐ S☐ C☐
Cancer: M☐ F☐ S☐ C☐ Asthma: M☐ F☐ S☐ C☐
Seizures: M☐ F☐ S☐ C☐ Bleeding problems: M☐ F☐ S☐ C☐
Mental Disease: M☐ F☐ S☐ C☐

M- Mother, F-Father, S-Sibling, C-Child

Screenings:
Last Mammogram Year:_____
Last Pap smear Year:_____
Last PSA tested Year:_____
Last colonoscopy Year:_____

Office:480-298-9951 www.chollamedicalgroup.com Fax:866-246-5494

Medical History Form Continued

Where were you born?_____

Highest level of education?_____

Occupation:_____
Are you still working or retired?_____

Are you Married ☐ Widow ☐ Divorced ☐ Single ☐ ?

Do you have Children?_____ How many?_____

Any Grandchildren?____ How Many?_____

Who resides in your home:_____

Hobbies:_____

Do you exercise regularly? Y ☐ or N ☐

Do you smoke?	Do you Drink Alcohol?	Do you use recreational or illicit drugs?
Y ☐ N ☐ Quit ☐	Occ, ☐ Socially, ☐ Often, ☐ Heavily ☐	N ☐ Y ☐ What_____

Check any symptoms that you are having

☐ Wt Loss ☐ Fevers ☐ Chills ☐ Night sweats

☐ Hair loss ☐ Skin changes ☐ Rashes ☐ New lumps/moles

☐ Headaches ☐ Blurred vision ☐ Dizziness ☐ Hearing loss ☐ vision changes

☐ Runny nose ☐ Seasonal Allergies ☐ Nose bleeds

☐ Bleeding gum ☐ Dental pain ☐ Sore Throat ☐ Swollen glands

☐ Shortness of breath ☐ Cough ☐ Breathing problems

☐ Hypertension ☐ Heart murmur ☐ Chest pains ☐ Palpitations ☐ Abnormal EKG

☐ Changes in appetite ☐ Nausea ☐ Vomiting ☐ Reflux ☐ Trouble swallowing

☐ Bowel troubles ☐ Constipation ☐ Hemorrhoids ☐ Abdominal pains ☐ Hepatitis

☐ Urinary Frequency ☐ Pain with urination ☐ Blood in your urine ☐ Incontinence

☐ Leg edema ☐ Blood Clots ☐ weakness ☐ Joint pain

☐ Numbness ☐ Nerve pain ☐ Tremors ☐ Fainting ☐ Seizures

☐ Anemia ☐ Bleeding problems ☐ Hot or Cold intolerance ☐ Thyroid problems

☐ Mood problems ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Dementia

☐ Behavioral problems ☐ Substance Abuse