



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!

MEDICATION LIST

<u>MEDICINE</u>	<u>STRENGTH, QUANTITY AND DOSAGE</u>

PLEASE LIST ANY CURRENT OR PREVIOUS SPECIALISTS OR PRIMARY CARE PROVIDERS

<u>NAME</u>	<u>PHONE NUMBER</u>	<u>DATE OF YEAR OF LAST VISIT</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



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? _____



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)



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 waived in senior communities on scheduled visit days		
Trip fee:	Schedule Home Visits	Not a covered benefit
	Unscheduled Visits	

*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 per 15 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



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?

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Tubal/vasectomy	Other: _____
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hysterectomy	_____
<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Joint/Orthopedic	_____
<input type="checkbox"/> C-section	<input type="checkbox"/> 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 wear glasses? ___ or Contacts. Reading glasses only? ___

Vaccines: do you have a current...

Flu Vaccine Do you have
 Pneumonia Vaccine any false teeth
 Shingles Vaccine 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

Screenings:

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

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