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(s) front & back. We need this information to verify insurance prior to visit being scheduled. **Fax it to: 1-866-246-5494**
- ***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: ***1-866-246-5494***

CONTACT US AT ***(480) 298-9951*** *FOR ANY QUESTIONS.*

THANK YOU!

***If you need assistance when completing the New Patient Registration Forms, we will gladly assist - please contact us via email or call our office to speak to our Patient Concierge.**

CHOLLA
MEDICAL GROUP, INC.

INSURANCE VERIFICATION FORM

PATIENT NAME: _____

D.O.B: _____

SS#: _____

PHONE #: _____

ADDRESS: _____

SIGNATURE: _____

FACILITY: _____

CONTACT NAME: _____

PHONE #: _____

COPY OF INSURANCE CARD - FRONT/BACK

This form must be faxed in <u>first</u> to verify insurance prior to visit being scheduled.

_____

Office: 480-298-9951
Fax: 1-866-246-5494

CHOLLA MEDICAL GROUP, INC.

10631 S. 51st Street, Ste 1, Phoenix, AZ 85044-5225 cmgstaff@chollamedical.com
Office: 480-298-9951 www.chollamedicalgroup.com Fax: 1-866-246-5494

Patient Information:

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

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

Address _____ Apt/Room # _____ City _____ Zip _____

Facility/Group Home name_____ Marital Status: S☐ M☐ W☐ D☐

Home Phone _____ Cell Phone _____

Have you ever served in the Armed Forces? Y ☐ N ☐

Are you currently receiving VA benefits? Y ☐ N ☐

E-mail _____ Pharmacy Phone#_____

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☐

*POA Last 4 digits of Social Security #: _____DOB:_____

*Due to HIPPA regulations a person seeking information about a patient, must be propertly indentified by a unique identifier for information to be released.

The Patient/POA acknowledges that all of this information is true and correct and that it has been furnished to this office with full knowledge that the patient/POA is responsible for all services rendered and that he/she is contractually bound to pay for said services. This includes all costs of collections and responsible attorney's fee, if collections become necessary. Patient/POA hereby waives his/ her confidentiality rights should collection action become necessary. Patient/POA hereby authorizes and request payments under insurance plans be made directly to the above provider for any services provided. Patient/ POA also authorizes the release of any information requested by his/ her insurance carrier to process insurance claims.

Printed Name: _____

Signature: _____

Date: _____

CHOLLA MEDICAL GROUP, INC.

MEDICATION LIST

MEDICINE	STRENGTH, QUANTITY AND DOSAGE

PLEASE LIST ANY KNOWN ALLERGIES TO MEDICINE

_____ _____ _____

_____ _____ _____

PHARMACY NAME:_____PHONE:_____

CHOLLA
MEDICAL GROUP, INC.

Authorization for Release of Protected Health Information

I hereby authorize _____ to disclose Protected Health Information (PHI) 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.
10631 S. 51st Street, Suite 1
Phoenix, Arizona 85044-5225
Phone #: 480-298-9951
Fax #: 1-866-246-5494

☐ 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:_____