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: JOHN L. DOE

D.O.B: 07/04/1943

SS#: 000-00-0000

FACILITY: CHOLLA ASSISTED LIVING GROUP HOME

CONTACT NAME: MATTHEW SAMPLE

ADDRESS: 10631 S 51ST STREET. PHOENIX, AZ 85044

PHONE #: 480-298-9951

* **INSURANCE NAME** AND **NUMBER** IS REQUIRED FOR THE FOLLOWING:

PRIMARY INSURANCE: MEDICARE 1-800-633-4227

SECONDARY INSURANCE: BCBS 1-800-678-2583

SIGNATURE: Jane Doe

COPY OF INSURANCE CARD - FRONT/BACK

This form must be faxed in first 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 DOE **First Name** JOHN **MI** L.

Gender: M ☑ F ☐ DOB 07/04/1943 Race: W Soc. Sec. No. 000-00-0000

Address 10631 S. 51ST STREET Apt/Room # 218 City PHOENIX Zip 85044

Facility/Group Home name CHOLLA ASSISTED LIVING GROUP HOME Marital Status: S ☐ M ☑ W ☐ D ☐

Home Phone 480-298-9951 Cell Phone 480-418-7246

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

Are you currently receiving VA benefits? Y ☑ N ☐

E-mail JOHNDOE@GMAIL.COM Pharmacy Phone# OMEGA PHARMACY 480-000-0000

Emergency Contact Person: Last Name DOE First Name JANE MI M.

Address 10631 S. 51ST STREET City PHOENIX State AZ Zip 85044

Home Phone 480-298-9951 Cell Phone 480-418-7246

Work Phone N/A ext. ____ E-mail JANEMDOE@GMAIL.COM

Relationship to Patient WIFE Responsible party: Y ☑ N ☐ Power of Attorney: Y ☑ N ☐

*POA Last 4 digits of Social Security #: 1234 DOB: 07/05/1944

*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: JANE M. DOE

Signature: Jane Doe

Date: 11/28/2018

CHOLLA MEDICAL GROUP, INC.

MEDICATION LIST

MEDICINE	STRENGTH, QUANTITY AND DOSAGE
Tylenol Extra Strength	500 mg Tab 2 tablet every 4 hours as needed
ALPRAZolam	0.5 mg Tab 0.5 tablet orally 2 times per day

PLEASE LIST ANY KNOWN ALLERGIES TO MEDICINE

Aspirin _____ Amoxicillin _____ _____

_____ _____ _____

PHARMACY NAME: OMEGA PHARMACY **PHONE:** 480-000-0000

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: JOHN L. DOE
SS #: 000-00-0000
Date of Birth: 07/04/1943

Requestor (if other than Patient):
Name: Jane M. Doe
Relationship: Wife
Source of Legal Authority: POA

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 _____

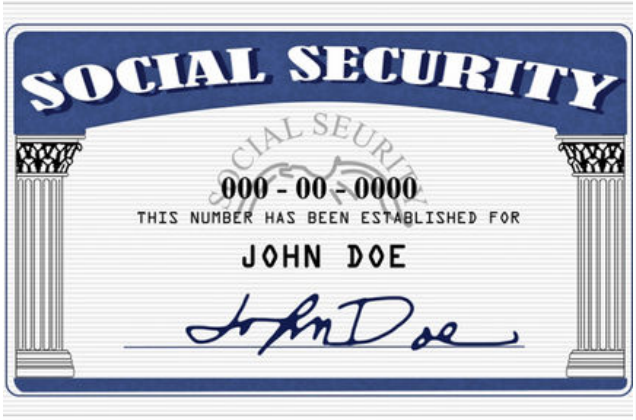
I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for use in medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that 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: Jane Doe Date: 11/28/2018

Relationship to Patient: WIFE

Name of Person Completing this Form: JANE M. DOE



MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JOHN DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
MALE

IS ENTITLED TO / EFFECTIVE DATE

HOSPITAL (PART A) 01-01-2007
MEDICAL (PART B) 01-01-2007

SIGN HERE →

SAMPLE

ND

Member Name
John D. Doe
ID
YQE

Medical and Rx Benefits
RxBIN **610455**
RxPCN **NDBCS**
Plan Code **320 820**

Office Visit Copay **$XX**
ER Visit Copay **$XX**
Additional copays may apply
No copay after OOPM is met*
Pediatric dental and vision

PPO

ND

Subscriber: Identify yourself by the ID Number on the face of this card.

Health and Vision Provider: File claims with your local Blue Cross and/or Blue Shield Plan.

Dental Provider: File claims to Blue Cross Blue Shield of North Dakota at the address to the right.

*OOPM: Out-of-pocket maximum

www.BCBSND.com

Member
Member Services: **1-800-342-4718**
Worldwide Access: **1-800-810-2583**
Pharmacy Access: **1-800-711-9861**
Provider
Provider Service: **1-800-368-2312**
Eligibility: **1-800-676-2583**
Pharmacist: **1-800-821-4795**
Dental Provider: **1-888-772-4256**
Vision Provider: **1-888-772-4259**

Blue Cross Blue Shield of North Dakota
4510 13th Avenue S.
Fargo, ND 58121
An independent licensee of the Blue Cross and Blue Shield Association.

SAMPLE MEDICAL POWER ATTORNEY

FULL POWER OF ATTORNEY

Date: _____

I, _____, the undersigned, of _____,
do hereby confer full power of attorney on _____,
of _____ as true and lawful attorney-in-fact for me and in my name, place and stead, and on my behalf, and for my use and benefit, regarding the following:

FIRST: To ask, demand, litigate, recover, and receive all manner of goods, chattels, debts, rents, interest, sums of money and demands whatsoever, due or hereafter to become due and owing, or belonging to me, and to make, give and execute acquittances, receipts, satisfactions or other discharges for the same, whether under seal or otherwise;

SECOND: To make, execute, endorse, accept and deliver in my name or in the name of my aforesaid attorney all checks, notes, drafts, warrants, acknowledgments, agreements and all other instruments in writing, of whatever nature, as to my said attorney-in-fact may seem necessary to conserve my interests;

THIRD: To execute, acknowledge and deliver any and all contracts, debts, leases, assignments of mortgage, extensions of mortgage, satisfactions of mortgage, releases of mortgage, subordination agreements and any other instrument or agreement of any kind or nature whatsoever, in connection therewith, and affecting any and all property presently mine or hereafter acquired, located anywhere, which to my said attorney-in-fact may seem necessary or advantageous for my interests;

FOURTH: To enter into and take possession of any lands, real estate, tenements, houses, stores or buildings, or parts thereof, belonging to me that may become vacant or unoccupied, or to the possession of which I may be or may become entitled, and to receive and take for me and in my name and to my use all or any rents, profits or issues of any real estate to me belonging, and to let the same in such manner as to my attorney shall seem necessary and proper, and from time to time to renew leases;

FIFTH: To commence, and prosecute on my behalf, any suits or actions or other legal or equitable proceedings for the recovery of any of my lands or for any goods, chattels, debts, duties, and to demand cause or thing whatsoever, due or to become due or belonging to me, and to prosecute, maintain and discontinue the same, if he or she shall deem proper;

SIXTH: To take all steps and remedies necessary and proper for the conduct and management of my business affairs, and for the recovery, receiving, obtaining and holding possession of any lands, tenements, rents or real estate, goods and chattels, debts, interest, demands, duties, sum or sums of money or any other thing whatsoever, located anywhere, that is, are or shall be, by my said attorney-in-fact, thought to be due, owing, belonging to or payable to me in my own right or otherwise;

SEVENTH: To appear, answer and defend in all actions and suits whatsoever that shall be commenced against me and also for me and in my name to compromise, settle and adjust, with each and every person or persons, all actions, accounts, dues and demands, subsisting or to subsist between me and them or any of them, and in such manner as my said attorney-in-fact shall think proper; hereby giving to my said attorney power and authority to do, execute and perform and finish for me and in my name all those things that shall be expedient and necessary, or which my said attorney shall judge expedient and necessary in and about or concerning the premises, or any of them, as fully as I could do if personally present, hereby ratifying and confirming whatever my said attorney shall do or cause to be done in, about or concerning the premises and any part thereof.

Powers conferred on said attorney-in-fact shall not be restricted or limited by the aforementioned specifications regarding situation of representation. The rights, powers and authority of said attorney-in-fact granted in this instrument shall commence and be in full force and effect on _____, (Month & Day) _____, (Year) and such rights, powers and authority shall remain in full force and effect thereafter until I give notice in writing that such power is terminated.

It is my desire, and I so freely state, that this power of attorney shall not be affected by any subsequent disability or incapacity that may befall me.

FURTHERMORE, upon a finding of incompetence by a court of appropriate jurisdiction, this power of attorney shall be irrevocable until such time as said court determines that I am no longer incompetent.

_____

Signature

I, _____, whose name is signed to the foregoing instrument, having been duly qualified according to the law, do hereby acknowledge that I signed and executed this power of attorney; that I am of sound mind; that I am eighteen (18) years of age or older; that I signed it willingly and am under no

constraint or undue influence; and that I signed it as my free and voluntary act for the purpose therein expressed.

_____

Signature

My commission expires on _____

_____

Notary Public