CHOLLA MEDICAL GROUP, INC.

Documents Needed Before First Visit

Please provide all or as many of the following:

☐	Complete the Insurance Verification Form *This does not apply to Cash-Pay Patients ☐ 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 demographics with patient information & POA contact information
☐	Signed Consent Agreement
☐	Complete Authorization for Release of Protected Health Information ☐ Please send in any old medical records that may assist us in caring for you as our patient. You may use the provided medical record release form to obtain this information from your previous physician or hospital.
☐	Please attach a current medication list, if available.

Please **FAX** this information to: **1-866-246-5494**
Contact us at **(480) 298-9951** with 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 Services Specialists.

CHOLLA MEDICAL GROUP, INC.

INSURANCE VERIFICATION

PATIENT NAME: _____

D.O.B.: _____

SS#: _____

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

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Member ID #	Member ID #

COPY OF INSURANCE CARD(S) – FRONT/BACK

This form must be faxed in first to verify insurance prior to visit being scheduled.

SIGNATURE: _____

FACILITY/GROUP HOME INFORMATION

Facility/Group Home Name _____

Facility/Group Home Address _____

Facility Contact Name _____

Phone # _____ Fax # _____

CHOLLA MEDICAL GROUP, INC.

Patient Information:

Last Name_____ First Name_____ MI_____

DOB_____ Soc. Sec. No._____ Gender: Male ☐ Female ☐

Race_____ Marital Status: S ☐ M ☐ W ☐ D ☐

Address_____ Apt/Room #_____ City_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail_____

Pharmacy Name_____ Pharmacy #_____

Have you ever served in the Armed Forces? Y ☐ N ☐
Are you currently receiving VA benefits? Y ☐ N ☐

Medical Power of Attorney: Last Name_____ First Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail _____

*POA 4 digit identifier_____ DOB_____
*Due to HIPPA regulations a person seeking information about a patient must be properly identified by a unique identifier for information to be released.

Financial Power of Attorney: Last Name_____ First Name_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ E-mail _____

Emergency Contact: Name_____

Relationship to Patient_____ Phone # _____

CHOLLA
MEDICAL GROUP, INC.

Patient Name: _____

1. **Medical Power of Attorney Declaration:** A representative of Cholla Medical Group, Inc. is required to explain and inquire of potential patients whether or not they have a POA making medical decisions on their behalf. No evaluation or treatment will be provided without a signed consent form from the patient or the Medical POA.
2. **Terms of Agreement and Consent:** I understand that my physician is part of Cholla Medical Group, Inc. ("CMG") and I agree that my physician and other CMG healthcare providers may render such medical treatment, including diagnostic procedures, lab tests and x-rays, as they deem clinically necessary and advisable. I understand that I have the right to consent, or to refuse any proposed clinical procedure or plan of care. This agreement and consent remains valid from the day forward to include all future services relating to the patient or until cancelled in writing by the patient or POA.
3. **Financial Responsibility:** The patient or Financial POA is responsible for any amount not paid by the insurance company. I authorize Cholla Medical Group, Inc. or my insurance company to release any information required to process my claim(s). Co-pays and deductibles are designated by my insurance company and/or health plan. Medicare requires CMG to bill for co-pays, co-insurance and deductibles. I agree to pay all co-pays, co-insurance and deductibles. I understand that I am financially responsible for any outstanding balance on my claim(s), furthermore for costs of collections and responsible attorney's fee, if collections become necessary.
   ********In addition, under the Arizona Community Property Law, the spouse of the Financial POA understands that they too are responsible for payment for any medical services rendered to the patient in the case that the Financial POA is unable to fulfill payment.*
4. **Privacy Agreement:** By signing this form I understand my rights and responsibilities as a patient, I acknowledge receipt and have read and understand the Privacy Policy, of which I may obtain a copy upon request by contacting the CMG office.

My signature below certifies that I have read and agree with all the notices, disclosures, and consents posted on this agreement.

Patient/Medical POA

Print Name_____

Signature_____Date_____

Financial POA

Print Name_____

Signature_____

Date_____

*Financial POA's Spouse

Print Name_____

Signature_____

Date_____

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_____
Soc. Sec. #_____
DOB_____

Requestor (if other than patient):
Name_____
Relationship_____
Source of Legal Authority_____
_____

Name & 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 records 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_____