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: JOHN L. DOE

D.O.B.: 07/04/1943

SS#: 000-00-0000

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

Primary Medical Insurance		Secondary Medical Insurance	
Ins. Co. Name	Medicare	Ins. Co. Name	BCBS
Member ID #	000-00-0000-A	Member ID #	YQE

COPY OF INSURANCE CARD(S) – FRONT/BACK

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

SIGNATURE: Jane Doe

FACILITY/GROUP HOME INFORMATION

Facility/Group Home Name: Cholla Assisted Living Group Home

Facility/Group Home Address: 10631 S. 51st Street. Phoenix, AZ 85044

Facility Contact Name: Matthew Sample

Phone #: 480-298-9951 Fax #: 1-866-246-5494

CHOLLA MEDICAL GROUP, INC.

Patient Information:

Last Name Doe First Name John MI L.

DOB 07/04/1943 Soc. Sec. No. 000-00-0000 Gender: Male ☑ Female ☐

Race white Marital Status: S ☐ M ☑ W ☐ D ☐

Address 10631 S. 51st Street Apt/Room # 218 City Phoenix Zip 85044

Home Phone 480-298-9951 Cell Phone 480-321-7654 E-mail johndoe@gmail.com

Pharmacy Name Omega Pharmacy Pharmacy # 480-000-0000

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

Are you currently receiving VA benefits? Y ☑ N ☐

Medical Power of Attorney: Last Name Doe First Name Jane

Address 10631 S. 51st Street City Phoenix State AZ Zip 85044

Home Phone 480-298-9951 Cell Phone 480-123-4321 E-mail janemdoe@gmail.com

*POA 4 digit identifier 1234 DOB 07/05/1944

*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 Stone First Name Emma

Address 123 W. Posada Ave. City Mesa State AZ Zip 85212

Home Phone 480-123-4567 Cell Phone 480-321-7654 E-mail emmadoestone@gmail.com

Emergency Contact: Name Jane M. Doe (same as above)

Relationship to Patient wife Phone # 480-123-4321

CHOLLA
MEDICAL GROUP, INC.

Patient Name: John L. Doe

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 Jane M. Doe

Signature Jane Doe Date 02/27/19

Financial POA

Print Name Emma Stone Doe

Signature Emma Stone

Date 02/27/19

*Financial POA's Spouse

Print Name Jack Stone

Signature Jack Stone

Date 02/27/19

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
Soc. Sec. # 000-00-0000
DOB 07/04/1943

Requestor (if other than patient):
Name Jane M. Doe
Relationship wife
Source of Legal Authority medical POA

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**

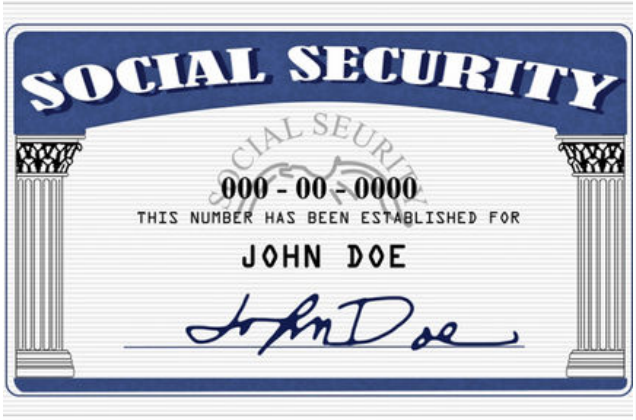
I request the release of **all** medical records created between Date: _____ and _____

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 JD

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 02/27/19
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