



Documents Needed Before First Visit

Please provide all or as many of the following:

<input type="checkbox"/>	Complete the Insurance Verification Form *This does not apply to Cash-Pay Patients <div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> legible copy of PRIMARY & SECONDARY INSURANCE card(s) front & back *We need this information to verify insurance prior to visit being scheduled <input type="checkbox"/> Fax it to: 1-866-246-5494 *Once insurance has been verified, we will contact you and request the patient registration forms. </div>
<input type="checkbox"/>	Complete demographics with patient information & POA contact information
<input type="checkbox"/>	Signed Consent Agreement
<input type="checkbox"/>	Complete Authorization for Release of Protected Health Information <div style="border: 1px solid black; padding: 2px;"> <input type="checkbox"/> Please send in any old medical records that may assist us in caring for you as our patient. You may use the provided <u>medical record release form</u> to obtain this information from your previous physician or hospital. </div>
<input type="checkbox"/>	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.



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 # _____



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 # _____



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

*Financial POA's Spouse

Print Name _____

Print Name _____

Signature _____

Signature _____

Date _____

Date _____



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 _____