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.

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 I have read and understand the Privacy Policy, which can be found on Cholla Medical Group's website www.chollamedicalgroup.com and 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____________________________________

10631 S. 51st Street, Ste. 8, Phoenix, AZ 85044-5225 **cmgstaff@chollamedical.com**
Office: 480-298-9951 **www.chollamedicalgroup.com** **Fax: 1-866-246-5494**

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____