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.

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**

Cholla Medical Group, Inc.
10631 S. 51st Street, Suite 8
Phoenix, AZ 85044
(o) 480-298-9951 (f) 866-246-5494

PATIENT REGISTRATION

First Name: _____ Last Name: _____ (MI): _____

DOB: _____ / _____ / _____ Gender: M / F Marital Status: S / M / D / W

Community/Facility Name: _____ Facility Move-in Date: _____ / _____ / _____

Community/Facility Address: _____ Phone #: _____ Fax #: _____

Social Security Number: _____ Medicare Number: _____

Preferred Language: _____Race: _____Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Pharmacy:

Location: _____ Phone #: _____ Fax #: _____

☐ I am NOT on Hospice ☐ I AM ON Hospice (Hospice Company: _____)

☐ I DO have a Medical Power of Attorney (MPOA) ☐ I DO NOT have a Medical Power of Attorney

MPOA or Primary Contact: _____ Relation to Patient: _____

Primary Phone #: _____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

☐ I DO have a Guarantor or Financial POA (FPOA) ☐ I DO NOT have a Guarantor or Financial POA

FPOA or Guarantor: _____ Relation to Patient: _____

Primary Phone #: _____ Email Address: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

-Please complete all sections that apply-

Without accurate insurance information we will be unable to bill your insurance and we will have to bill you directly.

PRIMARY INSURANCE (Medicare, Medicare Advantage, Commercial Plan) (Part B, Part C)

Insurance Provider and Plan Name: _____

Member ID# _____

SECONDARY INSURANCE (Medicare Supplement Plan or "Medigap" Plan) (Part F, G, K, L, M, N, Etc)

Insurance Provider and Plan Name: _____

Member ID# _____

Medicaid/AHCCCS/ALTCS or TRICARE (Medicaid is always the last payer to other insurances)

Insurance Provider and Plan Name: _____

Member ID# _____

*FAX COMPLETED FORMS AND INSURANCE CARDS TO **1-866-246-5494***

Cholla Medical Group, Inc.
10631 S. 51st Street, Suite 8
Phoenix, AZ 85044
(o) 480-298-9951 (f) 866-246-5494

Name of Patient: _____

Date of Birth: ____ /____ /____ Community/Facility Name: _____

SELECTION OF PRIMARY CARE PHYSICIAN and MEDICAL CONSENT
I hereby request medical care and treatment by Cholla Medical Group, Inc. and its Associates. I designate Cholla Medical Group, Inc. and its Associates as my only Primary Care Providers and request that they monitor and assist with all aspects of my health care including Chronic Care Management and Care Plan Oversight and as such I agree to provide Cholla Medical Group, Inc. with a detailed medical history.

CHRONIC CARE MANAGEMENT (CCM)
I agree to allow Cholla Medical Group, Inc. to provide me with Chronic Care Management (CCM), Home Health and Hospice Care Plan Oversight services and to be designated as my only CCM provider. Services include: Easy access to clinical staff, consultation and guidance in managing my chronic conditions, reviewing my medications, help with scheduling specialist visits and tests that my doctor ordered, receiving a plan of care with personal health goals, sharing e-records and coordination of care with other providers, and working closely with my home health and hospice. I understand that Cholla Medical Group, Inc. may bill my insurance for these services and depending on my insurance, I may be responsible for a co-pay. I can refuse or opt-out of these services and stop my CCM at the end of any month by contacting Cholla Medical Group, Inc. by telephone or in writing.

FINANCIAL RESPONSIBILITY
I authorize Cholla Medical Group, Inc. to bill my Insurance and for my insurance company to make direct payments to Cholla Medical Group, Inc.. I accept financial responsibility for payment of insurance mandated charges such as Deductibles, Copays, and Coinsurance. Cholla Medical Group, Inc. cannot bill your insurance if we are provided with incorrect information; therefore, to avoid being billed directly, I understand that it is my responsibility to continuously provide up-to-date Insurance information.

NOTICE OF PRIVACY PRACTICES
Medical information is considered private and confidential. However, I am aware, that my information may be shared or disclosed verbally, electronically, and on paper as needed to others who are involved in my care and as needed for medical billing. Cholla Medical Group, Inc. participates in Government Health Information Exchange (HIE) programs to which you can opt out at any time. Furthermore, I understand that Cholla Medical Group, Inc. may disclose my health information when required to do so by law.

HOSPICE CARE
I understand that in the event that Hospice services are required, Cholla Medical Group, Inc. will remain as Primary Care Provider and act as my Hospice Care - Attending Physician (GV), unless otherwise notified in writing.

TRANSFER OF CARE
I understand that Cholla Medical Group, Inc. may not remain as my Primary Care Provider in the event that I move from my current care facility. Cholla Medical Group, Inc. also reserves the legal right to terminate services, at any time, without cause, upon (30) days prior notice. I understand that if a change in provider is needed for any reason that prompt written notification be sent to Cholla Medical Group, Inc.

Notice of Health Information Practices
Attestation of Receipt of the Notice

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

My Signature below certifies that I have read and understand and consent to all terms & conditions listed above.

_____

Signature of patient or Legal POA 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 8
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 the 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_____

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing
You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.