CHOLLA MEDICAL GROUP, INC.

Documents Needed Before First Visit

Please provide all 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

Revised 08/01/22

CHOLLA MEDICAL GROUP, INC.

New Patient Information and Consent Forms

Patient Information				
Name:	Date of Birth:	SSN:	Gender: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ D ☐ W

Facility/GH:	Primary Phone:	☐ Home ☐ Cell	Are you a Verteran?	☐ Y ☐ N
Facility/Group Home Address:	Patient Email:			
Facility/Group Home Contact:	Phone:	Fax:		

MPOA/Emergency Contact Information				
Medical Power of Attorney (MPOA):	Relationship to Patient:		*MPOA DOB/PIN	
MPOA Address:	Phone:	☐ Home ☐ Cell	Okay to leave message?:	☐ Y ☐ N
Emergency Contact: (If same as MPOA write "Same")	Relationship to Patient:			
MPOA Email:	Phone:	☐ Home ☐ Cell	Okay to leave message?	☐ Y ☐ N

***MPOA must provide DOB/PIN to be used by our office/medical team to authenticate when discussing medical care for patient.**

Insurance Information		
Primary Insurance Company:	Member ID:	Group Number:
Secondary Insurance Company:	Member ID:	Group Number:

Preferred Pharmacy	
Pharmacy Name	Pharmacy Address

10631 S 51st St, Suite 8
Phoenix, AZ 85044

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

CHOLLA MEDICAL GROUP, INC.

Medical History

Patient Name: _____
DOB: _____

Any known Allergies?
☐ No ☐ Yes (please specify): _____

Past Medical History: Check all that apply		
☐ COPD/Emphysema	☐ High Cholesterol	☐ Hypertension
☐ Stroke	☐ Rheumatoid Arthritis	☐ Alcoholism
☐ Dementia	☐ HIV	☐ Seizure Disorder
☐ Seasonal Allergies	☐ Depression	☐ Hepatitis
☐ Sleep Apnea	☐ Anemia	☐ Diabetes
☐ Irritable Bowel Syndrome	☐ Anxiety	☐ Diverticulitis
☐ Lupus	☐ Thyroid Disorder	☐ Arrhythmia (irregular heartbeat)
☐ DVT (blood clot)	☐ Liver Disease	☐ Ulcerative Colitis
☐ Arthritis	☐ GERD (acid reflux)	☐ Macular Degeneration
☐ Asthma	☐ Glaucoma	☐ Neuropathy
☐ Bipolar Disorder	☐ Heart Disease	☐ Osteopenia/Osteoporosis
☐ Bladder Problems/Incontinence	☐ Heart Attack (MI)	☐ Parkinson's Disease
☐ Bleeding Problems	☐ Hiatal Hernia	☐ Peripheral Vascular Disease
☐ Cancer (please specify): _____		☐ High Blood Pressure
☐ Peptic Ulcer	☐ Headaches	☐ Kidney Stones
☐ Psoriasis	☐ Crohn's Disease	☐ Kidney Disease
☐ Pulmonary Embolism (PE)	☐ Other (please specify): _____	

Health Screening History:			
Colonoscopy	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N
Mammogram	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N
Dexa (Bone Density)	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N
Pap Smear	Date:	Facility/Provider:	Abnormal Result? ☐ Y ☐ N

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CHOLLA MEDICAL GROUP, INC.

Health History

Patient Name: _____

List **all medications** you take, including over the counter medications and vitamins. Include specific doses and when taken. If you do not know, please call your pharmacist to confirm.

Medication Name:	Dosage:	When Taken:

List **all prior surgeries** and approximate dates performed.

Surgery:	Date Performed:

Social / Cultural History:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College

Are there any vision problems that affect ability to communicate? ☐ No ☐ Yes

Are there any hearing problems that affect ability to communicate? ☐ No ☐ Yes

Are there any limitations to understanding or following instructions (written or verbal)?

☐ Yes Written ☐ Yes Verbal ☐ Both Written and Verbal ☐ Neither

Smoking/Tobacco Use: ☐ Current ☐ Past ☐ Never

Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never

Are there any cultural or religious concerns you have related to our delivery of care?

☐ No ☐ Yes (please specify): _____

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CHOLLA MEDICAL GROUP, INC.

Health History

Family Medical History: Check all that apply

Mother: ☐ Living, Age: _____ ☐ Deceased, Age: _____

☐ COPD/Emphysema	☐ Diabetes	☐ High Blood Pressure
☐ Stroke	☐ Asthma	☐ Kidney Disease
☐ Dementia	☐ Heart Disease	☐ Migraines

☐ Cancer (type): _____

Father: ☐ Living, Age: _____ ☐ Deceased, Age: _____

☐ COPD/Emphysema	☐ Diabetes	☐ High Blood Pressure
☐ Stroke	☐ Asthma	☐ Kidney Disease
☐ Dementia	☐ Heart Disease	☐ Migraines

☐ Cancer (type): _____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

Medical Provider:	**Phone Number:**

_____
Patient Name

_____
Patient/POA Signature Date

_____
If patient unable to sign, state reason

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CHOLLA
MEDICAL GROUP, INC.

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.**

*My Signature below certifies that I have read and understand and consent to all terms and conditions listed above. *This agreement is to remain in the patient chart**

_____

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 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_____