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.

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_____