CHOLLA
MEDICAL GROUP, INC.

Documents Needed Before First Visit

Please provide all of the following:

	Complete the New Patient Information Form *Include a copy of your IDs Legible copy of PRIMARY & SECONDARY INSURANCE card(s) front & back *We need this information to verify insurance prior to visit being scheduled **PLEASE CALL OUR OFFICE AT 480-298-9951 TO PROVIDE INSURNACE INFO** *Once insurance has been verified, we will contact you and request the patient registration forms. (Completed forms should be emailed to: **cmgstaff@chollamedical.com**)
	Complete Medical & Health History Forms **(a total of 12 pages)**
	Signed Consents Agreement and Controlled Substances 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.

***A DNR and Arizona Living Will (End of Life Care) forms are also included in the event that a current one doesn't exist. IF you already have these forms, please include them with this package.**

Once insurance has been verified, please **EMAIL** entire New Patient information to:
cmgstaff@chollamedidcal.com.

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.

New Patient Information

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

Facility/GH:	Primary Phone:	☐ Home ☐ Cell	***Are you currently on HOSPICE?**	☐ Y ☐ N
Facility/Group Home Address:	Patient/POA Email:			
Facility/Group Home Contact:	Phone:	Fax:		

***If patient is currently under Hospice care, Cholla Medical reserves the right to decline admission.**

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): _____	

New patient questionnaire
1. When was the last Annual Wellness Visit? _____
2. Most recent hospitalization Reason_____ Date _____ Hospital?_____
3. Do you have an Advanced Directive? If yes, please provide a copy
4. Who is your current or previous PCP?

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Phoenix, AZ 85044

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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

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

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

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/Group Home or IF I get admitted into Hospice. **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.

Controlled Substance Agreement

I, _____ understand that in order to receive prescribed medications at **Cholla Medical Group, Inc.** (hereafter referred as **CMG)**, I agree to comply with the following:

A. **USE OF MEDICATIONS**: I will take all medications as prescribed. I will speak with my provider at **CMG** before making any change in either the dose or frequency of taking my medications. There will be no early refills of controlled substances due to self escalation of medications. Narcotic pain medications must all be obtained from the same pharmacy (any exceptions must be approved by **CMG**).

B. **SEEKING PRESCRIPTIONS**: I will neither seek nor fill controlled prescriptions for any medications including pain relief from any other health care provider unless discussed/ authorized by **CMG**.

C. **MEDICAL RECORDS RELEASE:** I will inform all of my health care providers that I receive controlled prescriptions including pain management medication(s) through **CMG** and will maintain an unrestricted and current medical records release on file with **CMG**. I authorize **CMG** to provide a copy of this Controlled Substance Contract to release medical information to necessary pharmacies.

D. **DRUG SCREENING: I will participate in drug screening as a part of my plan of care. I understand that drug screening will be conducted ongoing and may be required more frequently at the discretion of CMG. Presumptive and Definitive Screening may include urinalysis, blood testing and/or pill counts. I further understand that if I fail two drug screens or the absence of the prescribed medication detected in my system during the course of my treatment, it will result in discharge or from the medical practice.**
***Failure means: the presence of Illegal drugs, or unprescribed/undetected medications**

E. **ALCOHOL USE:** Any use of alcohol with prescriptions is against **CMG** policy. Testing for alcohol use may be added to random and routine urine drug screens at the discretion of the physician. Any use of alcohol deemed inappropriate by the physician will be grounds for discharge from **CMG**.

F. **ILLEGAL AND NON-PRESCRIBED DRUG USE**: I understand that the use of any controlled medication, not prescribed by **CMG**, may result in termination of care. I authorize **CMG** to cooperate fully with any city, state, or federal law enforcement agency. I agree to waive any applicable privileged, right of privacy, or confidentiality with respect to these authorities.

G. **LOST OR STOLEN MEDICATION**: I agree to safeguard all medication prescribed by **CMG** and understand that **lost, stolen, or damaged medications will not be replaced.**
***Does not apply to Facilities/Group Homes with Medication Management Control**

H. **PRESCRIPTIONS WHILE TRAVELING: CMG** may choose to provide prescriptions for up to 60 days when I am traveling out of state. I will only be eligible for early medication when proof of travel can be obtained. Identification includes paper tickets and electronic confirmation sheet that shows how much I paid for travel tickets. I will have to arrange for shipment of controlled substances by my pharmacy at my own expense. If I will be out of state longer than 60 days, I need to arrange for my healthcare at my travel destination. On my return to Arizona, I need to advice **CMG** of the name and address of my medical provider out of state. I also authorize **CMG** to contact my provide to obtain any detailed information deemed necessary of my medical care.

I. **DRIVING AND OPERATING EQUIPMENT**: Many controlled substances, including pain medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy.

J. **MISSED APPOINTMENTS**: I will contact the clinic if I will be 5 to 10 minutes late. If I arrive more than 15 minutes late, I will be rescheduled. Three missed appointments per year are grounds for discharge from **CMG**. ***Does not apply to House-call Patients**

K. **CHARGES: All fees from patients are due at the time of visit. Non-payment of fees may result in the account being sent to collections and patient termination from CMG. *Does not apply to House-call Patients**

L. **TERMINATION: I will no longer be eligible for care at CMG if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in any way, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at CMG.**

M. **TREATMENT OF STAFF: Our office has a zero tolerance policy for verbal /physical abuse towards our staff. swearing, yelling at, or threatening our staff will result in termination of our medical service.**

N. **EMERGENCY ROOM VISITS: I am allowed to receive controlled substances, including pain medication in the emergency room, but it is a violation of the CMG contract to receive narcotic medication to take home and it must be discussed with my doctor prior to receiving medication. A violation includes any prescription and/or samples. *Does not apply to House-call Patient.**

I HAVE THOROUGHLY READ THIS AGREEMENT BEFORE RECEIVING TREATMENT AT CMG. I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED. I KNOW THAT FAILURE TO COMLPY WITH ANY OF THESE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATIONS OF SERVICE.

Patient's Signature: _____Date: _____

POA/Witness Signature: _____Date: _____

CHOLLA MEDICAL GROUP, INC.

Authorization for Release of Protected Health Information

I hereby authorize _____ to disclose Protected Health Information (PHI) as deemed below. ***Please leave blank.**

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_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)

(IMPORTANT—THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT**: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to bevalid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this form.

1. My Directive and MySignature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient Signature: _____ Date: _____

Patient's Printed Name: _____

PROVIDE THE FOLLOWING INFORMATION: **OR** **ATTACH RECENT PHOTOGRAPH HERE:**

My Date of Birth
My Sex
My Race
My Eye Color
My Hair Color

2. Information About My Doctor and Hospice (if I am in Hospice)**:**

Physician:_____ Telephone: _____

Hospice Program, if applicable (name):_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE) (Last Page)

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider:_____ Date: _____

4. Signature of Witness to MyDirective:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature:_____ Date:_____

LIVING WILL (End of Life Care)
Instructions

GENERAL INSTRUCTIONS: Use this form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean.

The Living Will is your written directions to your health care power of attorney, also referred to as your "agent", your family, your physician, and any other person who might make medical care decisions for you if you are unable to communicate yourself.

It is a good idea to talk to your doctor and loved ones if you have questions about the type of care you do or do not want.

IMPORTANT: If you have a Living Will and a Health Care Power of Attorney, you must attach the Living Will to the Health Care Power of Attorney.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
KRIS MAYES

Living Will

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Some general statements about your health care choices are listed below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully BEFORE you initial your preferred statement. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4, BUT if you initial paragraph 5 the others should not be initialed.

_____ 1. If I have a terminal condition I do not want my life to be prolonged, and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

**Comfort care* *is treatment given in an attempt to protect and enhance the quality of life without artificially prolonging life.*

_____ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I DO NOT want the following:

_____ a. Cardiopulmonary resuscitation (CPR). For example: the use of drugs, electric shock and artificial breathing.

_____ b. Artificially administered food and fluids.

_____ c. To be taken to a hospital if at all avoidable.

_____ 3. Regardless of any other directions I have given in this Living Will, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ 4. Regardless of any other directions I have given in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ 5. I want my life to be prolonged to the greatest extent possible (If you initial here, you should not initial any of the others).

PLEASE NOTE: You can attach additional instructions on your medical care wishes that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

_____ A. I HAVE NOT attached additional special instructions about End of Life Care I want.

_____ B. I HAVE attached additional special provisions or limitations about End of Life Care I want.

MY SIGNATURE VERIFICATION FOR THE LIVING WILL

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Living Will expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all three pages of this Living Will

Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principals Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____