AZ at Home Inc.

Bringing excellence home, changing the way you receive healthcare. Not just better healthcare, but a better healthcare experience.

DATE: ______________________

NAME: ______________________ (LAST / FIRST / MIDDLE)

SEX: ________ (male) / ________ (female)

BIRTHDATE: ______ (mo.) / ______ (day) / ______ (year) AGE: __________

ETHNICITY: ________ Hispanic/Latino ________ Non-Hispanic/Latino

RACE: ______________________

Single ( ) Married ( ) Divorced ( ) Widow ( )

PREFERRED LANGUAGE: ______________________

PHONE: (HOME) ________ (area code) / ______________________

(CELL/BUSINESS) ________ (area code) / ______________________

ADDRESS: ______________________

LOT/APT#: ______________________

EMAIL ADDRESS: ______________________

CITY, STATE: ______________________

ZIP: ______________________

FAMILY DR: ______________________

SOCIAL SECURITY NUMBER: ______________________

ADDRESS: ______________________

OCCUPATION: ______________________

PHONE: ______________________

EMPLOYER: ______________________

ADDRESS: ______________________

____

REFERRING DR:

ADDRESS: ______________________

PHONE: ______________________

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: ______________________

RELATIONSHIP TO PATIENT: ______________________

PHONE: ______________________

ADDRESS: ______________________

CITY, STATE: ______________________

ZIP: __________

ALTERNATE CONTACT:

NAME: ______________________

PHONE: ______________________

IS PATIENT IN AN ASSISTED LIVING FACILITY? YES NO

IS PATIENT IN A GROUP HOME? YES NO

IF YES, PLEASE PROVIDE:

FACILITY NAME: ______________________

ADDRESS: ______________________

____

PHONE #: ______________________

PHARMACY NAME: ______________________

ADDRESS: ______________________

____

PHONE #: ______________________

PLEASE PROVIDE INSURANCE CARD(S) SO THAT RECEPTIONIST CAN MAKE A COPY. THANK YOU.

Name:______________________________ DOB:______________ Today's Date: ______________

Personal medical history		Check if YES	Insulin dependent		Type 1	Type 2	Year diagnosed
Endocrine:	Diabetes		Yes	No			
	Thyroid disease						
	High cholesterol						
Cardiovascular:	Heart disease						
	High blood pressure		How many years? ________				
Oncology:	Cancer		Please specify: ______________________				
Immunologic:	Lupus						
	Hepatitis						
Respiratory:	COPD						
	Asthma or emphysema						
Musculoskeletal:	Arthritis						
Neurologic:	Multiple sclerosis						
Constitutional:	Weight loss/gain						
Gastrointestinal:	Ulcers						
Genitourinary:	Kidney disease						
HENT:	Hearing loss						
Integumentary:	Skin condition		Please specify: ______________________				
Psychiatric:	Anxiety						
	Depression						

Other (please specify): ____

Major surgeries: ____

Eye surgeries: ____

Social history	Yes/No	How much?	# day	# week	Occas.	Former
Do you drink alcohol?						
Do you smoke?						

	Yes	No
History of blood transfusion?		
Received a pneumonia vaccine?		
Have you had a flu shot?		
Do you have a living will?		

Family medical history	Yes	No	Mother	Father	Brother	Sister	G-parent
Blindness							
Macular degeneration							
Glaucoma							
Retinal Detachment							
Cancer							
Diabetes							
Heart disease							
High blood pressure							

CURRENT PRESCRIPTION & OVER THE COUNTER MEDICATION/SUPPLEMENT LIST

NAME:______________________________DOB:__________________DATE: ________________

PHARMACY:_________________________PHARMACY PHONE #: ____________________________

DRUG ALLERGIES: ____

DRUG NAME (PLEASE PRINT)	DOSAGE	FREQUENCY	ROUTE (oral, nasal, IM, drops, topical, suppository)	ADD OR DISCONTINUE DATE

Patient Financial Responsibility

NAME:____DOB:____________________DATE: ____________________

As a courtesy to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly.

It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary services, such as lab work, hospitalization, or supplies that are not covered by your plan; you may be billed directly for those charges.

The office bills only for services performed by our providers. Laboratories and Radiology are separate entities and will bill you or your insurance company for services that are performed. If you have any questions about your laboratory bill please contact them or your insurance company directly.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

AZ at Horne Inc. offers a fee for service schedule for cash/uninsured patients. This payment is required at the time service is rendered.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSABILITIES OUTLINED WITHIN THEM:

- **PATIENT RIGHTS REGARDING MEDICAL RECORDS**
- **PATIENT FINANCIAL RESPONSINILITY INCLUDING COLLECTIONS**
- **CONFIDENTIALITY AND PRIVACY OF MEDICAL RECORDS**

____ __________________________
Patient/Guardian Signature Date

Patient/Guardian Printed Name ____

POA Signature _________________________________ __________________________
Date

POA Printed Name ____

Patient Rights Regarding Medical Records

NAME:____DOB:____________________DATE: ____________________

***All requests to inspect, copy, amend, restrict, or share health information must be made in writing. All changes to preferred forms of communication must also be made in writing.**

You have the following rights regarding health information we maintain about you:

Right to inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records.

If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. This review will be conducted by another licensed health care professional chosen by our practice. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any staff member.

Changes to This Notice:
We reserve the right to change this notice and apply it to any past, present, or future health information we have about you. We will post a copy of the most current notice in our facility with the effective date on the first page. You may request a copy of our most current notice at any time.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. **You will not be penalized for filing a complaint.**

Other Uses of Health Information: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. You have the right to revoke this permission -for any health information that has not yet been shared.

Confidentiality and Privacy of Medical Records

NAME:____DOB:____________________DATE: ____________________

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you, and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment reimbursement and prior authorization for treatment.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to use a different method to contact you.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner, health examiner, or funeral directors as necessary to carry out their duties.

________________________________ ______________________

Patient/POA Signature Date

AZ at Home Inc.

Bringing excellence home, changing the way you receive healthcare. Not just better healthcare, but a better healthcare experience.

RELEASE TO:
AZ at Home Inc.
12600 N 113th Ave Ste C-6
Youngtown, AZ 85363
888-551-6092 fax
480-275-2022 office

***Office use only*

Patient Name: ______________________________ DOB: ____________________

INFORMATION TO BE RELEASED: (Check all applicable)

☐ All Information ☐ All Progress Notes ☐ Lab Reports ☐ X-ray Reports

☐ Electrocardiogram (ECG) ☐ Allergy Records ☐ Immunization Records ☐ Other: ____________

RECORDS FROM THE TIME PERIOD: / / through / /

PURPOSE OF DISCOLSURE: (Check applicable purpose)

☐ **Continued Medical Care** ☐ **Payment of Insurance Claim** ☐ **Legal**

☐ **Personal** ☐ **Workers' Compensation Claim** ☐ **Other:** ____________

- I understand that this authorization shall be valid for five years.
- I understand that I may revoke this consent at any time except to the extent that action has already been taken.
- I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided up request prior to duplication.
- The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature: ______________________________ Date: ____________

SPECIAL AUTHORIZATION

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following types of information you must sign below.

☐ Alcohol ☐ Drugs ☐ Mental Health ☐ HIV Status or Treatment

Patient/Guardian Signature: ______________________________ Date: ____________

Chronic Care Management Patient Agreement

NAME:____DOB:____________________DATE: ____________________

Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, and by consenting to this agreement, you allow ________________________________ ("Provider") to provide chronic care management services to you.

CCM services are only available to patients with two or more chronic conditions. Medicare defines a chronic condition as a condition that is expected to last for at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

Benefits of CCM Services Include:

- 27/7 access to a care provider to help with your chronic healthcare needs
- A comprehensive plan of care for health needs, available on paper or electronically
- Coordination with both home and community-based service providers
- Transition management among health care providers, including referrals, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Medications oversight and management
- Use of a certified electronic health record (EMR) as mandated by Medicare

Should you desire to receive CCM services through your provider, he/she agrees to only bill Medicare for CCM services one per 30-day billing cycle. Furthermore, your provider agrees only to bill Medicare for CCM services if you have more than one chronic condition.

Beneficiary Acknowledgement and Agreement

By signing this agreement, you agree to the following terms:

- You consent to your provider providing CCM services to you.
- You certify that your provider has fully explained the scope of CCM services to you.
- You acknowledge that only one practitioner can furnish and be paid for CCM services during a calendar month.
- You authorize electronic communication of your medical information between treating providers as part of your care
- You understand that CCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the CCM services.
- You understand that you have the right to terminate CCM services at any time by revoking this agreement effective at the end of the then-current month. You may revoke this agreement verbally by notifying AZ at Home Inc. by telephone at (480)-275-2022 or by mailing your written revocation to AZ at Home Inc. 12600 N 113th Ave Ste C-6 Youngtown, AZ 85363. Your provider will then give you written confirmation, including the effective date of revocation.

Beneficiary/Responsible Party Signature: ____

Print Name: ____ Date: ____________________