

All Information must be filled out completely:

PLEASE PRINT CLEARLY

Patients Last Name	First Name	Middle Initial	Telephone
Mailing Address (PO Box)		City	State Zip
Street Address –if different from above		Marital Status:	
Social Security Number	Date of Birth	Sex	() Female () Male

Patients Employer Information

Employer Name	City	State	Zip
Employer Address	Employer Phone		
() _____ - _____			

Emergency Info you must list an alternate name and phone number
(Someone other than you, not you or your home)

Emergency Phone Number:
() _____ - _____

Winter visitor Only please list your permanent address:

Mailing Address (PO Box)	City	State	Zip
Phone Number () _____ - _____			

This must be filled out completely in order to file your claim.

Primary Insurance Company Name/Address/City/State and Zip:	ID #	Group #
Secondary Insurance Company Name/Address/City/State and Zip:	ID #	Group #

Responsible Party Information –The guarantor information is the person that is the primary card holder such as your spouse, if a minor child who carries the insurance on the child.

Guarantor Last Name	Guarantor First Name	Middle Initial	Telephone
Guarantors Street address		City	State Zip
Guarantors Social Security Number	Guarantors Date of Birth	Sex	() Female () Male
Guarantors Employer Name	Guarantors Employer Phone Number		
Guarantors Employer Address	City	State	Zip

I hereby authorize Arcadia Family Clinic to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning my illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to my dependents or myself. I understand that I am financially responsible for any amounts not covered by my health insurance. It is your responsibility to notify us of changes to the above information.

Signature: _____ Date: _____

General Information and Medical History

Patient Name: _____

DOB: _____

Medications you are currently taking - *List dosage*

Prescription Medications:

Over the Counter Medications:

Supplements:

Family History: List medical history about your family members!

Adopted No Family History _____

Father Living: Yes No Age Disease(s): _____

Mother Living: Yes No Age Disease(s): _____

List other family members diagnosed with illnesses below (example brother, sister, aunt, uncle, cousin, grandparents)

Family Member	Family Member	Family Member
ADHD	Fainting	Rheumatic Fever
Alcoholism	Fatigue/dizziness	Rheumatoid Arthritis
Allergies	Gallbladder	Seizure Disorder
Alzheimer	Glaucoma	Skin Problems
Anemia	Headaches	Stroke
Aneurysm	Heart Disease	Suicide Attempt
Arrhythmia	Heart Murmur	Swelling of the Feet
Arthritis	Hepatitis A	Thyroid Disease
Asthma	Hepatitis B	Ulcers
Birth Defects	Hepatitis C	Varicose Veins
Bleeding Disorders	High Cholesterol	Cancer _____
Breast Cancer	High Blood Pressure	
Cerebral Palsy	HIV/AIDS	Illnesses not listed :
Chest Pain	Irritable Bowel	
Chronic Cough	Kidney Disease	
Chronic Diarrhea	Liver Disease	
Colon Cancer	Low Back Pain	
Constipation	Mental Illness	
Depression	Migraine	
Diabetes	Panic Disorder	
Dizziness	Polio	
Drug Addiction	Renal Disease	

Social History: This section is about you the patient and not family members. Please place a mark next to the appropriate items.

Child No History ___

Alcohol	___ No	___ Yes	How Much	_____	How Often	_____
Caffeine	___ No	___ Yes	How Much	_____	How Often	_____
Exercise	___ No	___ Yes	How Much	_____	How Often	_____
Children	___ How many _____					
Drug Use	___ Past History		___ Present	___ No History		
Employment	___ Full Time	___ Part Time	___ Retired	___ Disabled		
Marital Status	___ Married	___ Divorced	___ Single	___ Widowed	___ Unemployed	
Tobacco Use	___ Chew	___ Cigars	___ Less than 1 PPD	___ Greater than 1 PPD	___ Never smoked	
	___ Previous Smoker	Date Stopped _____				

Place a check next to items below that pertain to **your** health only!

___ **No Serious Illnesses**

	Date Diagnosed		Date Diagnosed		Date Diagnosed
ADHD	Fainting	Rheumatic Fever
Alcoholism	Fatigue/dizziness	Rheumatoid Arthritis
Allergies	Gallbladder	Seizure Disorder
Alzheimer	Glaucoma	Skin Problems
Anemia	Headaches	Stroke
Aneurysm	Heart Disease	Suicide Attempt
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Bleeding Disorders	High Cholesterol	Cancer _____
Breast Cancer	High Blood Pressure		
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Constipation	Mental Illness		
Depression	Migraine		
Diabetes	Panic Disorder		
Dizziness	Polio		
Drug Addiction	Renal Disease		

Illnesses not listed :

Do you have allergies to any medication(s)?

No _____

Yes _____ (please list what you are allergic to below as well as what type of reaction the allergy causes?)

Do you have allergies to food?

No _____

Yes _____ (please list what you are allergic to below as well as what type of reaction the allergy causes?)

Please list your surgical history along with dates:

Preventative Care: (Please provide dates and locations of the following preventative care items if possible, and if it pertains.)

Full Physical (Labs, EKG,etc) _____ Tetanus _____ Flu Shot _____ Pneumonia _____

Pap Smear _____ Mammogram _____ Bone Density Scan DEXA _____

Colonoscopy _____ Stress Test _____

Have you had any history of Abnormal Testing for any of the above ? If yes please describe :

Advanced Directive ___ Living Will ___ Power of Attorney for healthcare

*****If you would like a copy of an advanced directive please ask one of the receptionists for a copy. If you have an advanced directive please supply us with a copy.

**Privacy Notice Acknowledgment and
Patient Communication and Consent**

Date: _____

Pharmacy Name you would like to use and the cross streets:

Patient Name: _____ DOB _____

We must call on occasion to discuss confidential protected health information. Below is a list of ways for us to communicate this information with you. Please check how you would like us to get this information to you:

_____ Okay to call my home and leave a message. Phone Number: _____

_____ Do not call home phone, call only this number (_____) _____ - _____

- Due to the privacy rules **if you do not** list anyone below we **will not** be able to discuss anything regarding your health with anyone other than you. I give permission to the following individuals listed below to discuss information regarding my health.

- If a **minor child** please list who may bring your child to the doctor and make medical decisions in your absence.

Must Sign Below for all information given:

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Notice of Privacy Practices from Arcadia Family Clinic.

Patient Name (please print)

Date

Patient or Person Authorized to Sign

If not patient relationship to patient (parent, legal guardian, personal representative, etc.)

Financial Responsibility

We are dedicated to providing the best possible care and service to you and your family. Your complete understanding of your financial responsibility is an essential element of care and treatment.

Non-Covered Services: It is the patient's responsibility to know their insurance coverage benefits and present their card at each visit. We ask that you contact your insurance carrier to review your benefits prior to being seen. Although you may receive a pre-certification or authorization number from your insurance company, this does not guarantee that your insurance company will pay for your procedure.

Change in Insurance Plans: You are expected to notify our office if your insurance coverage changes. We ask you to update your record at each visit to our office. It is your responsibility to notify the office immediately of these changes. **Balances left over 30 days will become the responsibility of the patient.** We have always filed and will continue to file insurance claims for patients for our services; however, any unpaid or denied insurance claim over 30 days old is the responsibility of the patient to pay.

Payment is required at the time of service: Co-payments are due at the time of service. Patients who are not covered by health insurance, on a plan that we do not participate with, or if we are not able to verify your coverage must pay at the time of service. **Any unpaid or denied claim over 30 days old becomes the responsibility of the patient.** Patients who have plans that we do participate with are asked to pay their co-payment, co-insurance, deductibles, or any non-covered services at the time of their visit. We charge a \$20.00 fee for any returned checks over and above what your financial institute may charge.

Collection Agency Fees: Should your account become severely delinquent, the patient or guarantor agrees to pay all costs of collection including attorney fees, collection fees and contingent fees to collection agencies of not less than 35%. The Contingency fees will be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Motor Vehicle Accidents: We do not bill for any motor vehicle accidents regardless of fault. You must pay in full at the time of service. You will be supplied with the necessary forms to turn in to the insurance carrier.

Missed Appointments: New patients must arrive at least 30 minutes prior to their scheduled appointment to fill out the necessary paperwork and verify eligibility with your insurance carrier. Established patients are asked to arrive at least 15 minutes prior to their appointment. Due to the high volume of no show appointments we have implemented a policy that if we log three no show appointments in a calendar year we will ask that you seek a new provider.

Minors: For all services rendered to minor patients, we will look to the parent or guardian who brought the patient to the appointment for payment.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to time by the practice.

Signature of Patient or Responsible Party if a minor

Date

Printed Name of Patient (or Minor)

Date

IMPORTANT INFORMATION FOR OUR VALUED PATIENTS

We appreciate the confidence you have shown by choosing our clinic to provide your medical care. We make every effort to give you the best service possible. In order to achieve this, we have developed the following systems to make your visit with us a pleasurable one.

APPOINTMENTS:

When you call for an appointment we make every effort to see you on the same day or next day. If your physician is unavailable, we have other physicians in our office who are able to see you to ensure that you do not go without medical care. Every visit here requires an appointment. This includes “nurse only” appointments for lab work, injections and blood pressure checks. Making an appointment ensures your chart will be ready for the nurse and expedites the check-in process at the front desk. New patients are required to arrive 30 minutes early for an appointment so that the initial paperwork and insurance verification can be completed. If you are an established patient with a change in personal information or insurance, please arrive 15 minutes early.

If you are unable to keep your appointment, please call our office (602.955.6632) 24-48 hours prior to your appointment time to cancel so that your appointment time can be made available to other patients. You may be charged a \$25.00 fee for no show or late appointments.

TEST RESULTS:

You will be contacted by our physicians or medical assistants via telephone or letter informing you of your test results within 7-14 working days. If you have not heard from our office within 15 working days, please contact our office and speak with your doctor’s medical assistant.

MEDICATION REFILLS:

Medication refills should be directly coordinated with your pharmacy. The pharmacy will contact our office with all the needed information. We require 48-72 hours notification for refill requests. Please do not allow yourself to run out of medicine. Your physician requires advance notice as he/she needs to evaluate your medical needs. Medications, especially narcotics, will not be filled during the weekends or evenings.

REFERRALS:

When your doctor wants you to be referred to a specialist, it will take 7 to 10 working days for completion. If it is an urgent referral, it will be done within 24 hours. You will receive all needed information regarding your referral by mail or phone so that you are able to call and schedule your appointment. It is vital that you take your referral with you to your specialist appointment or they may require you reschedule. If your specialist is requiring additional visits, please contact our office 7 to 10 days prior to your next appointment with them.

PAYMENTS:

The patient is responsible for payment of the office visit. If you have insurance our billing department will file the claim as a courtesy. It is the patient’s responsibility to present his/her insurance card to the receptionist and to advise our office of any changes in address or insurance coverage. Co-payments are always required on the day of service and for each office visit – we do not bill for co-pays. If you do not bring your co-pay with you, you may be asked to reschedule your appointment. In the event you do not have insurance, payment in full is expected on the day of service.

INSURANCE:

It is the patients' responsibility to understand their insurance plan and our office will try to assist you whenever possible. Please be aware of what benefits your insurance plan covers and does not cover, you will be responsible for services/items that your insurance does not pay for.

OFFICE HOURS:

Our office hours are 7:00am – 6:00pm Monday through Friday. We forward our phones to the answering service during lunch daily from 12:00 noon – 1:30pm.

AFTER HOURS/EMERGENCY:

A physician is available after hours by calling our answering service at 602.667.4528. However, if you have a true medical emergency, the best course of action is to call 911 or go to the closest emergency room to get immediate assistance. You may also call the number located on the back of your insurance card for additional instructions.

HOSPITAL AFFILIATION:

All physicians in Arcadia Family Clinic are on staff at John C. Linclon Health Hospital North Mountain, part of the John C. Linclon Health Network; a non-profit organization whose many components serve the healthcare and economic development needs of the people who live within our community.

OUR COMMITMENT TO YOU:

Arcadia Family Clinic is a group of medical professionals dedicated to providing comprehensive care to our community. Our goal is to enhance each patient's quality of life by delivering the most appropriate care in a service-oriented environment designed to maximize your comfort and confidence. We do this by listening to your questions and concerns, carefully and thoroughly. We provide guidance, resources and appropriate medical therapy to give you more control over your own personal health. We want to be your partner in better health care: providing the kind of conscientious, preventative care that helps individuals to stay healthy and happy throughout every stage of life. The physicians and staff of Arcadia Family Clinic have made every effort to build our practice into the kind of place we could choose ourselves. Thank you for choosing Arcadia Family Clinic for your healthcare needs.