PATIENT INFORMATION

Please Print

Date: ______ / _______ / _______

Patient Name: ____

(Last Name) (First Name) (M.I.)

DOB: ______ / ______ / _______ (mm / dd / year) **Social Security #:** ______ - _____ - ______ **Gender:** ☐ M ☐ F ☐ Other

Preferred Name: ______________________

Marital Status (check one): ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ w/ Partner ☐ Widow(er)

Mailing Address: ____

(Street) (Apt. / Unit / Lot #)

____

(City) (State) (Zip Code)

Home #: (_______) ________ - ________ **Cell Phone #:** (_______) ________ - ________

Employer / School: _________________________ **Occupation:** _________________________

Work #: (_______) _______ - _______ **Ext:** __________

E-mail Address: _________________________________ @ ________________________

May we take your Picture for your Electronic Medical Record? ☐ No ☐ Yes

Preferred method of contact for reminder calls, lab results, diagnostic results, or any other health related information.

Check <u>ALL</u> that apply: ☐ Home # ☐ Cell Phone ☐ Work #

Ok to leave message on home voicemail: ☐ No ☐ Yes **Ok to leave message on cell phone:** ☐ No ☐ Yes

Race / Ethnicity: ☐ American Indian/ Alaskan Native ☐ Native Hawaiian/ Pacific Islander ☐ Asian ☐ White ☐ Black/ African American ☐ Hispanic/ Latino ☐ Other ☐ Decline to report

Language: __________________

Name of Emergency Contact: _____________________________________ **Relationship:** __________________

Phone # of Emergency Contact: (_______) ________ - ________

If patient is a minor, name of Legal Parent / Guardian / Representative filling out form.

____ _______ / _______ / _______

(Print Last Name) (Print First Name) (M.I.) (Date)

____ **Relationship to minor:** _________________

(Signature of Legal Parent / Guardian / Representative)

How did you hear about us? (Please check one)

☐ Google ☐ Yelp ☐ Mailer ☐ Online Ad ☐ Referred by: __________________ ☐ Other: _________________

INSURANCE / PHARMACY / ADVANCED DIRECTIVES

Please Print

Date: ______ / ______ / ______

INSURANCE INFORMATION

Primary Insurance Information:	**Secondary Insurance Information:**
Insurance Name: ____________________	**Insurance Name:** ____________________
ID #: ____________ **Group #:** __________	**ID #:** ____________ **Group #:** __________
Address: ____________________ ____________________	**Address:** ____________________ ____________________
Phone #: (______) ______ - ______	**Phone #:** (______) ______ - ______
Subscriber's Name: ____________________	**Subscriber's Name:** ____________________
Subscriber's DOB: ______ / ______ / ______	**Subscriber's DOB:** ______ / ______ / ______
Relationship to patient: ______________	**Relationship to patient:** ______________

PHARMACY INFORMATION

Retail Pharmacy:

Name of Pharmacy: ____________________ **Cross Streets:** ____________________

Phone #: (______) ______ - ______ **Fax #:** (______) ______ - ______

Mail Order Pharmacy:

Name of Pharmacy: ____________________ **Phone #:** (______) ______ - ______

Address: ____

(Street) (City) (State) (Zip Code)

ADVANCE DIRECTIVES (Living Will)

I ______________________________, have previously executed the following:

a.) Health Care Power of Attorney: ☐ YES ☐ NO

(If you answered "Yes", please provide the following information below)

Name of Representative: ____________________ **Phone #:** (______) ______ - ______

b.) Living Will: ☐ YES ☐ NO

c.) Pre - Hospital Medical Directive: ☐ YES ☐ NO

(If you answered "Yes", please submit your orange card to the receptionist.)

______________________________________ **Date:** ______ / ______ / ______

(Print patient name)

____

(Signature of Patient or Legal Parent / Guardian / Representative)

FINANCIAL POLICY / CANCELLATION POLICY AGREEMENT

Financial Policy

All insurance providers have different coverage and benefit levels depending on what you have chosen to purchase or what your employer has chosen. ***It is your responsibility to be aware of your benefits***. We strongly encourage you to be in contact with your insurance agency to determine the level of coverage your plan provides, as well as having an understanding of the financial figures you will be responsible for.

We participate with most insurance plans. If you are an HMO patient, you must choose *Dr. Ehreema Nadir, MD* for your primary care physician. This can be done by calling your insurance company prior to your appointment and have them list our physician as the PCP. You will be responsible for the visit if *Dr. Ehreema Nadir, MD* is not listed as the PCP, or you will have to reschedule to a later date when the physician is effective.

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company and we are not party to that contract. Be aware that some services may not be covered by your insurance policy. By presenting for care, you agree that you are responsible for all services and charges regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. This constitutes fraud and will not be done and you will be responsible for the balance.

All co-pays, balances and deductibles are due at the time of service. We file your insurance and then any balances that are due by you must be paid within **90 days** unless prior arrangements have been made with the billing department. If you have a billing or insurance related question, please contact our billing office at *(480) 306-5151* and they will be happy to assist you. We ask patients to refrain from discussing billing questions with the physicians, nurse practitioners or physician's assistant as they devote their time and expertise to your health care and cannot answer billing questions.

Any account left unpaid after 90 days will be turned over to an outside collection agency. Any collection fees necessary to collect this debt will be added to the outstanding balance. Please keep in mind that should your account go into collections, any arrangements/payments will need to be made directly with the collection agency. In addition, once an account has been turned over to the collection agency, the patient may receive a letter of discharge from our practice.

Cancellation Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. You MUST give our office 24 hours notice prior to your scheduled appointment. Multiple "No-Shows" in any 12 month period may result in termination from our practice. "No-Show" fees will be billed to the patient. This fee is NOT covered by any insurance plan and will be your responsibility. ***Our practice fees are listed below.***

Practice Related Fees:

- **$50.00** – Request to complete Disability, FMLA, Life and various other types of independent health forms. Forms MUST be present at the time of visit, or you will be asked to be rescheduled.
- **$25.00** – Returned checks for non-sufficient funds will have a processing fee that will be charged back to the patient. We will be unable to accept any personal checks after the first occurrence.
- **$50.00** – Charge for missed appointments or appointments canceled with less than 24 hour notice with the Physician, Nurse Practitioner or Physicians Assistant.
- **$75.00** – Charge for missed appointments or appointments canceled with less than 24 hour notice with the Psychiatric Nurse Practitioner and Nephrologist.

By signing below, I acknowledge that I have read and understand the financial and cancellation policies of American Medical Associates and agree to the policies set forth.

______________________________ (Print Name of Patient)

______________________________ (Date)

______________________________ (Signature of Patient or Legal Parent/ Guardian/ Representative)

______________________________ (Relationship to patient)

PATIENT MEDICAL REVIEW

PLEASE PRINT

DATE: _______ / _______ / _______

Patient Name: ____ DOB: ______ / ______ / ______
(Last Name) (First Name) (M.I)

Do you have ANY Allergies , Sensitivities and/ or reactions to the following?

Latex: ☐ NO ☐ YES

Shellfish or Iodine? ☐ NO ☐ YES

Drug(s)? (List All Drug Allergies) ☐ NO ☐ YES

____

____

Environmental? (If yes, please list below): ☐ NO ☐ YES

____

Any Foods? (If yes, please list below): ☐ NO ☐ YES

____

____

Please List ALL Hospitalizations, Surgeries & Major Illnesses:

DATES:	Procedures or Condition(s):
1.) ____________	____________________
2.) ____________	____________________
3.) ____________	____________________
4.) ____________	____________________
5.) ____________	____________________

For FEMALE patients only. Please answer the following:

Are you pregnant, or possibly pregnant? ☐ NO ☐ YES Are you breastfeeding? ☐ NO ☐ YES

Obstetrical: # of pregnancies: ____ # of living children: ____ # of miscarriages: ____ # of abortions: ____

Date of last Pap: __________ ☐ Normal ☐ Abnormal / Date of last Mammogram: __________ ☐ Normal ☐ Abnormal

Date of Last menstrual period: ______________ Do you self exam? (Breast): ☐ No ☐ Yes

For MALE patients only. Please answer the following:

Last PSA screen: __________ ☐ Normal ☐ Abnormal / Last Testicular Exam: __________ ☐ Normal ☐ Abnormal

Do you self exam? (testicular): ☐ No ☐ Yes

Immunizations: (If you have a copy of your immunization record, please give to the medical assistant to make a copy for your chart)

Immunizations:	Date:	*Immunizations:*	Date:
☐ Influenza	________	☐ Pneumovax	________
☐ Shingles	________	☐ Gardisil	________
☐ Hepatitis A	________	☐ Tetanus	________
☐ Hepatitis B	________	☐ dTap	________
☐ MMR	________	☐ Other:	________

Screenings: (Please check and provide dates if you've had the following.)

	Date:	Findings:
☐ Colonoscopy	________	☐ Normal ☐ Abnormal
☐ Bone Density	________	☐ Normal ☐ Abnormal
☐ Stool Cards	________	☐ Normal ☐ Abnormal

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PATIENT MEDICAL REVIEW

PLEASE PRINT

DATE: ______ / ______ / ______

Patient Name: ____ **DOB:** ______ / ______ / ______

(Last Name) (First Name) (M.I)

Check if you have had the following (check ALL that apply):

☐ Alcoholism / Addiction	☐ Crohn's Disease	☐ Heart Murmur	☐ Lupus	☐ Pelvic Infection
☐ Anemia	☐ Drug Dependency	☐ Heart Valve	☐ Lyme's Disease	☐ Pneumonia
☐ Anxiety / Depression	☐ Diabetes: Type I or II	☐ Hemochromatosis	☐ Measles	☐ Psoriasis
☐ Arthritis	☐ Dialysis	☐ Hepatitis A, B or C	☐ Meningitis	☐ Rheumatic Fever
☐ Asthma	☐ Diverticulitis	☐ Hiatial Hernia	☐ Migraines / Headaches	☐ Rheumatoid Arthritis
☐ Auto-Immune Disorder(s)	☐ Eczema	☐ High Cholesterol	☐ MTHFR	☐ Scarlet Fever
☐ Bleeding Disorder	☐ Emphysema	☐ HIV / AIDS	☐ Multiple Sclerosis	☐ Scleroderma
☐ Cancer: ____________	☐ Epilepsy / Seizures	☐ Hysterectomy	☐ Mumps	☐ Shingles
☐ Cataracts	☐ Fibromyalgia	☐ Hormone Replacement	☐ Osteoarthritis	☐ Stent placement
☐ Chicken Pox	☐ Gall Bladder Disease	☐ Hypertension	☐ Osteoporosis	☐ STD (s) / STI (s)
☐ Clotting Disorder	☐ Gallstones	☐ Joint Replacement	☐ Pacemaker	☐ Stomach Ulcer(s)
☐ Colitis	☐ Gastroparesis	☐ Kidney Disease	☐ PCOS	☐ Stroke
☐ Congestive Heart Failure	☐ Glaucoma	☐ Kidney Stones	☐ POTS	☐ Thyroid Disorder
☐ Connective Tissue Disorder	☐ Gout	☐ Leg Cramps	☐ Polio	☐ Tuberculosis
☐ COPD	☐ Heart Disease	☐ Liver Disease	☐ Prostate Condition	☐ Vitiligo

Do you have any other condition(s) NOT listed above? ____

____

Health Habits & Personal Safety:

Have you ever smoked? ☐ No ☐ Yes If yes, how many packs/day? ____ / How many Years? ____ / Quit? ______ yrs.

Any other tobacco, Vap or E-Cigarettes? ☐ No ☐ Yes If yes, please describe: ______________________

Do you drink caffeinated beverages / coffee? ☐ No ☐ Yes If yes, How many ounces / day? ____________

Do you drink alcohol? ☐ No ☐ Yes / If yes, How much? ________ How often? ________ What Kind? ________

Do you exercise? ☐ No ☐ Yes If yes, How often? __________

Do you sleep well? ☐ No ☐ Yes / How many hours of sleep do you get? __________

Do you follow any special diet? ☐ No ☐ Yes If yes, What type? __________

Do you currently use recreational or street drugs? ☐ No ☐ Yes If yes, please describe: ______________

Are you sexually active? ☐ No ☐ Yes If yes, Are you trying to conceive? ☐ No ☐ Yes

If not trying to conceive, please list contraceptive barrier method used: ____________________

Any discomfort with intercourse? ☐ No ☐ Yes

Are you at risk for HIV infection? ☐ No ☐ Yes

Do you live alone? ☐ No ☐ Yes If no, who do you reside with? ______________________

Do you have frequent falls? ☐ No ☐ Yes

Do you have hearing or vision loss? ☐ No ☐ Yes

Do you have concerns with any skin lesions or any other skin concerns? ☐ No ☐ Yes

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(Rev. 04/15/2019)

PATIENT MEDICAL REVIEW

PLEASE PRINT

DATE: ______ / ______ / ______

Patient Name: ____ DOB: ______ / ______ / ______
(Last Name) (First Name) (M.I)

Mental Health:

Do you have any concerns with memory loss? ☐ No ☐ Yes

Do you feel depressed? ☐ No ☐ Yes / Do you cry frequently? ☐ No ☐ Yes

Is stress a major problem for you? ☐ No ☐ Yes / Do you panic when stressed? ☐ No ☐ Yes

Have you ever attempted suicide or seriously thought about hurting yourself? ☐ No ☐ Yes

Do you have problems with eating or your appetite? ☐ No ☐ Yes

Family Medical History: (Check **ALL** that apply):

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Sibling (s)	Child(ren)
Alcoholism / Addiction						
Bleeding Disorder						
Cancer						
Diabetes						
Heart Attack						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Mental Health Disorders						
Stroke						
Tuberculosis						

Mother living? ☐ YES ☐ NO If no, cause of death? ______________________

Father living? ☐ YES ☐ NO If no, cause of death? ______________________

I certify the information provided on the patient medical review form is true and correct to the best of my knowledge and I have listed ALL surgeries, hospitalizations, major illnesses, medications, supplements, allergies and noted ANY medical condition(s) past and current. I understand that it is my responsibility to inform my physician / provider if I, or my minor child have a change in health.

______________________ (Print Patient Name Clearly) ______________ (DATE)

______________________ (Signature of Patient or Legal Parent / Guardian / Representative) ______________ (Relationship to Patient)

______________________ (Reviewed & Signed by American Medical Associates Staff) ______________ (DATE)

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(Rev. 04/15/2019)

MEDICATION LIST

Please Print

Date: _______ / _______ / _______

Patient Name: ____ **DOB:** ______ / ______ / ______

List All Medications (Include ALL Supplements & over-the-counter medications)	**Dose** (milligrams)	**How Often**	**Prescribing Physician**
1.)			
2.)			
3.)			
4.)			
5.)			
6.)			
7.)			
8.)			
9.)			
10.)			
11.)			
12.)			
13.)			
14.)			
15.)			
16.)			

I certify that the above information is to be true and to the best of my knowledge.

____ _______ / _______ / _______
(Print Last Name) (Print First Name) (M.I) **(DATE)**

____ ____________________
(Signature of Patient or Legal Parent / Guardian / Representative) (Relationship to patient)

Notice Of Privacy Practices

The Notice of Privacy Practices describes how this practice may use and disclose your medical information, as well as your rights to access your medical information.

The HIPAA Privacy Rule permits this practice to disclose your protected health information to carry out Treatment, Payment, or other Healthcare Operations. We may also disclose your health information for purposes required by law. HIPAA also grants you rights to access and control your protected health information. We must abide by the information outlined in the Notice of Privacy Practices. As HIPAA evolves, we reserve the right to update our Notice of Privacy Practices at any time.

USES & DISCLOSURES

Your protected health information may be used and disclosed by your physician, our office staff and others who are involved in your treatment, payment, or other healthcare operations. The following are common examples that our practice is authorized to make.

Treatment: Our practice will use and disclose your protected health information to provide, coordinate, or manage your health care. This includes the coordination or management of your healthcare with another provider. We will disclose protected health information to any other physicians who may be treating you. We may also disclose your protected health information to another physician or healthcare provider, such as a laboratory, who becomes involved in your treatment.

Payment: Our practice will use and disclose your protected health information, to obtain payment for your services performed by us or by another provider. This may include disclosures to health insurance plans, insurance providers and collection agencies.

Business Associates: We will share your protected health information with third party "business associates" that perform various activities on our behalf. Examples of a business associate include, billing services, transcription services, and legal services. Prior to disclosing any protected health information with a business associate, we will establish a written contract that contains the terms that will protect the privacy of your information. Business Associates and their subcontractors must also comply with HIPAA Privacy and Security Regulations.

Health Care Operations: Our practice will use and disclose your protected health information in order to support our practice's business activities. Examples include, but are not limited to, quality assessment, employee reviews, medical student training, licensing, fundraising, and conducting or arranging for other business activities.

HIPAA Permits and requires additional uses and disclosure that may be made without your authorization or opportunity to agree or object. These situations include:

Disclosures Required By Law & Workers Compensation: We are permitted to use or disclose your protected health information to the extent that the law requires the use or disclosure. We will maintain compliance with the law and will limit the disclosure to the minimum necessary. If required, you will be notified of any disclosure. We are permitted to disclose your protected health information as authorized to comply with workers' compensation laws and other similar established programs.

Abuse or Neglect: We believe abuse or neglect to be a serious issue. We may disclose your protected health information to a public health authority authorized to receive reports of child abuse or neglect. We may also disclose your information if, in our best judgment, we believe you have been a victim of abuse, neglect or domestic violence. When disclosing protected health information in cases of abuse or neglect, we will follow applicable state and federal laws.

Public Health & Communicable Diseases: We are permitted to disclose your protected health information for public health purposes or to a public health authority that is permitted by law to collect or receive the information. Examples may include disclosure to prevent or control disease, or injury. We are permitted to disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease. We may disclose your information if said person may be at risk of contacting or spreading the disease or condition.

Research & Health Oversight: We are permitted to disclose your protected health information to researchers when an institutional review board that has reviewed the research proposal, as well as established protocols to ensure the privacy of your information has approved their research. We are permitted to disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Legal Proceedings: We are permitted to disclose protected health information in connection with any judicial or administrative proceeding, subpoena, or in responding to a court order or tribunal.

Law Enforcement: We may also disclose protected health information, under lawful conditions to law enforcement. Permitted law enforcement purposes include; 1.) Legal processes and otherwise required by law, 2.) Limited information requests for identification and location purposes, 3.) Pertaining to victim of a crime; 4.) Suspicion that death has occurred as a result of criminal conduct; 5.) In the event that a crime occurs on the premises of our practice, and 6.) Medical emergency associated with a crime.

Patient Copy

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Patient Copy

Organ Donation, Coroners, & Funeral Directors:

We are permitted to disclose protected health information to a coroner or medical examiner to perform other duties. Disclose may be made in reasonable anticipation of death. Protected health may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Military Activity & National Security: We are permitted to use or disclose protected health information of individuals who are Armed Forces personnel under the following circumstances; **1.)** For activities deemed necessary by appropriate military command authorities; **2.)** For the Purpose of a determination by the Department of Veteran Affairs of your eligibility for benefits, or **3.)** To foreign military authority if you are a member of that foreign military services. We are also permitted to disclose your information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protected services to the President or others legally authorized.

Written Authorization: Unless required by law, your written authorization will be required for all other uses and disclosures of your protected health information. You may revoke authorization at any time, by written request. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Note: We are unable to undo any disclosures previously made with your authorization.

Opportunity to agree or object: The following are examples of instances where we may use and disclose your protected health information; however, you have the opportunity to agree or object to the use or disclose of all or part of the disclosure. If you are not present or able to agree or object to the use or disclosure, then we may, Using professional judgment, determine whether the disclosure is in your best interest.

- Unless you object, we may disclose to a member o your family, a relative, or a close friend, your protected health information that directly relates to that person's involvement in your health care. We may use or disclose protected health information to notify or assist notifying a family member personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your information to authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.
- Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition and your religious affiliation. This information, except religious affiliation, will be disclosed to individuals who ask for you by name. Your religious will only be given to a member of the clergy, such as a priest or rabbi.

Patient Rights

You have the right to inspect and copy your protected health information. As long as we are maintaining your protected health information, you may inspect and obtain a copy of your protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physicians use for health care decisions. As permitted by federal or state law, we may charge you a *"reasonable copy fee"* for a copy of your records.
However, federal law prohibits you from inspecting or copying: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access. You have the right to appeal the denial. Please Contact our Practice Manager if you have any questions.

You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information; **1.)** For the purpose of treatment, healthcare operations, or payment; **2.)** to family members or friends who may be involved in your care or; **3.)** For notification purposes as described in this Notice of Privacy Practices. Your written request must state the specific restriction requested and to whom you want the restriction to apply. We are <u>NOT</u> required to agree to a restriction that you request, unless your account has been paid in full. However, if your physician does not agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction other than emergency treatment situations.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We strive to accommodate all reasonable requests. As condition, we may ask for additional information, such as payment, alternative address, or additional contact information. We will not request explanation for the request. Notify our Practice Manager in writing for all requests.

You have the right to receive an accounting of certain disclosures made. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to a family member(s) or friend (s) involved in your care. Or for notification purposes, national security or intelligence, law enforcement or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You may request an amendment of your protected health information in a designated record set for so long as we maintain this information. We may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement and we may provide you with a copy of any rebuttal. Please contact our Practice Manager if you have questions.

HIPAA CONSENT / RECIEPT OF ACKNOWLEDGEMENT FORM

Patient Name: ____ **Date of Birth:** ______ / ______ / ______

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy.

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and/ or health insurance payers as is necessary and appropriate for your care. Patient hereby waives his/her confidentiality right should collection action become necessary. You have the right to request restrictions in the use of your protected health information and to request changes in certain polices used within this office. However, we are not obliged to alter internal policies to conform to your request.

My protected health information may be released to the following people:

Name (First & Last Name): ____ **Relationship:** ______________

Address: ____ **Phone #:** (______) ______ - ______

Name (First & Last Name): ____ **Relationship:** ______________

Address: ____ **Phone #:** (______) ______ - ______

Name (First & Last Name): ____ **Relationship:** ______________

Address: ____ **Phone #:** (______) ______ - ______

HIV/AIDS/STD: This form authorizes release of medical information including HIV related. Confidential HIV-related information is any information indicating that a person has had an HIV related test, or has an HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Please check:

I DO ______ **I DO NOT** ______

Consent to the release of any positive or negative test result for AIDS/ HIV or STD infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

With this consent, I give American Medical Associates permission to call my home or other alternative location provided in the patient information form and leave a detailed message on voicemail or in person with someone listed above in reference to the items that assist the Practice in carrying out treatment, payment and health care operations, such as appointment remainders, insurance items, and any calls pertaining to my clinical care such as lab and diagnostic results. I understand that it is office policy that I update this form yearly. I understand this consent expires 1 year after my initial signature and date.

____ ______________
(Patient Print Name) (DATE)

____ ______________
(Signature of Patient or Parent / Guardian / Legal Representative) (Relationship to Patient)

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HIPAA CONSENT / RECIEPT OF ACKNOWLEDGEMENT FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________ **Date of Birth:** ______ / ______ / ______

HIPAA – Notice of Privacy Practices:

- I have been provided with a copy of American Medical Associates Privacy Practices.
- I understand that the Notice may be changed at any time.
- I may request a new copy of American Medical Associates Privacy Practices in person or by writing to the Practice Manager, American Medical Associates, 1915 E Chandler Blvd. Ste. 1, Chandler, AZ 85225
- I understand that if any changes need to be made to my authorization as to whom my protected health information may be released to, must be done in person and a new form submitted.

______________________________ ______________
(Print Patient name) (Date)

______________________________ ______________
(Signature of Patient or Parent/ Guardian / Legal Representative) (Relationship to Patient)

For Staff Use Only:
We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: ____ Individual refused to sign ____ An Emergency situation prevented us from obtaining acknowledgement. ____ Other (please specify): ______________________________ Signature of Staff: ______________________ Date: __________

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I give permission to release the health information of: (One patient per form/ one facility per form)

Patient Name: ____

(Last Name) (First Name) (M.I.)

DOB: _______ / _______ / _______ **Last 4 numbers of Social Security:** ____________

Address: ____

(Street) (Apt. / Unit / Lot #) (City (State) (Zip)

Phone #: (________) ________ - ________

Purpose of Release (Check reason):

☐ Patient Use ☐ Insurance ☐ Disability ☐ Worker's Compensation ☐ Legal Purposes ☐ Further Medical Care

☐ Other: ____

Treatment Dates: From: ________ / ________ / ________ **To:** ________ / ________ / ________

Release Information From:

Facility: ____________________________

Address: ____________________________

____

Phone #: (________) ________ - ________

Fax #: (________) ________ - ________

Release Information To:

Name of Practice: ***American Medical Associates***

Address: ***1915 E. Chandler Blvd. Ste.1***

Chandler, AZ 85225

Phone #: ***(480) 306-5151*** **Fax #:** ***(480) 306-4648***

Hospital (Check all that may apply):

☐ **Hospital Abstract**

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Diagnostic Results
- ☐ Medications
- ☐ Allergies
- ☐ Physicians Orders
- ☐ Progress Notes
- ☐ Emergency Record
- ☐ Cardiac Reports / EKG
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Other: ____________

☐ Entire Record

Office / Clinic (Check all that may apply):

☐ **Office / Clinic Abstract**

- ☐ Office Visits
- ☐ Physical Exam
- ☐ Consultation Reports
- ☐ Diagnostic Test Results
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Medications
- ☐ Billing Information
- ☐ Other: ____________

☐ Entire Record

Format: (only select one)

☐ Paper copy (charges may apply) ☐ Electronic copy ☐ CD (PDF viewer, charges may apply) ☐ Other: ____________

Delivery Method:

☐ Registered US Mail ☐ Pick-up ☐ Fax ☐ Other: ____________

I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.
- This is a full release including information related to behavioral / mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV / AIDS, and other sexually transmitted diseases, unless limited by the above selections.
- Refusing to sign this form will not prevent my ability to receive treatment.
- I have a right to receive a copy of this form upon request.

This permission expires 90 days after the date of my signature unless another date or event is written here: _____ / _____ / _____

____ _______ / _______ / _______

(Print Last Name) (Print First Name) (M.I) **(DATE)**

____ ____________________

(Signature of Patient or Legal Parent / Guardian / Representative) (Relationship to patient)

AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

I give permission to release the health information of: (One patient per form/ one facility per form)

Patient Name: ____
(Last Name) (First Name) (M.I.)

DOB: ______ / ______ / ______ **Last 4 numbers of Social Security:** ____________

Address: ____
(Street) (Apt. / Unit / Lot #) (City (State) (Zip)

Phone #: (________) ________ - ________

Purpose of Release (Check reason):

☐ Patient Use ☐ Insurance ☐ Disability ☐ Worker's Compensation ☐ Legal Purposes ☐ Further Medical Care
☐ Other: ____

Treatment Dates: From: ______ / ______ / ______ **To:** ______ / ______ / ______

Release Information From:

Facility: ______________________________

Address: ______________________________
____

Phone #: (________) ________ - ________

Fax #: (________) ________ - ________

Release Information To:

Name of Practice: ***American Medical Associates***

Address: ***20928 N. John Wayne Pkwy. Ste.*** C-4
Maricopa, AZ 85139

Phone #: ***(480) 306-5151*** **Fax #:** ***(520) 217-3238***

Hospital (Check all that may apply):

☐ **Hospital Abstract**

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Diagnostic Results
- ☐ Medications
- ☐ Allergies
- ☐ Physicians Orders
- ☐ Progress Notes
- ☐ Emergency Record
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- ☐ Laboratory Reports
- ☐ Radiology Reports
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☐ Entire Record

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☐ **Office / Clinic Abstract**

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____ ______ / ______ / ______
(Print Last Name) (Print First Name) (M.I) (DATE)

____ ______________________
(Signature of Patient or Legal Parent / Guardian / Representative) (Relationship to patient)