SUNNY VIEW MEDICAL CENTER

Revised 7/13

PATIENT REGISTRATION FORM

Designate Primary Physician [_] S. Terry Clark, MD [_] James Corcoran, DO [_] Michael Lipson, MD
[_] James F. Doris, MD

Meaningful Use Data

Ethnicity: [_] Hispanic or Latin [_] Not Hispanic or Latin [_] Declined/Unreported

Race: [_] American Indian [_] Asian [_] Black or African American
[_] Hispanic or Latin [_] White or Caucasian [_] Other Race
[_] Decline/Unreported

Language: [_] English [_] French [_] Indian(Eastern) [_] Italian [_] Spanish [_] Other

(Please Print)

Patient Name: _____ Patient Social #: _____

Gender: [_] Male [_] Female Birth Date: _____ Age: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact/Relationship: _____ Phone: _____

Guarantor (*If patient is under 18 years of age*)

Parent/Guardian: _____ Parent/Guardian Social #: _____

Relationship to Patient: _____ Parent/Guardian Birth Date: _____

Employer/School

Employer/School Name: _____ Phone: _____

Address: _____ City, State, Zip: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____ Fax: _____

Insurance Information (*Please provide insurance card*)

Primary Insurance	Secondary Insurance
Insurance Name: _____	Insurance Name: _____
Policy Holder: _____	Policy Holder: _____
Policy Holder Birth Date: _____	Policy Holder Birth Date: _____
Relationship to Patient: _____	Relationship to Patient: _____

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION/ASSIGNMENT OF BENEFITS: I hereby authorize Sunny View Medical Center to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company(s), or their affiliates.

Signed (Patient or Guardian)_____ Date_____

Authorization to Disclose My Personal Health Information

Your personal health information is used by staff members to perform their jobs; order diagnostic testing, refer you to other providers, and file claims with your insurance carrier. We can not disclose personal health information to other persons such as a spouse, family member, friend, or entity, without your written authorization or in other legally limited circumstances.

[_] I do not authorize my personal health information to be released to other persons.

Informational privacy is the individual's ability to control what information is available, if any, and who has access to that information.

[_] I authorize my personal information to be release to:

_____ _____

Name of person or entity Relationship

[redacted]

[_] All of my personal health information

[_] Appointment, visit, or financial information

[_] My health information relating to the following treatment or condition: _____

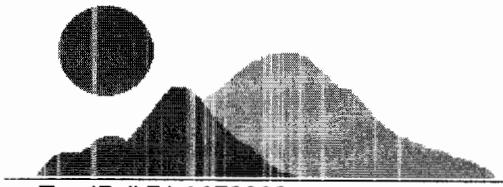
_____

[_] My health information for the date(s): _____

I understand I do not have to sign this authorization in order to receive health care treatment.

I understand that I may revoke this authorization in writing at any time.

[redacted] _____ [redacted] _____



Sunny View Medical Center

Tax ID # 71-0972832

S. Terry Clark II, M.D.
James P. Corcoran IV, D.O.
Michael J. Lipson, M.D.
James F. Doris, M.D.
Emily Knochel, PA-C

FINANCIAL POLICY

We at **Sunny View Medical Center, PLLC** are dedicated to providing the best possible care, service, and treatment to you and your family. Your complete understanding of our financial policy is an essential element. If you have any questions regarding the content of our Financial Policy, please feel free to discuss them with our Billing Manager.

- **A parent or guardian must accompany all minors** (anyone less than 18 years of age) unless a Minor Treatment Consent form is on file. The consent form is limited to minors 16-17 years of age and will be given upon request.
- **We have contractual agreements with many health plans.** This means that we agree to bill the health plan for services rendered and require you to pay the co pay, co-insurance and/or deductible at the time of service.
- **If you have a health plan that we are not contracted with or unable to verify coverage, we will require 80% of the billed charges at the time of service.** *If we do not accept or are not contracted with your secondary insurance, you will be responsible for what your primary insurance determines is your responsibility.*
- In the event that your health plan determines that a service is not a benefit of your contract or you do not have authorization to receive the service you will be responsible for payment of the denied service(s).
- **Patient responsibility balances must be paid prior to your next scheduled appointment.**
- After reasonable requests for payment you fail to pay the balance, the account will be subject to collection proceedings. Accounts in collection are immediately discharged from Sunny View Medical Center, PLLC. All fees including but not limited to collection fees, attorney fees, and court fees shall be patient responsibility.
- **The fee for a returned check is $28.00.**
- If you are unable to keep your scheduled appointment, you must contact the office to cancel the appointment at least 24 hours prior to your appointment time. If you do not show for your scheduled appointment you will be subject to a **NO SHOW fee of $25 - $50 based on type or occurrence**. Excessive NO SHOW occurrences will result in being discharged from Sunny View Medical Center, PLLC.
- **In the event that you move and do not leave forwarding information** (phone number or address) and our correspondence is returned; the physician/patient relationship that had existed will be considered terminated and you will be discharged from Sunny View Medical Center, PLLC.
- It is to be understood that **arbitration is the method Sunny View Medical Center, PLLC uses to resolve any dispute** as to medical malpractice. That is any disagreement as to whether services were unnecessary, improper, negligent, or incompetently rendered are to be determined via submission to arbitration proceedings as provided by Arizona law.
- A wellness exam consists of a physical examination by your physician. Please be aware that because of restrictions placed on us by your insurance company, chronic medical problems, acute illnesses, injuries or unrelated illnesses or complaints are not included in a wellness exam. **A separate office visit may apply.**

I have read and understand the FINANCIAL POLICY of SUNNY VIEW MEDICAL CENTER, PLLC and agree to abide by its terms.

Signature of Patient or Responsible Party _____ Relationship to Patient _____ Date _____

Notice of Privacy Practices

SUMMARY OF YOUR PRIVACY RIGHTS

I. Understanding Your Health Record/Information
II.

Each time you visit Sunny View Medical Center for services, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your health record serves as a:

- Plan for your care and treatment
- Communication source between health care professionals
- Tool with which we can check results and continually work to improve the care we provide
- Means by which Medicare, Medicaid/AHCCCS, or private insurance payers can verify the services billed
- Tool for education of health care professionals
- Source of data for medical research, facility planning and marketing
- Source of information for public health authorities charged with improving the health of the people
- Legal document that describes the care you received

Understanding what is in your health record and how the information is used helps you to:

- Ensure its accuracy
- Better understand why others may review your health information
- Make an informed decision when authorizing disclosures

III. Your Health Information Rights

Although your health record is the physical property of Sunny View Medical Center, the information belongs to you.

You have the right to:

- Inspect and receive a copy of your health record
- Request a restriction on certain uses and disclosures of your health information
- Request a correction/amendment to your health record if you believe the health information we have about you is incorrect or incomplete, we may amend you record or include your statement of disagreement.
- Request confidential communications about your health information. You may ask that we communicate with you at a location other than your home or by a different means of communication such as telephone or mail.
- Receive a listing of certain disclosures Sunny View Medical Center has made of your health information upon request.
- Revoke your written authorization to use or disclose health information. This does not apply to health information already disclosed or used or in circumstances where we have taken action on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.
- Obtain a paper copy of Sunny View Medical Center Notice of Privacy Practices upon request.

IV. Understanding Your Health Record/Information

Sunny View Medical Center is required by law to:

- Maintain the privacy of your health information
- Inform you about our privacy practices regarding health information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or a alternative locations
- Honor the terms of this notice or any subsequent revisions of this notice

Sunny View Medical Center reserves the right to change its privacy practices and to make the provisions effective for all protected health information it maintains. Sunny View Medical Center will post any revised Notice of Privacy Practices at a public place in the health care facility and you may also request a copy of the notice.

V. How Sunny View Medical Center may use and disclose your health information to provide your treatment.

We will use and disclose your health information to provide your treatment. For example: Your personal information will be recorded in your health record and used to determine the course of treatment for you. Your health care provider may determine he/she may need to consult with another specialist in the area; he/she will share the information with such specialist and obtain his/her input.

If Sunny View Medical Center refers you to another health care facility, Sunny View Medical Center may disclose your health information to that health care provider for treatment decisions.

We will use and disclose your health information for payment purposes.
For example: If you have private insurance, Medicare, or Medicaid/AHCCCS coverage, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.
We will use and disclose your health information for health care operations. Sunny View Medical Center may disclose your health information to business associates so that they can perform their jobs. We require our business associates to protect and safeguard your health information in accordance with all applicable federal laws.

Other disclosures and uses we can make without your written authorization:
Appointment Reminders: Sunny View Medical Center may contact you with a reminder that you have an appointment for medical care or to advise you of a missed appointment.

Notification of Family/Friends: Unless you object, Sunny View Medical Center may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other persons responsible for your care about your location, your general condition, or your death.

Deceased Persons: In the event of your death Sunny View Medical Center may disclose your health information to funeral directors, medical examiners, or coroners as necessary for them to carry out their duties.

Food and Drug Administration (FDA): Sunny View Medical Center may use or disclose your health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

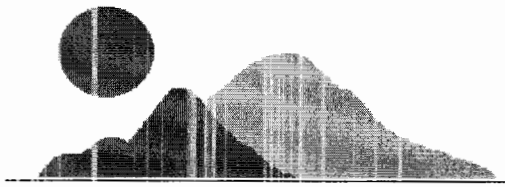
Public Health: Sunny View Medical Center may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medication or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition as required by law.

Correctional Institution: If you are an inmate of a correctional institution, Sunny View Medical Center may use or disclose health information necessary for your health and the health and safety of others such as officers or employees or other inmates.

Workers Compensation: Sunny View Medical Center may use or disclose your health information for workers compensation purposes as authorized or required by law.

Other Uses: Sunny View Medical Center may use or disclose your health information to assist in disaster relief efforts or for specialized government functions. Other uses and disclosures of your health information will be made only as otherwise authorized by law or with your written authorization.

If you wish to exercise any of the above rights, please contact our Privacy Officer at 602-956-9595 Ext. 124, in person or in writing during normal business hours.



Sunny View Medical Center

Tax ID # 71-0972832

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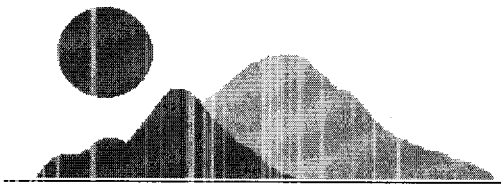
James P. Corcoran IV, D.O. NPI#1730128091
Michael J. Lipson, M.D. NPI#1528053030
James F. Doris, MD NPI#1033101001
Emily Knochel, PA-C, NPI#1669622502
Rami D. Lipson, D.C., FIAMA NPI#1467447979

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have seen the Privacy Notice for Sunny View Medical Center, PLLC and a copy was made available to me.

Signature of Patient or Responsible Party	Relationship to Patient	Date



Sunny View Medical Center

4400 N. 32nd ST Suite #110
Phoenix, AZ 85018
Phone: 602-956-9595 Fax: 602-956-3232

Patient Name _____ DOB_____

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone message (i.e. lab results) when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine or voice mail system.

Please read the following choices and tell us whether or not we can leave a voicemail regarding your medical information, such as lab & test results.

Choose one of the following:

☐ **I DO CONSENT** to leave detailed messages as follows:

I, _____, give SUNNY VIEW MEDICAL CENTER and their staff my permission to leave detailed phone messages regarding my medical care. This will remain in effect until rescind in writing.

Phone number_____

☐ **I DO <u>NOT</u> CONSENT** to leave detailed message:

I, _____, wish to be contacted personally and I DO **<u>NOT</u>** AUTHORIZE detailed messages regarding my medical care be left on an answering machine.

Signature _____ Date _____

Sunny View Medical Center

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Last Name: _____ First Name: _____ DOB: _____ Date: _____

Why are you consulting a Physician? _____

Medical History

Medical ☐ None (*High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.*)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Pregnancy History (if applicable)

Year	Sex	Complications

Surgery ☐ *None (Type and Year – Example, Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.)*

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies to medications? ☐ None (If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)

_____
_____

Current prescription medicines ☐ **None**

Name of drug	mg dose	# tablets	# times per day

Current prescription medicines

Name of drug	mg dose	# tablets	# times per day

OTC medicines. (Aspirin, Tylenol, Ibuprofen, Aleve, vitamins and herbals.)

_____ _____ _____ _____

Family History

	Living	Deceased	Illness	Cause of Death/Age
Father	☐	☐		
Mother	☐	☐		
Sister (s)	☐# ___	☐# ___		
Brother (s)	☐# ___	☐# ___		

Family History of:	Yes	No	Family Member		Yes	No	Family Member
1. Heart Disease	☐	☐		5. Diabetes	☐	☐	
2. Kidney Disease	☐	☐		6. Gastrointestinal Problems	☐	☐	
3. Kidney Stones	☐	☐		7. Bleeding Problems	☐	☐	
4. Prostate Cancer	☐	☐		8. Other	☐	☐	

Social History

Smoke? ☐ Yes ☐ No If yes, how much? _____ # of packs/day _____ # of years When did you stop smoking? _____

Alcohol? ☐ Yes ☐ No If yes, how much? _____ Occupation: _____

☐ Coffee – how much _____ ☐ Tea – how much _____ ☐ Soda – how much _____

Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when _____

(Continued on back)

Review of Systems

Circle Yes or No. **Have you ever had any problems related to the following systems?**

Constitutional Symptoms			**(Comments)**
Weight change	Y	N	
Chills/Fever	Y	N	
Sleep Disorder	Y	N	
Headache	Y	N	
Allergic/Immunologic			
Hay Fever	Y	N	
Drug allergies	Y	N	
Food allergies	Y	N	
Excessive infections	Y	N	
Integumentary (Skin)			
Rash	Y	N	
Lumps or bumps	Y	N	
Moles, skin tags	Y	N	
Persistent itch	Y	N	
Hematological/Lymphatic			
Swollen glands	Y	N	
Blood clotting problem	Y	N	
Bruising	Y	N	
Eyes			
Double vision	Y	N	
Glaucoma	Y	N	
Cataracts	Y	N	
Blurred Vision	Y	N	
Ear/Nose/Throat/Mouth			
Hearing changes	Y	N	
Sore throat	Y	N	
Sinus problem	Y	N	
Ringing in ears	y	N	
Cardiovascular			
Chest pain	Y	N	
Irregular heartbeat	Y	N	
Swelling in ankles	Y	N	
High blood pressure	Y	N	
Respiratory			
Wheezing	Y	N	
Frequent cough	Y	N	
Shortness of breath	Y	N	
Physician Comments:			

Gastrointestinal			**(Comments)**
Abdominal pain	Y	N	
Nausea/vomiting	Y	N	
Indigestion/heartburn	Y	N	
Change in bowel movements	Y	N	
Genitourinary			
Change in stream	Y	N	
Nocturia (getting up at night)	Y	N	
Urinary frequency > 8 times/day	Y	N	
Painful urination	Y	N	
Musculoskeletal			
Bone pain	Y	N	
Muscle pain	Y	N	
Joint pain	Y	N	
Weakness	Y	N	
Neurological			
Tremors	Y	N	
Dizzy spells	Y	N	
Numbness/tingling	Y	N	
Do you have difficulty falling asleep or wake without cause?	Y	N	
Psychological			
Are you generally happy?	Y	N	
Do you feel depressed?	Y	N	
Do you feel anxious?	Y	N	
Do you feel safe in your home?	Y	N	
Have you considered suicide?	Y	N	
Endocrine			
Excessive thirst	Y	N	
Too hot/cold	Y	N	
Tired/sluggish	Y	N	
Sexual History			
Change in sex drive?	Y	N	
Sexual performance satisfactory?	Y	N	
Do you want to talk about your sexuality?	Y	N	

General

Female:

Date of Last Pap _____

Date of Last Mammogram _____

Male:

Date of Last Prostate Exam _____

Male & Female:

Date of last Chest X-Ray _____

Date of last Tetanus Shot _____

Date of last Pnuemococcal _____

Date of last Colonoscopy _____

Last Dental Exam _____

Date of Last Eye Exam _____

Physician Signature: _____ Date: _____