Please Print

# PATIENT INFORMATION

Please
Answer ALL questions

☐ NEW PT. ☐ UPDATE Pt. Acct. # ______

Provider you are seeing today: ______ Bill to Acct. # ______

| PATIENT | SPOUSE/PARENTS |
|---|---|
| PATIENT Marital Status ☐ M ☐ D ☐ S ☐ W ☐ Sep | SPOUSE/PARENTS (If Pt. is minor) ☐ Mr. ☐ Mrs. ☐ Ms. |
| NAME: ______ (Last) (First) (MI) | NAME: ______ (Last) (First) (MI) |
| Sex ☐ M ☐ F Date of Birth ___/___/___ | Sex ☐ M ☐ F Date of Birth ___/___/___ |
| SS# ______ | SS# ______ |
| Responsible party: ☐ Self ☐ Spouse ☐ Parent(s) | Relationship to Pt.: ______ |
| Address: ______ | Address: ______ |
| (City) (State) (Zip) | (City) (State) (Zip) |
| Home Phone: ( ) ______ | Home Phone: ( ) ______ |
| Employer Name: ______ | Employer Name: ______ |
| Address: ______ | Address: ______ |
| (City) (State) (Zip) | (City) (State) (Zip) |
| Work Phone: ( ) ______ | Work Phone: ( ) ______ |
| Drivers License # ______ | Drivers License # ______ |

**PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(S) SO WE CAN MAKE A COPY**

| PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|
| Ins. Company ______ | Ins. Company ______ |
| Claims Mailing Address: ______ | Claims Mailing Address: ______ |
| (City) (State) (Zip) | (City) (State) (Zip) |
| Phone: ( ) ______ | Phone: ( ) ______ |
| Insured's Name ______ | Insured's Name ______ |
| Sex ☐ M ☐ F Date of Birth ___/___/___ | Sex ☐ M ☐ F Date of Birth ___/___/___ |
| Group/Employer Name: ______ | Group/Employer Name: ______ |
| Group/Policy # ______ | Group/Policy # ______ |
| ID/SS# ______ | ID/SS# ______ |
| Effective Date: ______ Co-pay $ ______ | Effective Date: ______ Co-pay $ ______ |

Person to contact in an emergency: ______ Phone: ( ) ______

Relationship: ______ How did you hear about us? ______

Referred by: ______ Phone: ( ) ______

Living Will? ☐ Yes ☐ No Durable Medical Power of Attorney? ☐ Yes ☐ No

**ASSIGNMENT & RELEASE:**

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process this claim. I authorize this office to RELEASE all MEDICAL INFORMATION NECESSARY to any hospital, specialist's office and any insurance company acting on my behalf concerning advice, care, treatment, services, including drug, alcohol or mental and nervous treatment unless specifically excluded by me below, FOR PURPOSES OF MEDICAL TREATMENT, AND EVALUATING AND ADMINISTERING CLAIMS.

SIGNED ______ DATE ______

PRIMARY CARE PROVIDER ______

.Please Print Patient's Name: ______________________________________ Date of Birth__________________

# Welcome to Desert Bloom Family Medicine!

**We treat patients from birth trough end of life.**

Desert Bloom providers consist of a team of physicians, nurse practitioners and physician assistants. You may make an appointment with any of the providers: Christopher Hiler, MD, Ethan Kennedy, DO, Jonathan Chorney, DO, Christine Rocks-Lopez, FNP-C, Helena In't Veld, FNP-C and Ivette Apodaca, PA-C

Office hours are Monday through Friday, 8-12 p.m. (we do not accept phone calls during noon hour.) We accept walk-ins for patients with acute medical problems only. Due to our desire to provide excellent and consistent patient care, walk-ins will **NOT** be seen for medication refills, lab reviews, or chronic medical conditions. **Walk-ins are seen on a first come basis with the first available provider.**

## WALK-IN POLICY

As a courtesy to our patients, and when it permits, we do offer walk-in appointments. However, the times allotted for these appointments are minimal therefore walk-in appointments are not for chronic medical problems, it is for acute problems only. Chronic medical conditions that do **NOT** qualify for walk-in appointment are things like your diabetic follow up, hypertension follow up, and pain management issues. Medication refills are **NOT** walk-in appointments. During peak seasons such as back to school and cold/flu season we may elect not to offer walk-in appointments. **It is always best to call the office ahead of time.** By signing this form, you agree to comply with our policy.

## Electronic Medication Transmission

Desert Bloom Family Medicine uses Electronic Health Record (EHR) software to receive and transmit medication request, refills, and receive medication histories. Most medication will be filled or refilled with electronic medication transmission. Initials __________ Date: ________________

## Photography Consent

Your photograph is required for narcotic prescriptions. By initialing below you are allowing Desert Bloom Family Medicine to photograph you for identification purposes. Additionally, there may be times you have a condition that requires photography for management. Initials____________ Date: ___________

## HIPAA Privacy Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I authorize Desert Bloom Family Medicine to speak to the following person(s) regarding my medical conditions/needs:

Name: ___________________________________ Relationship: _________________________________

Name: ___________________________________ Relationship: _________________________________

## Telephone Communication Authorization

I authorize Desert Bloom Family Medicine to contact me and leave messages at the following numbers:

Home:_____________________ Cellphone:_______________________ Work:___________________

**Please provide your email address if you would like to get an appointment reminder by email.**

Email: ________________________________________________________________________________

Print Name: __________________________________________Today's Date: ______________________

Signature: ___________________________________________Today's Date: ______________________

# HEALTHY LIFE CORP, LLC

DESERT BLOOM FAMILY MEDICINE
10240 W. INDIAN SCHOOL RD, PHOENIX AZ 85037
P: (623) 385-7900 / F: (623) 792-1233
VALLE DEL SOL FAMILY MEDICINE URGENT CARE
4338 W THOMAS RD. PHOENIX AZ 85031
P: (623) 385-7999/(623) 385-7950 F: (623) 385-7951


## Advanced Beneficiary Notice of Non-Coverage (ABN)

**Please read and sign below:**

- Your provider may order test during your visit **DONE HERE OR AT AN OUTSIDE FACILITY** that **MAY** or **MAY NOT** be covered by your insurance policy. We do not know the limitations of YOUR policy.
- IF you decide to have these test performed and your insurance does not cover all or a portion of the costs associated with these test, **IT WILL BECOME YOUR FINANCIAL RESPONSILIBITY TO PAY FOR ANY NON-COVERED SERVICES ORDERED BY THE OFFICE.**
- **We will only use appropriate diagnosis codes relevant to your healthcare on your order for you testing or insurance claim.** Codes cannot be added or removed after your testing to try to get "non-covered" services covered. **THIS IS FRAUD**
- **Any bills you received are your financial responsibility.**
- Our office will not call insurance companies, laboratories or diagnostic imaging facilities on your behalf regarding your bills. Any appeals regarding non-covered services must be done by the patient or guarantor.
- Certain insurances require time limits for certain services such as yearly physicals, Mammograms, Pap Smears, or other kinds if testing. If you choose to have these services **before** the date your insurance states you can have each year, you may be billed and you will responsible for charges if your insurance does not cover the service. It is your responsibility to know the limitations and terms of your insurance plan.

**By signing below, I acknowledge that any services or testing ordered or done by this office will become my financial responsibility if my insurance plan does not cover the services.**

**Patient Name (printed):**______________________________________________

**Patient DOB:** _____/_____/_______

**Patient/Guardian or Guarantor Signature:** ________________________________

**Name of Current Insurance plan:** ______________________________________

**Date:** _____/_____/_______

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## Controlled Substance Agreement

I, ______________________________________ Understand that in order to receive care for the treatment of pain or the use of controlled medications, I agree to and will comply with the following:

1. USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with the undersigned provider before making any change in either the dose or frequency of my medications. There will be no early refills of controlled medications without prior authorization. Narcotic pain medications must all be obtained from the same pharmacy each time (any exceptions must be approved by the undersigned physician). I will abstain from Alcohol use.__________ **(initial)**
2. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for any controlled medication from any other health care provider (including within our office) unless authorized by the undersigned physician. I will not harass or repeatedly speak with the pharmacist or office staff about refills which may be early. I will not call the physician after hours about my controlled substance prescription refills.________ **(initial)**
3. ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand that the use of any controlled medication not prescribed by the undersigned physician may result in termination of care. I authorize the practice to cooperate fully with any city, state or federal law enforcement agency, include this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of controlled medicines. I authorize the practice to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right to privacy confidentiality with respect to these authorizations.________ **( initial)**
4. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by the undersigned physician and understand that lost or damaged medications will not be replaced. Police reports will not suffice for obtaining a new prescription regardless of the situation. ________**( initial)**
5. REFUSAL OR NEGLECTING TO GET TESTING DONE REQUESTED BY THE PROVIDER: If you fail to get your labs, X-rays, MRI's, etc. done as required by our provider before your next appointment we may refuse to refill your prescription until you get the testing we required._________ **(initial)**
6. FOLLOW UP MONTHLY APPOINTMENTS: You must make a follow up appointment on your way out of the office, if you do not and you call to get in and an appointment is not available you WILL wait until next available appointment. Refills for controlled substances are not done on a walk-in basis. NO EXCEPTIONS!________**(initial)**
7. RANDOM BLOOD AND/OR URINE DRUG SCREENS AND PILL COUNTS: If you called to come into the office for a random drug screen or pill you have 24 hours to get into the office. Bring our original pill bottle with ALL medications filled. Failure to do so will forfeit your right for the next month's refill. NO excuses_________**(initial)**
8. TERMINATION: I will no longer be eligible for care if I am in possession of illicit drugs or substances, trafficking controlled or illegal substance, intoxicated or if arrested for DUI. If alter my prescription in any way, sell or share my medications, will no longer be eligible for care_________**( initial)**

**I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM ALL. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE.**

______________________________________________________________

**Patient Name (print)** **Patient Signature** **Date of Birth** **Date of Signature**

______________________________________________________________

**Provider Name** **Date Signed**