Parkview Internal Medicine

PATIENT REGISTRATION

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

DOB:_____ /_____ /_____ **Sex:** ☐ ***Male*** ☐ ***Female*** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Home Address:_____ **Apt #:**_____

City:_____ **State:**_____ **Zip:**_____

Home #: (_____)_____ **Work #:** (_____)_____ **EXT:**_____ **Cell #:** (_____)_____

Preferred Daytime Phone: ☐ Home ☐ Cell ☐ Work

Email:_____ **Employer:**_____

IF WINTER VISITOR, PLEASE LIST YOUR PERMANENT ADDRESS

Address (PO BOX): **City:** **State:** **Zip:**

ADDITIONAL INFORMATION

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Other:_____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

☐ do not want to provide this information

EMERGENCY CONTACT INFORMATION

Name:_____ **Relationship:**_____

Home #: (____)_____ **Work #:** (____)_____

PREFERRED PHARMACY

Name:_____ **Phone #:** (_____)_____

Location (Crossroads):_____

Mail-Order Pharmacy:_____

PREVIOUS PHYSICIAN INFORMATION

Physician Name:_____

Phone Number: (_____) _____

Fax Number: (_____) _____

Office Address:_____

Financial /Insurance Information

PRIMARY INSURANCE

Insurance Name:_____

Policy Holder's Name:_____ **Employer:**_____

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Policy Holder's DOB:_____ **SS#:**_____ **Sex:** ☐ ***Male*** ☐ ***Female***

Member ID #:_____ **Group #:**_____

SECONDARY INSURANCE

Insurance Name:_____

Policy Holder's Name:_____ **Employer:**_____

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other: _____

Policy Holder's DOB:_____ **SS#:**_____ **Sex:** ☐ ***Male*** ☐ ***Female***

Member ID #:_____ **Group #:**_____

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT

Responsible Party Name:_____ **DOB:**_____ **SS#:**_____

Address:_____ **Relationship to Patient:**_____

City:_____ **State:**_____ **Zip:**_____ **Employer:**_____

Home #: (_____)_____ **Work #:** (_____)_____ **Cell #:** (_____)_____

BENEFIT ASSIGNMENT / ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby authorize PARKVIEW INTERNAL MEDICINE to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning the patient's 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 health insurance. It is my responsibility to notify the office of changes in information.

Signature:_____ **Date:**_____

Patient's Medical History

MEDICATIONS

Medication Name:	Strength:	Dose:	Frequency:

ALLERGIES

☐ Patient has no known allergy ☐ Patient has no known drug allergy ☐ Latex ☐ Keflex
☐ Penicillin ☐ Sulfa ☐ Eggs ☐ Ciprofloxin ☐ Iodine
☐ Other: _____

PAST / PRESENT MEDICAL CONDITIONS

Cardiac: ☐ Heart Attack ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Hypertension ☐ Irregular Heart Beat
Neurology: ☐ Stroke ☐ Seizures/Epilepsy ☐ Dementia ☐ Parkinson's
Endocrine: ☐ Diabetes ☐ Thyroid Disorder ☐ Osteoporosis ☐ Elevated Cholesterol
Lungs: ☐ Asthma ☐ COPD ☐ Valley Fever ☐ Sleep Apnea ☐ Lung Cancer
Gastrointestinal: ☐ GERD ☐ Colon Cancer ☐ IBS ☐ Cirrhosis/Liver Disease
Urinary: ☐ Enlarged Prostate ☐ Kidney Stones ☐ Prostate Cancer ☐ Kidney Failure
Rheumatology: ☐ Arthritis ☐ Fibromyalgia ☐ Lupus
Blood: ☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Bleeding Disorder
Psychiatric: ☐ Anxiety Disorder ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia
Circulation: ☐ DVT ☐ Pulmonary Embolus ☐ Peripheral Vascular Disease ☐ Carotid Artery Disease
Cancer: ☐ Cancer (type)
Other Condition(s) not listed:_____ ☐ NONE

HOSPITAL & SURGERY HISTORY

DATE:	SURGERY/REASON FOR HOSPITAL STAY:

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE/DECEASED	MEDICAL CONDITION(S)
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

SOCIAL HISTORY

Caffeine: ☐ Yes ☐ No If yes, how much? _____

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

Smoking: ☐ Yes ☐ No ☐ Former If yes, how many/often? _____

Marijuana: ☐ Yes ☐ No If yes, how often? _____

Exercise: ☐ Yes ☐ No If yes, what and how often? _____

Living Will: ☐ Yes ☐ No

Retired: ☐ Yes ☐ No

PREVENTIVE CARE

Date of last physical exam: _____

Date of last mammogram: _____

Date of last colonoscopy: _____

Date of last bone density scan (DEXA): _____

Date of last Pap smear: _____

Date of last PSA: _____

Date of last stool test: _____

IMMUNIZATIONS

Hep. A: ☐ Yes ☐ No Date received: _____

Hep. B: ☐ Yes ☐ No Date received: _____

Influenza: ☐ Yes ☐ No Date received: _____

Pneumonia: ☐ Yes ☐ No Date received: _____

Prevnar 13: ☐ Yes ☐ No Date received: _____

Tetanus: ☐ Yes ☐ No Date received: _____

Shingles: ☐ Yes ☐ No Date received: _____

TB: ☐ Yes ☐ No Date received: _____

MMR: ☐ Yes ☐ No Date received: _____

OFFICE POLICY

PARKVIEW INTERNAL MEDICINE

These policies at **Parkview Internal Medicine** are designed to make the care we provide more streamlined, efficient and patient-centered for you.

1. APPOINTMENTS

To accommodate everyone's needs, we offer appointments days, weeks or months in advance as well as same day scheduling. If you have an urgent need please call us and we will get you in as soon as possible.

2. LATE/ NO SHOW POLICY

We pride ourselves on taking your time seriously and hope you will do the same for us. If you are running 10 or more minutes late, we will have to reschedule you to a different day. We do ask that you call at least 24 hours in advance if you cannot make your appointment. After your 3rd No Show appointment we can dismiss you from the practice.

3. MEDICATION REFILLS

- If possible, it is best to get refills during your regular office visit. For your convenience we can e-prescribe or fax your prescriptions directly to your pharmacy.
- We encourage patients to contact their pharmacy for refills or use the Patient Portal to request refills.
- Please allow our office 72 hours to complete the refill process.
- Please note that no prescription refills, routine OR controlled substances are done after hours or on weekends.
- If your medications need prior authorization, please note this may take 5-7 business days for processing.

4. AFTER HOURS CARE

If you have an emergency, please call 911 or go directly to the nearest emergency room. For less urgent medical concerns please call our answering service at (602) 433-3419 and the on call Provider will respond. Routine calls, such as, medication refills or referrals will be handled during regular office hours.

5. GROUNDS FOR TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

A physician may terminate a relationship with a patient by giving 30 day notice, during which the physician is responsible only for responding to urgent medical matters. We will reserve this action for patients who demonstrate repeated non-compliance with medical advice, missing multiple appointments, failing to pay their balances, disregarding the stated policies of the practice or acting in a way this is deceptive, dishonest or abusive.

6. REFERRALS/ PRE-CERTIFICATIONS

If you need to see a specialist, your insurance company may require a referral. It is your responsibility as the patient to determine if your insurance requires a referral, to verify that the specialist is on your plan and to obtain a referral from our office before visiting the specialist. New referrals require an office visit for documentation of medical necessity. Referral requests require one to two weeks' notice before your visit with the specialist.

7. DISABILTY FORMS/ WORKMANS COMP.

Dr. Dhupati will not sign **ANY** forms for Disability Claims or Workman's Comp.

Patient Signature: _____ Date: _____

FINANCIAL POLICY

PARKVIEW INTERNAL MEDICINE

Thank you for choosing Parkview Internal Medicine as your primary care physician office. **Please carefully read and sign below.** This policy has been put in place to ensure that financial payments due are recovered. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. I understand that all copayments and outstanding balances are due at the time of service. If I do not have my insurance card, and/or copayment, my appointment may be rescheduled based on availability until such time that I can provide the required documents or payments.

2. I understand that although we are contracted with several insurance companies, it is my responsibility to know my insurance benefits.

3. I understand that if I do not have the correct PCP assigned by my insurance company that my appointment will be rescheduled.

4. I understand that if my insurance company has not paid a claim on my behalf within 90 days because of information that I have not provided, the balance will be transferred to my account and I will be responsible for payment. If we receive payment at a later date, we will reimburse you.

5. I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).

6. I understand that there is a charge of $35 for any forms that I request the doctor to complete on my behalf. The payment for completion of these forms will be paid when the forms are accepted for the doctor to complete. These forms include but are not limited to FMLA paperwork, Life Insurance forms, Assisted Living forms and any other form requiring doctor completion when the patient is not present. Document completion could require you to be seen by a provider. Please allow 7-10 business days for completion.

7. I understand that there may be fees associated with medical records requests and that I may be responsible for these fees.

8. I **have read and I understand the above Financial Policy and I agree to abide by its terms.**

_____	_____
Printed Name (patient or guarantor)	Relationship
_____	_____
Signature (patient or guarantor)	Date

HIPAA Compliance Patient Consent Form

Parkview Internal Medicine
12647 W Smokey Dr. Suite 118-119
Surprise AZ 85378

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

PARKVIEW INTERNAL MEDICINE NOTICE OF PRIVACY PRACTICES

Uses and Disclosures:

Treatment- Your health information may be used to staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment- Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Options - Your health information may be used as necessary to support the day to day activities and management of Parkview Internal Medicine. For example, information on the services you received my used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement - Your health information may be disclosed to public health agencies, without permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with the government mandated reporting.

Public Health Reporting - Your health information may be disclosed to public health agencies as required by law. For example, when we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures (Require your authorization): Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of the disclosure of the information that occurred before you notified us of your decision.

Additional Uses of Information (Require your authorization)

Appointment Reminders - Your health information will used by our staff to send and or call you with appointment reminders. Our policy regarding reminder calls that are answered by voicemail or an answering machine, we will leave a message stating the name of our office, our telephone number, and the date and time of the upcoming appointment.

Information About Treatments - Your health information may be used to send you information on the treatment and management of your medical condition that you may find of interest. We may also send you information describing other health related goods and services that we believe may interest you.

Individual Rights - You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protect health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

PARKVIEW INTERNAL MEDICINE RESPONSIBILITIES: We are required to abide by privacy policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices: As permitted by law we reserve the right to amend or modify our privacy practices or policies. These changes in our policies and practices may be required by changes in the federal and state laws/regulations. Whatever the reason for these revisions, we will provide you revised policy upon you next office visit. The revised practices and policies will be applied to all protected health information.

Received By: Date:

PRESCRIPTION REFILL POLICY

Our goal is to assist patients with prescription requests in an efficient and timely manner. Parkview Internal Medicine participates with electronic prescribing directly to your mail order or local pharmacy. **Due to the volume of prescription requests, we have created the following guidelines and ask you to please follow them:**

1. It is the patient's responsibility to notify the office in a timely manner when refills are necessary. Call your pharmacy first, Approval may take up to **three (3) business days**, so do not wait to call. If you have a mail order pharmacy, please contact us **fourteen (14) days** before your medication is due to runs out.
2. Refills will only be addressed during normal business hours (**Monday-Friday 8am-4pm**) Please call our office at **623-544-1700, opt 3** & leave all information including: Name, Strength, Dosage & preferred pharmacy. No meds will be refilled on Saturday, Sunday, or Holidays.
3. Refills require close monitoring by your provider to ensure safety & effectiveness. Your Provider will prescribe the appropriate number of refills to last until your scheduled appointment. Generally, when you are down to zero refills, it is time to schedule an appointment.
4. Maintenance meds such as Blood Pressure, Diabetes, Cholesterol or Thyroid will only be approved if the patient has an appointment within 3-6 months as **decided by the doctor**.
5. Controlled Substances such as ADD/ADHD, Antianxiety, and sleep meds will require a **mandatory visit every three (3) months** for med management.
6. Antibiotics or New medications will require an appointment. They are not prescribed over the phone because it generally requires an office visit.
7. Some medications require prior authorizations. It is your responsibility to contact your insurance to see if they cover any alternatives or want you to try something prior to refilling that medication.
8. If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please call our office to schedule an appointment.

We ask that you please sign below to agree that you will follow the Refill Policy.

Patient signature: _____ Date: _____