ALL FAMILY CARE, PC

LAST NAME________________ FIRST NAME________________ MIDDLE________

MAILING ADDRESS________________ APT ____ CITY________________ STATE_____ ZIP________

PHONE________________ DOB________ AGE________ SS#________________ MARITAL STATUS________

ETHNICITY: HISPANIC____ NON-HISPANIC____ (REQUIRED BY FEDERAL GOVERNMENT)

RACE:________________ I DECLINE TO LIST MY RACE:_________ (REQUIRED BY GOVERNMENT)

PRIMARY LANGUAGE SPOKEN: ENGLISH:________________ OTHER:________________

EMPLOYER________________ OCCUPATION________________ STUDENT________

WORK PHONE________________ CELL PHONE________________

EMERGENCY CONTACT________________ PHONE____________ RELATIONSHIP TO PATIENT____________

WHOM MAY WE THANK FOR THE REFERRAL?________________

RESPONSIBLE PARTY INFORMATION

***WHO'S RESPONSIBLE FOR THIS VISIT? YOURSELF__PARENT__(PLEASE CIRCLE APPLICABLE ONE)

LAST NAME________________ FIRST NAME________________ MIDDLE________

ADDRESS________________ CITY________________ STATE______ ZIP__________

RELATIONSHIP TO PATIENT________________ DOB____________ SS#________________

EMPLOYER________________ OCCUPATION____________ PHONE NUMBER____________

INSURED'S INFORMATION PLEASE GIVE CARDS TO OFFICE STAFF PRIOR TO VISIT!!!

NAME OF POLICY HOLDER________________ DOB____________ SS#____________

PRIMARY INSURANCE________________ HMO_PPO_ICA_SELFPAY_EMPLOYER________________

ID#________________ GROUP#________________ INSURANCE COMPANY PHONE________________

INSURANCE ADDRESS________________ CITY________________ STATE__________ ZIP__________

DO YOU HAVE COPAY? YES__ NO__(PLEASE CIRCLE ONE) AMOUNT__________ EFFECTIVE DATES____________

SECONDARY INSURANCE________________________________

ID#________________ GROUP#________________ INSURANCE COMPANY PHONE________________

INSURANCEADDRESS________________ CITY________________ STATE________ ZIP__________

IF THIS IS AUTO/INDUSTRIAL INJURY, PLEASE PROVIDE THE FOLLOWING: DATE OF INJURY________________

CLAIM #________________ CLAIMS ADJUSTOR________________ PHONE #________________

Authorization to pay insurance benefits to physician: I hereby authorize payment directly to All Family Care, PC. Authorization to release information: I hereby authorize All Family Care, PC to release all medical information needed to process this claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the patient in the event that my insurance coverage does not pay. In the event of default, I promise to pay any collection costs and reasonable attorney fees, as may be required to collect for my services.

SIGNATURE OF PATIENT OF PATIENT OR PARENT IF MINOR________________________________ DATE__________

ALL FAMILY CARE, PC.

GARDEN LAKES PLAZA
4120 N. 108TH AVE. STE. #116
PHOENIX, AZ 85037
PHONE: 623-872-1818
FAX: 623-872-1819

CANYON TRAILS PROF. CENTER
700 N. ESTRELLA PKWY. STE: 120
GOODYEAR, AZ 85338
PHONE: 623-925-0636
FAX: 623-925-0637

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have read or been offered a copy of the office's Notice of Privacy Practices.

______________________________ ______________________________
Patient or legally authorized individual signature Date

______________________________ ______________________________
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

PATIENT PORTAL/EMAIL/TEXT AUTHORIZATION

You will be able to obtain you/your child's medical information securely online through our new Patient Portal free of charge. This information may include office notes, medical history, immunization history, prescription history, lab and radiology records. You will also be able to request WELL CHECKS AND REFERRALS. You may also receive phone messages/emails/text regarding upcoming appointments, billing statements, and reminders for yearly WELL CHECKS, mammograms, colonoscopies, seasonal shots such as FLU SHOTS.

In order for us to link the account to our system we will be need an email address. We can only have one email address per patient/legal guardian. If you wish to participate. Please complete the following:

Patient/legal Guardian Name:______________________________

Signature:______________________________DATE:______________________________

EMAIL:______________________________CELL PHONE #:______________

******PLEASE PRINT CLEARLY******

ADVANCED DIRECTIVES

The state of Arizona regulations require that your medical chart contain the following information. You will be asked if you have a living will, have assigned a Medical Power of Attorney or designated a Surrogate to act on your behalf.

Please complete the following and acknowledge your response by signing below.

_____I have a Living Will. State location if possible______________

_____I have a Medical Power of Attorney. Designee if available______________

_____I have Designated a Surrogate. Name of Surrogate____________________

_____I have none of the above and do not wish one

______________________________ ______________________________
Patient Signature Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:____

DATE OF BIRTH:________________ **SOCIAL SECURITY #** ________________

HOME ADDRESS:____

PHONE NUMBER:____

This authorization allows the following physician/facility to release my medical records including but not limited to progress notes, consultations, test results including imaging and lab work, immunizations, phycological/psychiatric records, HIV and communicable diseases to the Dr. Singh at ALL FAMILY CARE, PC.

PHYSICIAN/FACILITY NAME:____

ADDRESS:____

PHONE:____________________ **FAX:**____________________

SIGNATURE OF PATIENT /GURADIAN:______________________________ **DATE:**__________

WITNESS:______________________________ **DATE:**__________

AUTHORIZATION TO SHARE MEDICAL INFORMATION (OPTIONAL)

I do hereby authorize **ALL FAMILY CARE, PC** to allow the following individuals to have access and discuss with **Dr. Singh** my personal medical records, medical history and all pertaining information. I understand that this also includes psychiatric/psychological treatment, HIV and communicable related diseases. In accordance with federal regulation 42CFR Part 2, I hereby consent to the release of records pertaining to drug and alcohol abuse.

I understand that I may revoke this consent at any time in writing to the office of All Family Care, PC. This consent will automatically renew every 12 months without my written revocation.

____

Authorized Person (s) Relationship to patient

____

Date

ALL FAMILY CARE, PC.

FINANCIAL POLICY

Welcome to All Family Care

(Effective September 21 2017)

YOU WILL BE REQUIRED TO SIGN A NEW FINANCIAL AGREEMENT EVERY 12 MONTHS.

PATIENT NAME:______________________________**DATE OF BIRTH:**______________________________

Thank you for choosing **All Family Care, P.C.** We are committed to providing the finest personalized family care. Please carefully read and sign the following statement of our office policies prior to your treatment. Feel free to speak to our practice manager or billing department if you have any questions.

INSURANCE:

You are ultimately responsible for payment of services if your insurance carrier does not pay for any reason. **IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE.** Please present your insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. Current policies in the "ACA" Affordable Care Act may delay payment of your claims due to non-payment of policy premiums by the patient. If your insurance delays, denies or pays and then re-coups the payment of your claims due to non-payment of the policy premium, you will be responsible to pay the claim in full in accordance with our "Financial Policy" guidelines.

The patient is responsible for obtaining all necessary information regarding referrals or authorizations to another physician. Failure to do so may result in denial or delay of payments. Please allow five days for the office to obtain your referral.

NO SHOW/LATE CANCELLATION FEE:

If you need to cancel your appointment, please contact our office **at least 24 hours before** your appointment time. Because of the high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. A $50.00 fee will be assessed for all missed appointments not canceled with **at least 24 hour** advance notice.

BILLING:

As a courtesy to you, we will bill your insurance company for services rendered. In order to do so, we must have complete billing information, picture identification and your insurance card. Arizona law requires insurance companies operating in the state to process claims within 30 days. It is your responsibility to promptly provide your insurance company with any requested information needed to process your claim.

In order to keep billing costs to a minimum, all co-pays, co-insurance and deductibles are to be paid on the day of the visit without exception. We reserve the right to reschedule your appointment if the applicable co-payment is not paid in full at the time of appointment check-in. For your convenience, we accept credit and debit cards from Master Card, Visa, cash and check.

ALL FAMILY CARE, PC.

FINANCIAL POLICY

Welcome to All Family Care

(Effective September, 21 2017)

PATIENT NAME:______________________________**DATE OF BIRTH:**________________________

In addition to co-payments and deductibles, you are responsible to pay for denied or non-covered services as determined by your insurance company. If our physician is an "out of network provider" for your insurance, the deductibles and co-insurance amounts may be higher. Your insurance policy, not our office, determines the amounts. After your insurance company processes your claims, you will receive a statement every month from our office showing your account balance. Your statement will indicate which portion of the balance is due from you. Patient balances are due and payable in full upon receipt of your statement. Accounts which remain unpaid after 30 days will be assessed a late fee of $5.00 per month. Delinquent accounts will be transferred to a collection agency or our attorney after 90 days.

In the event of default, you will be required to pay collection costs and reasonable attorney fees. Accounts sent to collections are reported to all three major credit bureaus and are on file for as long as the law provides.

Please understand maintaining financial viability is the only way our office is able to continue providing quality medical care for our patients. Your understanding and cooperation enables us to deliver the quality healthcare you deserve and expect.

There will be a $30.00 service fee for all returned checks. Any checks returned for any reason must be paid with certified funds (cashier check, money order or cash).

PRESCRIPTION REFILLS:

Please plan ahead for prescription refills. We encourage you to address refills at the time of your office visit. Any changes in medication, new prescription, or mail in prescription problems require an office visit. No prescription refills will be granted on weekends, after hours or during routine well visits.

We respect your time and every attempt is made to run on schedule. Therefore, we ask you to arrive on time for your appointment. If you are late, you may be asked to reschedule. If your doctor is running behind due to emergencies and you need to reschedule, please notify the office staff. If you choose to stay, your visit will be given the same consideration.

I have read and understand the above policy and I agree to abide by the terms stated within.

____________________	________________________	__________
Printed name of patient	Signature of patient/responsible party	Date

ALL FAMILY CARE, PC.

YEARLY UPDATE PACKET

******PLEASE PRINT CLEARLY******

PATIENT PORTAL/EMAIL/TEXT AUTHORIZATION

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In order for us to link the account to our system we will be need an email address. We can only have one email address per patient/legal guardian. If you wish to participate. Please complete the following

Patient/legal Guardian Name:____

Signature:______________________________ **DATE:**__________________

EMAIL:________________________ **CELL PHONE #:**________________

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: **YOU NEED TO MAKE A CHOICE ABOUT RECEIVING THESE SERVICES**

We expect that YOUR INSURANCE may not pay for the services described below. YOUR INSURANCE does not pay for all of your health care costs. YOUR INSURANCE only pays for what they determine to be covered items and services. The fact that YOUR INSURANCE may not pay for a particular item or service does not mean that you should not receive it; there is a reason your doctor recommended it. The following list includes, but is not limited to, services that may not be covered by YOUR INSURANCE:

BLOOD DRAWS, LABS, VACCINATIONS, INJECTIONS, SPECIAL PROCEDURES OR ANY OTHER SPECIFIC ITEM OR SERVICES YOUR INSURANCE POLICY DEEMS NOT COVERED.

The purpose of this letter is to help you make an informed choice about whether or not you want to receive services from ALL FAMILY CARE, PC knowing that you might have to pay for them yourself. By signing below you agree to take financial responsibility for the cost of the item(s) or service(s) if your health insurance does not include this as a covered item or service.

______________________________________ ________________

Signature of Patient or person acting on Patient's behalf Date

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GOODYEAR, AZ. 85338
PHONE: 623-925-0636
FAX: 623-925-0637

TODAY'S DATE: ____________________

NAME: ______________________________

DATE OF BIRTH: ______________________ **S.S.#** __________________________

DO YOU HAVE A LIVING WILL? ☐ Yes ☐ No

ANY ADVANCE DIRECTIVES ☐ Yes ☐ No

PHARMACY Name : ____

Phone #: ____

MAIN REASON OF VISIT / CHIEF COMPLAINT:

- ____
- ____
- ____

MEDICATIONS:

Name	Dose and Frequency	Name	Dose and Frequency

ALLERGIES: ☐ No Medication Allergy

Name	Adverse Reaction	Name	Adverse Reaction

ALL FAMILY CARE, PC.

MEDICAL HISTORY. (Please Check All Applicable)

☐ High Blood Pressure
☐ Heart Attack
☐ Coronary Artery Disease
☐ Palpitations
☐ Atrial Fibrillation
☐ CHF
☐ Rheumatic Fever
☐ Hyperlipidemia
☐ Recurrent UTI
☐ Chronic Anemia
☐ Gout
☐ Arthritis
☐ Diabetes Mellitus
☐ Thyroid problem
☐ DVT/ PE
☐ Migraine Headache
☐ Stroke
☐ Mini Stroke / TIA
☐ Seizure
☐ Parkinson's
☐ Dementia
☐ Depression
☐ Anxiety
☐ Seasonal Allergies
☐ Sinusitis
☐ Kidney Problem
☐ Hernia
☐ Lupus
☐ Bleeding Problem
☐ Aneurysm
☐ Asthma
☐ COPD
☐ Emphysema
☐ Chronic Bronchitis
☐ Tuberculosis
☐ Pneumonia
☐ Hepatitis
☐ Heart Burn / GERD
☐ Gastric Ulcers
☐ Duodenal Ulcers
☐ Pancreatitis
☐ Diverticulitis
☐ Fibromyalgia
☐ Prostate Problem / BPH
☐ STD / HIV / AIDS

☐ Cancer. If yes. Where________________________ Any Metastasis: ________________________

☐ Any other Medical Cond.: ____

SURGICAL HISTORY (Please Check All Applicable)

☐ Cataract
☐ Ears
☐ Thyroid
☐ Angioplasty
☐ Appendectomy
☐ Prostate. Complete / TURP
☐ Gall Bladder (Cholecystectomy)
☐ Tonsellectomy
☐ Nose
☐ Heart Bypass / CABG
☐ Angioplasty with Stent
☐ Gastric Bypass
☐ Hernia repair _________
☐ Uterus (Hysterectomy) ☐ Complete ☐ Partial
☐ Adenoidectomy
☐ Throat
☐ Carotid
☐ Varicose Veins
☐ Colon
☐ Hemorrhoids

Breast Surgery ☐ Lumpectomy ☐ Mastectomy ☐ Augmentation ☐ Reduction

☐ Hip replacement R / L ☐ Knee replacement R / L ☐ Spine

☐ Plastic Surgery _________________________ ☐ Tumor / Cancer ______________________

☐ Any other Surgery . ____

Colonoscopy____________________ Upper Endoscopy____________________

IMMUNIZATION HISTORY

Tetanus:__________________ Hepatitis______________________

FLU Shot:_________________ Other: ______________________

Pneumonia ________________ ______________________

ALL FAMILY CARE, PC.

PERSONAL HISTORY : (Please Check All Applicable)

MARITAL STATUS ☐ **S** ☐ **M** ☐ **D** ☐ **Sep** ☐ **W**

SMOKING ☐ NO ☐ YES How Much?______PPD. Since (Year) _________

ALCOHOL ☐ NO ☐ YES How Much?__________ Since (Year) _________

ILLICIT DRUGS ☐NO ☐YES Name of Drug ____________________

Where do you Live: ☐ Own Home/Condo ☐ ALF ☐ ILF ☐ NH

Who do you live with: ☐ Alone ☐ With: spouse / son / daughter/Other

Children ☐ None Son: ______ Daughter: ______

Profession: ☐ Retired ☐ Working as: ___________________________

FAMILY HISTORY:

	AGE	ALIVE	DECEASED	AGE OF DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER					
SISTER					
SON					
DAUGHTER					

Do any of following conditions runs in your family. (Parents, Grand-Parents, Siblings, Children etc.)

Hypertension: ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Heart Attack: ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Dementia : ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Anxiety ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Suicide: ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Diabetes: ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Stroke: ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Cancer : ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Asthma: ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

Depression: ☐Mother ☐Father ☐Brother ☐Sister ☐Son ☐Daughter ☐Grand father ☐Grand mother

ALL FAMILY CARE, PC.

REVIEW OF SYSTEM:

General	YES	NO
Recent Fever	☐	☐
Undue Tiredness	☐	☐
Easy Fatigability	☐	☐
Unexplained Weight loss	☐	☐
Sleeping Difficulty	☐	☐
Head / CNS		
Headaches	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Double Vision	☐	☐
Seizures	☐	☐
Eye & ENT		
Blurring of Vision	☐	☐
Hearing Loss	☐	☐
Ringing in ears	☐	☐
Nasal congestion	☐	☐
Nose bleed	☐	☐
Sore Throat	☐	☐
NECK		
Goiter	☐	☐
Palpable mass	☐	☐
Pain	☐	☐
Stiffness	☐	☐
BREASTS		
Palpable mass	☐	☐
Nipple Discharge	☐	☐
Breast Tenderness	☐	☐
PULMONARY		
Shortness of Breath	☐	☐
Non-productive Cough	☐	☐
Cough with Phlegm	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
CARDIOVASCULAR		
Chest Pain at rest	☐	☐
Chest Pain with exertion	☐	☐
Shortness of breath		
with exertion	☐	☐
Lying flat	☐	☐
Palpitations	☐	☐
Ankle swelling	☐	☐

GASTROINTESTINAL	YES	NO
Abdominal Pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Vomiting Blood	☐	☐
Diarrhea	☐	☐
Chronic Constipation	☐	☐
Blood in Stool	☐	☐
Heart Burn	☐	☐
Black Stool	☐	☐
GENITO-URINARY		
Pain or Burning on Urination	☐	☐
Increased Frequency	☐	☐
Urgency	☐	☐
Hesitancy	☐	☐
Blood in Urine	☐	☐
Trouble starting urinating	☐	☐
Urinary Incontinence	☐	☐
RHEUMATOLOGY		
Swelling of joints of hands	☐	☐
Joint Pain	☐	☐
Back Pain	☐	☐
PSYCHIATRY		
Depression	☐	☐
Nervousness	☐	☐
Anxiety	☐	☐
Ever under psychiatrist care	☐	☐

FOR WOMEN	Yes	No
Painful periods	☐	☐
Irregular periods	☐	☐
Mid cycle bleeding	☐	☐
Birth control pills	☐	☐
Hormone replacement therapy	☐	☐
Ever had abnormal PAP	☐	☐
Ever had abnormal Mammo	☐	☐

Get period every ____________days

Last menstrual period: _______________

Last Mammogram : _________________

Last PAP test :______________________