Welcome To Our Office

Name (Last, First, MI): _____

Date of Birth: _____ Age: _____ SS#: _____

Phone: _____ Gender:M____ F____ Other____

Street Address: _____

City, State, Zip: _____

Email: _____

Emergency Contact Information

Name (Last, First, MI): _____

Preferred Phone: _____

Relationship to Patient: _____

Pharmacy

Preferred Pharmacy: _____

Phone number: _____ Address: _____

Insurance

Insurance Name: _____Policy number : _____

Group number: _____ Policy holder: _____

Relation to Policy holder: _____Policy holder DOB: _____

General Consent for Care and Treatment

Disclosure to the Patient: In this clinic, you will be seen by a Master's Prepared, Board Certified Adult Nurse Practitioner. YOU WILL NOT BE SEEN BY A PHYSICIAN. The State of Arizona recognizes the extensive education and training that a Nurse Practitioner obtains, and therefore grants her or him all authoritative rights (i.e. diagnose, treat, prescribe) that a physician is granted.

Signing this consent form provides the Nurse Practitioner with permission to perform reasonable and necessary medical examinations, perform or order testing, including labs and imaging, and establish a plan of care to treat conditions identified. You, as the patient, have the right to be involved in the development of the plan of care in every step of its development. At any time that additional or specific studies or procedures are considered, you have the right to have them fully explained to you, including risks and benefits, and most importantly, you have the right to decline them. The Nurse Practitioner is available to discuss the specifics of the plan of care anytime that there are questions or concerns. Should any additional test or procedure be deemed reasonable and necessary by both the Nurse Practitioner and the patient, a specific consent form for that individual event will be presented for review and signed with agreement.

Patient Name	Patient Signature	Date

Current Medications

Medication	Dose	Frequency	Date Started

Allergies to Medication

☐ No known allergies

Please list: _____

_____

_____

_____

Surgeries

☐ No prior surgical history

Please list: _____

_____

_____

_____

Hospitalizations

☐ No prior hospitalization history

Please list: _____

_____

_____

_____

Personal Medical History

Do you have a history of, or are you currently being treated for any of the following things:

☐ No previous medical history

☐ Acid Reflux (GERD)	☐ Heart Disorders	☐ Neurological Disorder
☐ Allergies	☐ Heart Murmur	☐ Obesity
☐ Anemia	☐ Hepatitis	☐ Osteoarthritis
☐ Anxiety	☐ High Cholesterol	☐ Osteoporosis
☐ Asthma	☐ Hypertension	☐ Pneumonia
☐ Auto Immune Disorder	☐ Hyperthyroidism	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hypothyroidism	☐ Seizures
☐ Depression	☐ Kidney Disorders	☐ Shingles
☐ Diabetes Type 1	☐ Liver Disorders	☐ STD
☐ Diabetes Type 2	☐ Lung Disorders	☐ Stroke
☐ Fracture	☐ Migraines	☐ Tuberculosis
☐ GI Disorders	☐ Multiple Sclerosis	☐ UTI

Other (Please list): _____

_____

_____

Women:

Pregnancies:		Children:	
Miscarriages:		Abortions:	
Last Pap Smear:		Any Abnormal Pap Smears:	
Last Mammogram:		Any Abnormal Mammograms:	
Sexually Active:		Birth Control Method:	

Social History

Tobacco Use:	☐ Denies ☐ Smoker ☐ Chewing ☐ Former
Alcohol Use:	☐ Denies ☐ Social ☐ Occasional ☐ Frequent ☐ Recovering
Drug Use:	☐ Denies ☐ Marijuana ☐ Other ☐ Recovering
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed

Family Medical History

Do you have a first degree family members (mother, father, sister, brother, son, daughter) with a history of, or currently being treated for, any of the following things:

☐ No family medical history ☐ Unknown family medical history

☐ Alcoholism	☐ GI Disorders	☐ Lung Disorders
☐ Anemia	☐ Heart Attack	☐ Migraines
☐ Anxiety	☐ Heart Disorders	☐ Multiple Sclerosis
☐ Asthma	☐ Heart Murmur	☐ Neurological Disorder
☐ Auto Immune Disorder	☐ Hepatitis	☐ Obesity
☐ Birth Defects	☐ High Cholesterol	☐ Osteoarthritis
☐ Cancer	☐ Hypertension	☐ Osteoporosis
☐ Crohn's Disease	☐ Hyperthyroidism	☐ Rheumatoid Arthritis
☐ Depression	☐ Hypothyroidism	☐ Seizures
☐ Diabetes	☐ Kidney Disorders	☐ Stroke
☐ Epilepsy	☐ Liver Disorders	☐

Other (Please list): _____

_____

_____

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Uses and disclosures of health information:
We use and disclose health information about you for treatment, payment, and healthcare operations.
For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

Patient Rights:

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us by calling 928-486-6135. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

I acknowledge that I was offered and received, if desired, a copy of the Notice of Privacy Practices.

_____	_____	_____
Patient Name	Patient Signature	Date

_____ **CANCELLATIONS, LATE PATIENTS, AND NO SHOWS:** Our goal at Concierge Health is to maximize the time your provider spends with you and minimize your wait time. In order to do so, we have a standardized policy for no-shows, cancellations, and late arrivals.

- **CANCELLATIONS:** We require 24-hour notice of cancellation for any appointments.
- **LATE:** You will be considered late if you arrive 15 minutes after scheduled appointment time. The provider reserves the right to reschedule visit to another date and time.
- **NO-SHOW:** If you do not arrive for a scheduled appointment and do not provide the office notice within at least 24 hours you will be considered a "No-Show".

  – Cancellation/No-show #1- Documented^

  – Cancellation/No-show #2- $35.00 charge will be incurred and charged to credit card on file or invoiced if no credit card on file*^

  – Cancellation/No-show #3- Discharged from office, per Provider's review/request and/or $35.00 charge* ^

  * All fees must be paid before a new appointment can be scheduled.

  ^Cancellations outside the required 24-hour notification window.

_____ **MEDICATION REFILLS: Please contact your preferred pharmacy to request medication refills**. Once the request has been received, refills will be completed within 2-3 business days.

_____ **FINANCIAL RESPONSIBILITY: It is your responsibility to ensure that all services rendered by Concierge Health on your behalf are paid in full.** You hereby agree to accept financial responsibility for all charges incurred in the course of your treatment. In the case of Medicare or other insurance that the providers have executed an agreement with, you understand that you are responsible for paying any deductibles or co- payments required under the terms of your insurance plan. Depending on your insurance coverage at the time of your visit to the clinic, you may be asked to make a deposit on your account prior to seeing a provider. Deposits will be applied toward charges incurred but may not represent payment in full for services. Should collection procedures become necessary, you agree to pay the collection agency's cost and/or reasonable attorney's fees. You hereby authorize the providers at Concierge Health to bill Medicare and/or your health insurance plan. You hereby authorize the release of information acquired in the course of the examination and treatment, should it become necessary to secure payment of benefits.

It is important that you bring proof of insurance each time you visit the clinic. Please make every effort to let us know if your insurance carrier (primary or secondary insurance) or your personal information (home address, employer, and phone number) has changed since your last visit.

If patient determines they will sign up for one of the predetermined plans they are expected to set up automatic payment of monthly charges. The patient will provide the front desk staff an active credit, debit, HSA, or FSA card. The information from this card will be entered into the applicable payment system and set up for recurrent payment. Concierge Health **does not** accept personal or business checks. Patients who have not signed up for recurrent monthly billing are expected to pay for services rendered at the time of service. Payment can be taken via cash or card through the Company's electronic payment system. If the patient does not wish to sign up for a predetermined plan they will be charged for services rendered at the beginning of the appointment.

_____**TELECOM AGREEMENT:** You agree that by signing below you consent and request that Concierge Health, its affiliates, and those acting on its/their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include those concerning the patient's care, scheduling, reminders, prescriptions, advertisements or telemarketing messages concerning our benefits and services. Calls can be made to any number you provide or we obtain even if listed on a national or state Do Not Call registry. You understand that consent is not a condition of care.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

_____**LABS:** You may be required to come back for any and all lab results and may require an office visit and a charge.

I have read and understand the above.

_____ _____

Guarantor/Responsible Party or Patient Signature Date

TELEMEDICINE & FACE-TO-FACE INFORMED CONSENT FORM

PATIENT INFORMATION

Patient Name: **DOB:**

Site Where Patient is Seen via Telehealth:

Consulting Provider Name Seeing Patient via Telehealth: **Provider Location:**

INTRODUCTION

You are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. The information may be used for diagnosis, treatment, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to remain within the facility and obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. If you are unsure of what is happening, you may ask questions of the provider, anyone with the provider, or any telemedicine staff in the room with you. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures are being used to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision, which may require additional in-person visits.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information. You will be promptly notified if any security issues arise.

By Signing this Form, I understand the following:

1. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
2. I understand that if the provider believes I would be better served by a traditional face-to-face encounter, the provider may, at any time stop the telehealth visit and schedule a face-to-face visit. Therefore, I understand that technology problems may necessitate an in-person visit with the provider.
3. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
4. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care. I also consent to photographs of this video encounter being taken and stored in my patient file.

I hereby authorize Concierge Health LLC to use telemedicine in the course of my diagnosis and treatment.
(Agency or Provider Name)

Signature of Patient (or authorized person)_____ Date/Time _____

If authorized signer, relationship to patient _____

Witness_____ Date/Time _____