Southwest Internal Medicine Group

PATIENT REGISTRATION FORM (Please Print Legibly)

Last Name (*as listed on insurance card*) | **First Name** | **Middle Initial**

Address | **Apt/Unit** | **City / State / Zip Code**

Date of Birth | **Social Security #** | **Home/Cell Phone #:** | **Gender: ❍ Female ❍ Male ❍Transgender**

Do you have a Power of Attorney (POA) / Living Will? ❍ No ❍ Yes **Email:**_____

Race:
❍ American Indian or Alaska Native
❍ Asian ❍ Black or African American
❍ Hispanic ❍ Native Hawaiian or other Pac Islander
❍ White ❍ Other Race: _____
❍ **Decline to Respond**

Ethnicity Origin:
❍ Hispanic/Latino
❍ Not Hispanic or Latino
❍ **Decline to Respond**

Language:
❍ English
❍ Spanish
❍ Indian (Hindi)
❍ Russian
❍ Other_____

Marital Status: ❍ Single ❍ Married ❍ Legally Separated❍ Divorced ❍Partner ❍Widowed

Employment Status: ❍Employed ❍Not Employed ❍Self-Employed ❍Retired ❍Disabled ❍Active Military ❍ Reserves ❍Student

Employer Name | **Occupation** | **Telephone**

Emergency Contact Name | **Relationship to Patient** | **Telephones**

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN PATIENT)

Last Name (a*s listed on insurance card*) | First Name | Relationship to patient

Address | Apt/Unit | City / State / Zip Code

Date of Birth | Social Security # | Home/Cell Phone #: | Gender: ❍ Female ❍ Male ❍Transgender

MEDICAL INSURANCE(s) INFORMATION

PRIMARY Insurance

Insurance Name | Telephone

Subscriber ID # | Group #

Claims Address

SECONDARY Insurance

Insurance Name | Telephone

Subscriber ID # | Group #

Claims Address

PHARMACY INFORMATION (*this will be your designated pharmacy until notified of change*)

Pharmacy Name | Telephone | Cross/Streets

Mail Order | Telephone | ID #

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim(s) and authorize my insurance carrier to make payment to Southwest Internal Medicine Group/Roberto Ruiz, MD for services rendered.

Patient Signature or Legal Representative | Date

Printed Name if Signed by Legal Representative | Relationship to Patient

PATIENT REGISTRATION FORM: GENERAL FINANCIAL POLICY

SOUTHWEST INTERNAL MEDICINE GROUP (SWIMG)/ROBERTO RUIZ, MD PARTICIPATES WITH MAJOR INSURANCE CARRIERS HOWEVER, WE MAY NOT PARTICIPATE WITH THE NETWORK UNDER YOUR PLAN NOR WE KNOW INSURANCE COVERAGE DETAILS OF EACH INDIVIDUAL PLAN. SWIMG WILL MAKE REASONABLE EFFORTS TO VERIFY ELIGIBILITY AND BENEFITS PRIOR TO SERVICES BEING RENDERED, HOWEVER, THE INFORMATION OBTAINED FROM THE INSURANCE CARRIER DOES NOT GUARANTEE PAYMENT OF BENEFITS, NOR THAT THE TREATMENT, SERVICE(S) AND/OR SUPPLY(IES) PROVIDED ARE COVERED BY THE INSURANCE CARRIER.

IT IS THE RESPONSIBILITY OF THE POLICY HOLDER/PATIENT TO VERIFY PHYSICIAN INSURANCE/NETWORK PARTICIPATION AND INDIVIDUAL INSURANCE COVERAGE DETAILS. IF YOU ARE UNCERTAIN AS TO WHETHER YOUR HEALTH BENEFIT PLAN INCLUDES RECEIVING IN-NETWORK SERVICES OR PRIOR-AUTHORIZATION FROM ROBERTO RUIZ, MD OR THE RECOMMENDED PROVIDERS (SPECIALISTS), LABORATORY, DIAGNOSTIC OR ANY OTHER SERVICE, PLEASE CONTACT YOUR INSURANCE CARRIER.

- **Insurance/Demographic Information.** It is the responsibility of the patient/policy holder to provide the practice with current and accurate information about their insurance carrier(s) and demographic information at time of check-in and/or to notify the practice of any changes.
- **Patient Responsibility.** It is the responsibility of the patient/policy holder to know their co-pay, co-insurance, or deductible and to pay it prior to services being rendered. The patient/policy holder is financially responsible for any charge(s) not covered by their insurance carrier and has read the above disclaimer.
- **Balances.** Any balance due after the insurance carrier has made payment, the patient/policy holder will be mailed up to three (3) statements in an attempt to collect remaining balance. If payment has not been received prior to the third "final" statement, a phone call may be made in an attempt to collect payment. If there is no attempt to make payment within 24 hours, the patient/policy holder's account will be directed to an outside collection agency and patient will be released from our care.
- **Payment.** We accept payment by cash, money orders, and cashier's check, debit/credit card (VISA, Master Card, and Discover). The practice may also take a verbal requests to use credit card on file for payment on my account or they may also use the same listed credit on my account should my account become delinquent, or to cover a NSF check.
- **Non-sufficient funds (NSF) check**. A $35 NSF fee plus an administrative fee will apply. Payment by check will no longer be honored and the policy holder/patient will be required to pay with cash, money order, cashiers' check or debit/credit card.
- **Cancelations/No Show**. A $25 fee may apply for scheduled appointments not canceled within 24 hours or "NO SHOW" and a $50 fee for cardiovascular testing (per study).
- **Administrative Fees**. I understand that I responsible for items not covered by my insurance carrier such as injections/immunizations or medical forms (FMLA, letters for school, work, jury service.)
- **Results**. Any test results (laboratory, radiological, or other test results) will be communicated by SWIMG staff to patient over the phone, however, details or medical advice cannot be provided. An in-office consultation with the physician will be required to discuss the result and to effectively address patient questions and/or concerns. Consultations will not be provided over the phone with patient and/or family.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITIS

I have reviewed the above General Financial Policy and understand that is not all inclusive of SWIMG's financial policies.

Patient Printed Name (First, Middle Initial, Last)	Date of Birth
Patient Signature or Legal Representative	Date
Printed Name if Signed by Legal Representative	Relationship to Patient

PATIENT REGISTRATION FORM: DISSEMINATION OF MEDICAL INFORMATION

In general, the HIPAA Privacy Rule gives individuals the right to disclose a restriction on uses and disclosures of their Protected Health Information (PHI). The HIPAA Privacy Rule brochure, has been attached for your records. The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The privacy rule generally requires healthcare provider's to take reasonable steps to limit the use, disclosure of, and/or requests for PHI, as well as the minimum information needed to accomplish the intended purpose. These provisions do not apply to uses or disclosures made to an authorization requested by the individual.

Please check the primary telephone number, if any, where you want to receive information about your appointments, laboratory and diagnostic results or other healthcare information.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

Home Phone:
❍ Leave voicemail w/ detail information ❍ Leave voicemail w/ call back information ❍ Do Not Leave a Message

Cellular Phone:
❍ Leave voicemail w/ detail information ❍ Leave voicemail w/ call back information ❍ Do Not Leave a Message

Work Phone:
❍ Leave voicemail w/ detail information ❍ Leave voicemail w/ call back information ❍ Do Not Leave a Message

If you cannot be reached, who can receive or obtain information about your appointments, laboratory and/or diagnostic results or other healthcare related information? PLEASE NOTE: Uses and Disclosures may be permitted without prior consent in an emergency.

Name	Relationship to Patient	Tel/Address:
Name	Relationship to Patient	Tel/Address:
Name	Relationship to Patient	Tel/Address:

ACKNOWLEDGEMENT

I have reviewed the above Dissemination of Medical Information and have received a copy of Southwest Internal Medicine Group's Notice of Privacy Practices (HIPAA).

Patient Printed Name (First, Middle Initial, Last)	Date of Birth
Patient Signature or Legal Representative	Date
Printed Name if Signed by Legal Representative	Relationship to Patient

This authorization may be revoked at any time by completing a new Dissemination of Medical Information.

PATIENT REGISTRATION FORM: PRESCRIPTION HISTORY CONSENT

Your medication history transactions provides the physician with information about your current and past prescriptions. This allows your physician to be better informed about potential medication issues and to use that information to improve safety and quality of care.

Medication history data can indicate:

1. compliance with prescribed regimens
2. therapeutic interventions
3. drug-drug and drug-allergy interactions
4. adverse drug reactions
5. duplication of therapy

I understand that my prescription medication history may be obtained from health care drug historical information, third party pharmacy benefit, unaffiliated medical providers, insurance companies, and pharmacy benefit managers viewable by my providers and staff. It may include prescriptions dating back several years.

ACKNOWLEDGEMENT

I have reviewed the above Prescription History Consent and understand that this consent will be valid and remain in effect as long as I receive services from SWIMG unless revoked by me in writing.

Patient Printed Name (First, Middle Initial, Last)	Date of Birth
Patient Signature or Legal Representative	Date
Printed Name if Signed by Legal Representative	Relationship to Patient

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: **Date of Birth** **Tel Number**

I REQUEST AND AUTHORIZE TO RELEASE MEDICAL RECORD INFORMATION CONCERNING THE ABOVE MENTIONED PATIENT.

FROM:	**TO:**
Name or Facility	Name or Facility
Address	Address
Tel # Fax #	Tel # Fax #

THIS REQUEST AND AUTHORIZATION APPLIES TO:

❍ All healthcare information.

❍ Healthcare information relating to the following treatment, condition, and/or dates:_____

❍ Other_____

Patient or Legal Representative Signature

Date

Printed Name if Signed by Legal Representative

Relationship to Patient

This authorization expires in 60 days from the date of request. Please allow five 5 – 10 business days for completion.

NOTE: There is no charge when healthcare information is sent directly to a medical provider for the continuation of care. A processing fee, however is charged if a copy of health care information is requested by the patient, parent(s) or authorized representative.

Workers' Compensation - If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.

Public Health – As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications 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.

Abuse, Neglect & Domestic Violence - We may disclose your health information to public authorities as allowed by law to report abuse, neglect, or domestic violence.

Sign in Sheet- We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Inmates - If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and the health and safety of other individuals.

Law Enforcement - We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime on our premises; to report crime in emergencies; and other appropriate situations permitted by law.

Health Oversight - We may disclose your health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings - We may disclose your health information in the course of any judicial or administrative proceeding as allowed or required by law or as directed by a proper court order or in response to a subpoena, with your authorization, discovery request or other lawful process if certain specific requirements are met.

Serious Threat - To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions - We may disclose your health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses - Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided in this Notice.

Website - If we maintain a website that provides information about our office, this Notice will be on the website.

Research - We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Fund Raising - We may contact you as part of a fund raising effort. If you do not want to receive these materials notify our Privacy Officer.

I understand that my/the patient's health information is private and confidential. I understand that SWIMG works hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's health information.

I understand that SWIMG may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. An example may be if a patient is a danger to self or others.

I understand this is SWIMG detailed document called the "Notice of Privacy Practices for Protected Health Information". It contains more detailed information on how they may use and disclose the patient health information. I understand that I have a legal right to read the "Notice" before I sign consent located on the Patient / Demographic Information Form.

SWIMG may update this "Notice of Privacy Practices for Protected Health Information" at any time and without prior notice. If I ask, SWIMG will provide me with the most current "Notice of Privacy Practices for Protected Health Information".

Under the terms of this consent, I can ask SWIMG to restrict how my/the patient's health information is used or disclosed to carry out treatment, payment or healthcare operations. I understand that SWIMG does not have to agree to my/the patient's request. If SWIMG does agree to my/the patient's request, I understand that SWIMG will follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1) Signing and dating a form that SWIMG can give me called "Revocation of Consent for Use and Disclosure of Healthcare information"; **OR**

2) Writing, signing, and dating a letter to SWIMG. If I write a letter, it must say that I want to revoke my/the patient's consent to authorize the use and disclosure of my/the patient's health information for treatment, payment and healthcare

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Original Effective Date: April 14, 2003

Notice of Privacy Practice for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not use or disclose your health information except as described in this Notice.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for <u>treatment</u> purposes are:

- A nurse or medical assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area.
- He/she will share the information with such specialist and obtain his/her input.

Example of use of your health information for <u>payment</u> purposes: We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and the care given, which may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.

SOUTHWEST INTERNAL MEDICINE GROUP
Roberto Ruiz, MD, FACP
15255 N. 40th Street, Suite 127
Phoenix, Arizona 85032

Example of use of your health information for health care operations: We obtain services from our insurers or other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services, and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your medical record and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support it, to our office using the form we provide to you upon request. (We are not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include uses and disclosures of information for treatment, payment, or health care operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; or to family members or friends or uses relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care of your location, condition, or your death; we may charge a cost-based fee for more than one accounting in a 12-month period.
- Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Brenda E. Becker, Privacy Officer, at Southwest Internal Medicine Group (SWIMG), 15255 N. 40th Street, Suite 127, Phoenix, Arizona 85032, 602-253-0855, in person or in writing, during normal business hours. Our Privacy Officer will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the acknowledgment authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities - The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint - If you have questions, would like additional information, want to report a problem regarding the handling of your information, of if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact Brenda E. Becker, Privacy Officer at 602-253-0855. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses We Can Make Without Your Written Authorization

Notification of Family/Friends

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family/Friends

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief - We may use and disclose your health information to assist in disaster relief efforts.

Employers - We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.

Deceased Persons - We may disclose your health information to funeral directors, medical examiners, or coroners consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Organ Procurement Organizations - Consistent with applicable law, we may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Appointment Reminders, Marketing and Treatment Alternatives - We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not disclose your health information without your written authorization.

Food and Drug Administration (FDA) - We may disclose to the FDA 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.