
# PATIENT INFORMATION

DATE _____/_____/_____

FIRST NAME _____ MIDDLE INITIAL _____ LAST NAME _____

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY NUMBER _____-_____-_____ GENDER __ MALE __ FEMALE

MARTIAL STATUS __ MARRIED __ SINGLE __ DIVORCED __ SEPARATED __ WIDOWED

ADDRESS _____ APARTMENT/SUITE_____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

RACE _____ ETHNICITY _____ PRIMARY LANGUAGE _____

EMPLOYMENT STATUS __ EMPLOYED __ SELF EMPLOYED __ UNEMPLOYED __ DISABLED __ RETIRED __ STUDENT

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT _____ RELATION _____ PHONE _____

*PHARMACY INFORMATION*

PHARMACY NAME _____ PHARMACY PHONE NUMBER _____

PHARMACY ADDRESS (CROSS STREETS) _____

*PRIMARY INSURANCE INFORMATION*

NAME OF INSURANCE COMPANY _____ PHONE _____

ID/SUBSCRIBER NUMBER _____ GROUP NUMBER _____

SUBSCRIBER NAME _____ RALATIONSHIP TO PATIENT _____

SUBSRIBER SSN _____-_____-_____ SUBSCRIBER DOB _____/_____/_____ SUBSCRIBER GENDER __ M __ F

*SECONDARY INSURANCE INFORMATION (IF APPLICABLE)*

NAME OF INSURANCE COMPANY _____ PHONE _____

ID/SUBSCRIBER NUMBER _____ GROUP NUMBER _____

SUBSCRIBER NAME _____ RALATIONSHIP TO PATIENT _____

SUBSRIBER SSN _____-_____-_____ SUBSCRIBER DOB _____/_____/_____ SUBSCRIBER GENDER __ M __ F

Live Well FAMILY MEDICINE

# MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____

What are you seeing the doctor for today: _____

**Daily Medications:** (please include pain medications, herbs, vitamins & over the counter medications)

| Name | Dosage/Strength | Times/day | Name | Dosage/Strength | Times/day |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Past Surgical History:** (list type and date)

_____ _____

_____ _____

**Past Hospitalizations:** (list reason and date)

_____ _____

_____ _____

Have you received any of the following vaccines?

| | | | |
|---|---|---|---|
| Influenza | □Yes | □No | Date Received: _____ |
| Pneumonia | □Yes | □No | Date Received: _____ |
| Tetanus | □Yes | □No | Date Received: _____ |
| Shingles | □Yes | □No | Date Received: _____ |

Have you had a:

Colonoscopy: □Yes □No (if yes, please list most recent date) _____

Pap smear: □Yes □No (if yes, please list most recent date) _____

Mammogram: □Yes □No (if yes, please list most recent date) _____

Dexa scan: □Yes □No (if yes, please list most recent date) _____

Drug Allergies: □Yes □No (if yes, please list drug and reaction)

_____ _____

_____ _____

Past Medical History: (check conditions)

□ Anemia
□ Diabetes
□ Cancer/Type _____
□ Kidney Trouble
□ Bladder Issues
□ High Blood Pressure
□ Heart Trouble
□ High Cholesterol
□ Asthma
□ Neurological Disorder/Seizures
□ Depression
□ Stroke
□ Thyroid Disorder
□ Ulcer/Stomach Problems
□ Hepatitis (Type
□ Arthritis
□ Gout
□ Phlebitis/Blood Clots
□ AIDS/HIV
□ Substance Abuse
□ Fibromyalgia
□ Sleep Apnea

Please list any major medical conditions of your immediate Family Members:

Father: _____ Alive Deceased (circle one)

Mother: _____ Alive Deceased (circle one)

Sibling: _____ Alive Deceased (circle one)

Sibling: _____ Alive Deceased (circle one)

Do you use tobacco? □Yes □No

How often? _____

For how many years? _____

Do you exercise? □Yes □No

How Often? _____

What type? _____

Do you drink alcohol? □Yes □No

If yes, average consumption per week? _____

Is there any possibility you could be pregnant? □Yes □No

Do you have an advance directive? □Yes □No

Live Well FAMILY MEDICINE

# OFFICE AND FINANCIAL POLICIES

Welcome to Live Well Family Medicine, PLC. We are committed to giving you the best care possible and would like to take this opportunity to inform you of our office financial policies.

**New Patients:** All new patients must **complete the new patient paperwork** before seeing the provider. Information must be updated when changes occur. It is your responsibility to let us know of changes in address, phone number, email, insurance, pharmacy, etc.

**Insurance Billing:** We are only responsible for filing claims to contracted insurance companies. We file claims as a courtesy to our patients. Any deductibles, co-insurance and non-covered services are your responsibility.

**Deductibles and Co-pays:** Full payment is due at the time services are rendered. This includes co-payments, deductibles, and services not covered by your insurance. If you are on a high deductible plan we collect $150 for new patients and $100 for established patients until the deductible has been met. If you are not able to pay your co-pay or deductible you may be asked to reschedule your appointment.

**Returned checks:** There will be a $25 fee assessment for returned checks for non-sufficient funds, stop payments, and account closures. Your account will be flagged for failure to pay and checks will no longer be accepted as a form of payment for your account.

**Prescription refills:** We only provide prescription refills during an office visit with a provider. We require office visits on a regular basis for all patients taking prescription medications. Please bring all prescription bottles and a current detailed medication list with you to your appointment. As of October 2017, we will no longer respond to refill requests from pharmacies.

**Referrals:** All referrals will require an evaluation in the office. If your insurance requires an authorization please keep in mind that it will take from 5-7 business days for referral to be completed.

**Disability and FMLA paperwork:** There will be a charge of $25.00 for the completion of medical forms. FMLA forms require that you come in for an appointment. Payment is due at the time that you pick-up these forms. Please allow 10 to 14 days for the completion of these forms. If you would like the forms mailed or faxed to you or the insurance, payment will be due prior to mailing or faxing.

**Outstanding balances/collections:** Prior to providing additional services to you, payment in full of total outstanding balances will be required. We will send you 2 statements one month apart and any unpaid balances after 60 days will be assessed a $10 fee per month. If you have an outstanding balance for 6 months your account will be sent to an outside collection agency and you will be dismissed from our practice.

**Dismissal:** If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

**Common Reasons for Dismissal**:

• Failure to keep appointments, frequent no-shows • Non-compliance, which means you won't follow physician instructions about an important health issue • Abusive to staff
• Failure to pay your bill

**Dismissal Process:** We will send a letter to your last known address, via certified mail, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will see you. After that, you must find another doctor. We will forward a copy of your medical record to your new doctor after you let us know who it is and sign a release form.

**I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS & BILLING INFORMATION VIA:** Cell phone_____ Home phone_____ Text_____ Email_____ Any of the above _____

**I AUTHORIZE INFORMATION ABOUT MY HEALTH OR TREATMENT BE CONVEYED VIA:**
Cell phone_____ Home phone_____ Text _____ Email_____ Any of the above _____

**Acknowledgement:** I acknowledge that I have received and read a copy of the Office and Financial Policies.

_____
Patient/Guarantor Name (please print)

_____
Signature of Patient/Guarantor Date: _____

***Thank you for understanding our office policies. We are excited you chose Live Well Family Medicine as your primary care facility!***

2320 W Ray Rd Suite 1
Chandler, AZ 85224
480-800-3561

## MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Live Well Family Medicine. When you schedule an appointment with Live Well Family Medicine, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than **24-HOURS** prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- **Effective immediately** any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least a **24-HOUR NOTICE** will be considered a **NO SHOW** and charged a **$25 FEE.**
- Any established patient who fails to show or cancels/reschedules an appointment without a **24 HOUR NOTICE** a **SECOND** time will be dismissed from our office.
- Any new patient who fails to show for their initial visit will be charged a **$50 FEE if they wish to reschedule.**
- The fee is charged to the patient, not the insurance company, and is **DUE AT THE TIME OF THE PATIENT'S NEXT OFFICE VISIT.**
- As a courtesy Live Well Family Medicine will send a text message at two days and at one hour prior to your appointment. **IF YOU DO NOT RECEIVE A REMINDER, THE ABOVE POLICY WILL REMAIN IN EFFECT.**

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager. You may contact Live Well Family Medicine at (480) 800-3561. Should it be after regular business hours Monday-Friday, or a weekend, you may send a text message or leave a voice mail.

**I have read and understand the Medical Appointment Cancellation/ No Show Policy and agree to its terms.**

**Signature:** _____ **Date:** _____

**Printed Name:** _____ **Date of Birth:** _____

**If Patient is a Minor:**

**Print Name:** _____ **Date of Birth:** _____

# PATIENT PORTAL POLICY

Purpose of this Form:
Live Well Family Medicine, PLC offers secure viewing and communication as a service to patients who wish to view parts of their records and communicate with our staff and physicians. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works:
A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect and we will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) the secure message must reach the correct email address, and

2) only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us.
You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Types of Online Communication/Messaging:
Online communications should never be used for emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact your physician via telephone. If there is information that you don't want transmitted via online communication, please inform your practice.

Patient Acknowledgement and Agreement:
I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

_____ DATE: _____/_____/_____
PATIENT SIGNATURE

_____
PATIENT NAME (PRINTED)

# PATIENT SIGNATURES

Acknowledgement of Notice of Privacy Practices:

I have been offered a copy of the Notice of Privacy Practices. I understand that Live Well Family Medicine, PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Live Well Family Medicine at any time to obtain a current copy.

**Signature: _____ Date: _____

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Authorization for Release of Health Information:

I hereby authorize Live Well Family Medicine to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care. I also authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize Live Well Family Medicine and its Employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

**Signature: _____Date: _____

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Authorization for Release of Prescription Information:

I hereby authorize Live Well Family Medicine to release any prescription information to:

Name of Pharmacy _____ Cross Streets: _____

**Signature: _____ Date: _____

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Acceptance of Patient Financial Agreement:

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Policy.

**Signature: _____ Date: _____

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Acceptance of Patient Portal Authorization:

□ I am declining activation of my Patient Portal Account.

□ By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth in the Patient Portal Authorization Policy.

Email Address:

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | |

**Signature: _____ Date: _____

TELEPHONE CONSUMER PROTECTION ACT (TCPA) OPT IN CONSENT FORM

Our practice uses text messages to communicate with patients for a variety of purposes including appointment confirmations, appointment reminders, billing information, and request for feedback about your experience. The frequency of messages varies but is generally related to the frequency of your appointments. Mobile message and mobile data rates from your mobile carrier may apply. If you would like to receive these messages by text, you are required to "opt-in" due to recent changes to the Telephone Consumer Protection Act (TCPA). Please note that you can revoke consent to receive these messages at any time. Please take a moment to fill out this consent form indicating your desire to receive these messages in the future.

I give permission to this office to contact me by my cellular device for SMS text messages. By signing, I certify that I am the owner of this cellular device and its user contract. I understand that I can revoke consent at any time or can reply "STOP" to a text message to stop receiving text messages at any time.

_____ _____

Printed Name Cellular Number

_____ _____

Signature Date