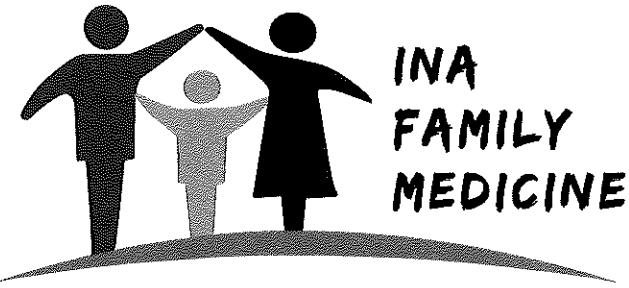


Timothy McNichols, MD **Peter Hanna, MD** **Stephanie Schmid, NP**

Hello,

Welcome to Ina Family Medicine!

We are happy to have you as a new patient, and excited to meet you! Included with this letter is the new patient packet and a reminder of your appointment, so you can complete it in the comfort of your own home.

We do request that you bring, fax or mail us the completed packet one week prior to your appointment date. Thank you in advance.

PLEASE PLAN AHEAD TO ARRIVE 15 MINUTES EARLY!

Thank you,

Ina Family Medicine Staff

1631 W. Ina Rd. • Tucson, AZ 85704 • Phone: 520-585-5738 • Fax: 520-585-5843

Ina Family Medicine
Medical Health History Form

PATIENT NAME:_____ DOB:_____ MRN:_____

MARITAL STATUS: M [ ] S [ ] D [ ] W [ ] HOW MANY CHILDREN DO YOU HAVE?_____

CURRENT OCCUPATION_____ IF RETIRED, PREVIOUS OCCUPATION_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING WITH DOSAGE AND FREQUENCY

	MEDICATION	DOSAGE	FREQUENCY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION

	MEDICATION	REACTION
1.		
2.		
3.		

PLEASE LIST ANY CHRONIC MEDICAL PROBLEMS OR SURGERIES YOU HAVE HAD, EVEN AS A CHILD

(Such as diabetes, high blood pressure, cancer, heart disease, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Family Medical History

PLEASE LIST MEDICAL CONDITION(S) FOR FAMILY MEMBERS

CONDITION	RELATION TO PATIENT	STATUS	AGE
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____
_____	_____	Living/Deceased	_____

SOCIAL HISTORY

SMOKING:

Smoking status? Current_____ Former_____ Never_____

If yes, most amount smoked per day_____ Do you use any other tobacco products?_____

Do you use E-Cigarettes?_____ If yes, How often?_____

Alcohol Consumption:

Alcohol consumption? Current_____ Former_____ Never_____

If yes, How often?_____ How much alcohol is consumed on a regular basis?_____

Recreational Drugs:

Have you ever used recreation drugs?_____

If yes, what kind and explain usage?_____

Exercise:

Do you exercise regularly? _____ What kind?_____How often?_____

Living arrangements:

Please list the name and relation of the person/people who you live with.

_____

_____

Have you had a shot to prevent pneumonia? Yes/ No [] Pneumovax 23- Year?_____ [] Prevnar 13 Year?_____

Have you had a shot to prevent shingles? Yes/ No What year?_____

When was your last tetanus shot?_____ When was your last flu shot?_____

Please fill in applicable:	Results (circle one)
Last colonoscopy?_____	Normal/Abnormal If abnormal explain_____
Last Mammogram?_____	Normal/Abnormal If abnormal explain_____
Last Pap(if you have a cervix)_____	Normal/Abnormal If abnormal explain_____
Last Dexa Scan?(Bone Density)_____	Normal/Abnormal If abnormal explain_____
Last Glaucoma/Eye Exam_____	Normal/Abnormal If abnormal explain_____
Are you sexually active?_____	Are you sexually active with a male/female?

Arizona Community Physicians

Patient Information

FIRST NAME | MIDDLE | LAST NAME | ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | EMERGENCY PHONE# | EMERGENCY CONTACT NAME / RELATION

DOB | SEX | MARITAL STATUS | EMAIL | RACE (optional)

PRIMARY CARE PHYSICIAN | STUDENT? FT OR PT | PREVIOUS NAME

EMPLOYER NAME | EMPLOYER ADDRESS | EMPLOYER PHONE

Billing Information
(If different than patient)

FIRST NAME | MI | LAST NAME | ADDRESS | CITY | STATE/ZIP | PHONE

Primary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP ID# | POLICY ID# | SELF SPOUSE CHILD OTHER — RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

Secondary Insurance Information

INSURANCE NAME | EFFECTIVE DATE | MEDICAL CLAIMS ADDRESS

GROUP ID# | POLICY ID# | SELF SPOUSE CHILD OTHER — RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) | SUBSCRIBER ADDRESS (if different than patient) | SUBSCRIBER PHONE (if different than patient)

SUBSCRIBER DATE OF BIRTH | SUBSCRIBER SEX | SUBSCRIBER SSN# | CO-PAY AMOUNT

SUBSCRIBER EMPLOYER | EMPLOYER ADDRESS | EMPLOYER PHONE#

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

PERSON GIVING CONSENT | RELATIONSHIP IF NOT THE PATIENT | DATE

ARIZONA COMMUNITY PHYSICIANS
REGISTRATION ADDENDUM

Patient Name:_____

Account Number:_____

Due to a governmental mandate that all healthcare is provided fairly, without regard to race or ethnicity, we have added new fields to our patient registration form. This information will be kept confidential.

Race (check one)

☐ Black, African American (01)
☐ Asian (02)
☐ Caucasian (White) (03)
☐ American Indian, Alaskan Native (08)
☐ Native Hawaiian/Other Pacific Islander (09)
☐ Unknown (98)
☐ Declined (99)

Ethnicity (check one)

☐ Hispanic
☐ Non- Hispanic
☐ Unknown

E-mail

_____

_____
Patient Signature

_____
Parent/Guardian Signature

Preferred Language (check one)

☐ English (EN)
☐ Spanish (ES)
☐ Arabic (AR)
☐ Chinese (all types) (ZH)
☐ French (FR)
☐ German (DE)
☐ Greek (EL)
☐ Italian (IT)
☐ Japanese (JA)
☐ Korean (KO)
☐ Navajo (NV)
☐ Polish (PL)
☐ Russian (RU)
☐ Tagalog' (TL)
☐ Ukrainian (UK)
☐ Vietnamese (VI)
☐ Other_____
(Specify)

☐_____
Patient declined filling out the form. Staff signature required

Name: _____ MRN: _____

Patient Yearly Office Policy Information

In an effort to provide better service and availability, we have developed a policy to reduce the frequency of patients who schedule an appointment and do not cancel 24 hours in advance or fail to show up for that appointment (no show). When this happens, it prevents other patients from being treated.

- If there is a need to cancel our appointment, please call 24 hours in advance. We understand that special unavoidable circumstances may cause you to not cancel within 24 hours. Fees in these instances may be waived, but only with managerial approval.

- There will be a $25 fee for any appointment that has not been canceled 24 hours prior to the appointment time.

- There will be a $25 fee for "no show" appointments.

Prescriptions

Prescription refills:
If you need a refill please call your pharmacy first. Please allow 48 hours for a prescription to be refilled. If you have not had an appointment within the last 3 months, you may be required to schedule an appointment before we refill your prescription.

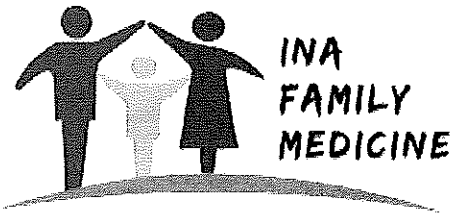
Controlled Substances:
If you need these types of medications, we can prescribe them when medically appropriate. However, please be aware that if you are requesting these medications an appointment will be necessary. You may also need to sign a written contract with your provider.

I have read and acknowledge the above information. If you have any questions about our policies, please contact Amber-Crystal Bartley, Site Coordinator for Ina Family Medicine at 520-585-5738.

_____ _____

Patient signature Date

ACP
ARIZONA COMMUNITY PHYSICIANS



MRN: _____

WELCOME TO ARIZONA COMMUNITY PHYSICIANS

When you see the provider, your insurance contract may require that we collect some or all of the following:

Co-pay…… Required by the insurance company.

Deductible…… The amount still unpaid for the year.

Co-insurance……..% of the bill not covered by insurance.

Balance Due……..Any previous unpaid balance.

Any deductibles collected are an estimated amount and there may be additional charges. Thank you for helping us stay compliant with your insurance company.

_____ _____

Signature Date

Name:_____

MRN:_____

Ina Family Medicine
1631 W. Ina Rd Suite 151
Tucson, AZ 85704
Phone (520)585-5738
Fax (520)585-5843

Welcome to Ina Family Medicine. Please take a moment to review our office policies. If you have any questions, please address them with our Office Manager.

All of our staff members are trained to assist you in obtaining the best care possible and to do so with courtesy and compassion. We strive to provide the best professional care possible. In turn, the providers expect you to treat the staff with courtesy and respect. Abuse of the staff will not be tolerated and may result in termination of your care at Ina Family Medicine.

1. Patients who are new to our office need to arrive 30 minutes prior to their scheduled appointment time. In addition, if you do not cancel/reschedule your first appointment within 24 business hours, you may not be able to reschedule future appointments with this office.
2. Established patients who have been seen in our office in the past three years need to arrive 15 minutes prior to their scheduled appointment time. We reserve the right to ask you to reschedule if you are late. If there is a need to cancel your appointment please do so *24 business hours* in advance. There will be a $25.00 fee if you do not show for your appointment or if you do not give *24 business hours* notice when canceling.
3. Co-pays are due at the time of service as dictated by your insurance; we do not bill copays. We will accept cash, check, Visa, MasterCard, American Express, and Discover.
4. To assist us in providing good medical care, it is very helpful if you bring in an updated list of medications and doses to each visit. We can provide you with a medication card if needed. If we are managing your diabetes or hypertension, please bring in your readings.
5. Please provide us with at least two phone numbers and an email address where we may contact you regarding your healthcare.
6. Your provider may charge a $40.00 cash fee for filling out forms such as FMLA and disability. The price is based on the amount of time required to complete the forms.
7. Contact your pharmacy for all prescription refill requests. Please allow 48 hours for prescription refills. Please note, any prescriptions that are called in after hours will not be reviewed until the following business day. Medications prescribed by specialists must be filled by the specialist that prescribed them.

Office Hours

Monday-Friday 8:00AM-5:00PM

Closed Holidays & the Friday after Thanksgiving

_____ _____

Patient /Guardian Signature Date

Arizona Community Physicians, P.C.

Release of Information Form

MRN_____

Patient Name_____**DOB**_____**Date**_____

The confidentiality of our patients' medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

Name/relationship_____Contact Number_____

By providing the below phone number(s) you are giving permission to leave voicemails regarding appointment information and/or detailed health information (i.e. lab results, radiology results or any other imperative information regarding your health).

Home:_____ Cell:_____Other:_____

DO NOT RELEASE Information to the following people:_____

_____

I acknowledge that either I or the physician may withdraw the releasing of test information at any time, upon written notice. Any questions I had have been answered.

SIGNATURE OF THE PATIENT/LEGAL GUARDIAN_____