

Medical History

Patient Name _____ Date of Visit _____

****PLEASE CHECK IN 15 MINUTES PRIOR TO APPOINTMENT WITH FORMS COMPLETED****

Primary Provider at Ocotillo Internal Medicine

- Jonathan Hackenyos, D.O.
- Cheryl Maurice, M.D.
- Drew V. Hall, M.D.
- Lily H. Delatte, MD

Other Physicians you see:

- 1.
- 2.
- 3.
- 4.
- 5.

Medications			
(Please list all prescribed or over the counter medications)			
Name of Medication	Dose (mg, ml)	# of tablets or capsules each dose	# of times per day
<i>Example- Drug A</i>	<i>20 mg</i>	<i>One tablet</i>	<i>Twice a day</i>

Medication Allergies	
Have you had an allergic or adverse reaction to any medication? <input type="checkbox"/> Yes—complete details below <input type="checkbox"/> No	
Medication	Type of Reaction

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Your Medical History

Check all that apply

- Hayfever (allergies)
- Hearing Loss
- Glaucoma
- Cataracts
- Other ear or eye disease _____

- Asthma
- COPD
- Valley Fever
- Lung Nodule
- Other lung disease _____

- High blood pressure (hypertension)
- Heart Attack (myocardial infarction)
- Congestive Heart Failure
- Atrial Fibrillation
- Elevated cholesterol (hypercholesterolemia)
- Other heart disease _____

- Acid reflux (GERD)
- Crohn's Disease
- Ulcerative Colitis
- IBS (irritable bowel syndrome)
- Hepatitis (type) _____
- Ulcer of stomach or esophagus
- Chronic constipation
- Other gastrointestinal illness _____

- Osteoarthritis
- Rheumatoid arthritis
- Fibromyalgia
- Lupus
- Osteoporosis
- Osteopenia
- Other rheumatologic disorder _____

- Cancer (type) _____

- Diabetes Mellitus
- Hypothyroidism (low thyroid)
- Hyperthyroidism (high thyroid)
- Menopause ____age (women only)
- Polycystic ovarian disorder (women only)
- Other endocrine disease _____

- Kidney disease
- Kidney stones (nephrolithiasis)
- Enlarged Prostate (men only)
- Frequent urinary tract infections
- Other kidney disease _____

- Stroke or TIA
- Migraine Headaches
- Seizures
- Dementia
- Parkinson's Disease
- Other neurological disease _____

- Skin cancer
- Eczema
- Other skin disease _____

- Anemia
- Leukemia
- Lymphoma
- Blood clot
- Other blood disorder _____

- Depression
- Anxiety
- Eating Disorder
- Attention Deficit Disorder
- Bipolar Disease
- Other psychiatric illness _____

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Immunizations			
Immunization	Date	Immunization	Date
<input type="checkbox"/> Influenza		<input type="checkbox"/> Pneumovax	
<input type="checkbox"/> Shingles(Zostavax)		<input type="checkbox"/> Gardasil	
<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> dTap	

Screening Male and Female			
<input type="checkbox"/> Stool Cards	Date	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<input type="checkbox"/> Colonoscopy	Date	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<input type="checkbox"/> Bone Density	Date	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

Screening Male			
<input type="checkbox"/> PSA	Date	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<input type="checkbox"/> Testicular Exam	Date	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

Screening Female			
<input type="checkbox"/> Pap Smear	Date	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
<input type="checkbox"/> Mammogram	Date	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal

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Review of Systems

Only circle any symptoms you are currently having or have had and are concerned about.

General	HEENT		Heart/Vascular	Respiratory
Weight loss	Visual changes	Nose congestion	Chest pain	Shortness of breath
Weight gain		Nose drainage	Rapid heart rate	Coughing
Fever	Eye itching	Nose bleeding	Irregular heart rhythm	Wheezing
Chills	Eye Redness	Sinus congestion	Leg swelling	Snoring
Fatigue	Loss of hearing	Sore throat	Pain in the legs when walking	
Insomnia	Ear infection	Hoarse Voice		

Gastrointestinal	Blood Disorder	Musculoskeletal	Skin
Stomach pain Nausea/vomiting Heartburn Trouble swallowing Diarrhea Constipation Blood in stool Stool incontinence Hemorrhoids	Bleeding disorder Easy bruising Anemia	Joint pain Joint swelling Muscle pain Back pain Neck pain Fractures	Rash Hives Dry skin Eczema Skin cancer
	Lymphatics		
	Enlarged lymph nodes Lymphedema		

Nervous System	Psychiatric	Genitourinary	Men
Dizziness Spinning Numbness/tingling Gait disturbance Balance difficulties Seizures Headaches	Depression Anxiety Phobias Eating disorder Substance Abuse	Burning with urination Frequent urination Nighttime urination Urinary incontinence Blood in the urine Sexual difficulties	Difficulties with urination Weak stream Scrotal/testicular lump STD.s

Pre Menopause	Post Menopause	Breast
Irregular menses Painful menses Vaginal discharge STD's LMP_____	Vaginal dryness Hot flashes/night sweats Vaginal Bleeding STD's	Breast lumps Nipple Discharge



Patient Information

First Name _____ Date of Birth ____/____/____

Last Name _____ Social Security No. ____-____-____

Address _____

City _____ State _____ Zip Code _____

Home Phone (____)-____-____ Cell Phone (____)-____-____

Work Phone (____)-____-____

Best Number to Reach You? _____

Sex: Male Female

Marital Status: Single Married Divorced Widow Separated Partner

Emergency Contact

Name _____

Relationship to Patient _____

Address _____

Home Phone (____)-____-____ Cell Phone (____)-____-____

Race: American Indian Asian Black or African American Hispanic
 Pacific Islander White Other Do not wish to respond

Ethnicity: Not Hispanic Hispanic, Latino/a Other Do not wish to respond

Language Preference: English Other _____ Do not wish to respond

Employment Status Working Student Retired Disabled

Email _____ (Please ask about our patient portal)



Primary Insurance

Name of Insurance Company _____

Claim Address _____

Policy/ ID No _____ Group No _____

Policy Holder Name _____

Relationship to Patient _____

Policy Holder's Address _____

Employer _____

Policy Holder's Social Security No. (required) _____ - _____ - _____

Policy Holder's Date of Birth ____ / ____ / ____

Secondary Insurance

Name of Insurance Company _____

Claim Address _____

Policy/ ID No _____ Group No _____

Policy Holder Name _____

Relationship to Patient _____

Policy Holder's Address _____

Employer _____

Policy Holder's Social Security No. (Required) _____ - _____ - _____

Policy Holder's Date of Birth ____ / ____ / ____



Person Responsible for Bills (if different than patient)

Name _____

Relationship to Patient _____

Address

Phone (____)- _____ **Cell** (____)- _____

Does patient have a Living Will or Medical Power of Attorney?

YES (If yes, please provide a copy.) **NO**

I acknowledge that all of the information given is true and correct and that it has been furnished to this office with full knowledge that, regardless of responsible party listed above, the person signing this document is ultimately liable for all said services rendered and that he/she is contractually bound to pay for said services.

Further, by signing below, I give Ocotillo Internal Medicine Associates permission to bill my insurance(s) on my behalf.

Patient or Guardian Signature

X _____ Date _____

Ocotillo Internal Medicine Financial Agreement



Insurance: Ocotillo Internal Medicine Associates (OIMA) is a primary care practice. Your insurance *may* require that you select a primary care physician. Failure to do so, prior to the office visit, will result in insurance denying full or partial payment of your claims. A copy of your insurance card is required.

We are required by our insurance contracts to collect all co-pays at the time of service. This includes annual visits. Any co-pays not received on the day of the visit will be subject to a \$10 processing fee.

It is your responsibility for knowing the benefits of the specific insurance plan(s) you have purchased. OIMA is not responsible for interpreting these benefits, or knowing how your insurance will process your claims.

Claims Submission: OIMA will file a claim with your insurance company on your behalf. If OIMA is not contracted with your insurance company, you hereby authorize assignment of payment directly to our office for services provided.

Self-Pay Patients: Patients without insurance coverage, or coverage that cannot be verified prior to an appointment, shall be responsible for paying the balance in full at the time services are provided. A \$65 deposit prior to the appointment is required (cash or credit card).

Balances: Unless other arrangements have been made in advance, the balance on accounts are due and payable at either the next appointment or upon the receipt of statement. It is the patient's responsibility to update demographic information at each appointment.

If an account becomes past due, OIMA will take the necessary steps to collect this debt, which will also include all associated collection fees, attorney/legal fees and court costs.

There is a \$50 NSF fee for any returned checks.

Appointments: Patients arriving more than 10 minutes after their appointment time will be asked to reschedule. We require 24 hour advanced notice of cancellation. A \$45.00 fee will be applied to your account for short-notice cancellations or missed appointments. A second offense will result in a \$90 fee. Patients who miss several appointments without calling may be discharged from our practice.

Annual Exam: Ocotillo Internal Medicine provides comprehensive medical care. As such, an annual appointment is required yearly of every patient. A new patient appointment (initial visit) is considered an annual appointment.

Annual exams at OIMA consist of the preventive portion as well as the assessment or management of specific symptoms or problems, acute and/or chronic. Insurance companies require all services to be itemized and coded appropriately. These codes are standardized and follow commercial insurance and Medicare guidelines.

In order to provide you with the optimal medical care and for your convenience we provide these services in one visit.

Please understand that because our annual appointments cover both types of services, some fees may be subject to your plan's co-pay, deductible or coinsurance and it will be your obligation to pay those fees for which OIMA is contractually obligated to collect. If the preventative code is **not covered**, per your insurance, our office will charge a \$65 fee.

To our Medicare/Medicare Advantage patients:

As part of an ongoing effort to enhance care coordination we are pleased to offer chronic care management services which will help better coordinate your care. Care coordination consists of non-face-to-face care services which Ocotillo will furnish to assist in your care among your different care provider and help you better manage your care.

By signing this agreement, you consent to have Ocotillo Internal Medicine Associates bill your insurance monthly for Chronic Care Management services provided to you by your Primary Care Physician. Please direct questions to our billing office. You may revoke this consent anytime by written request. There will be no out-of-pocket charges for the patient.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS FINANCIAL AGREEMENT.

No changes to this policy by the patient will be acknowledged. Questions may be directed to the billing office.

Print Name

Patient Signature

Date



HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Patient Name: _____ **Date of Birth:** _____

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient hereby waives his/her confidentiality rights should collection action become necessary. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office. However, we are not obligated to alter internal policies to conform to your request.

My protected health information can be released to the following people:

Name: _____ **Relationship:** _____ **Phone:** _____

Address: _____

Name: _____ **Relationship:** _____ **Phone:** _____

Address: _____

Name: _____ **Relationship:** _____ **Phone:** _____

Address: _____

HIV/AIDS/STD: This form authorizes release of medical information including HIV-related. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potential exposed to HIV. I **DO** ___ **DO NOT** ___ consent to the release of any positive or negative test result for AIDS/ HIV or STD infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____ **Date:** _____

With this consent, I give Ocotillo Internal Medicine permission to call my home or other alternative location provided in patient information form and leave a detailed message on voice mail or in person to someone listed above in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care such as lab and test results.

Patient Signature [or parent, guardian or legal representative]

Date (expires in 1 year)

RELEASE OF MEDICAL INFORMATION

Patient Name _____

Date of Birth _____ SSN# _____

I, _____, hereby authorize use or disclosure of protected health information about me.

I am authorizing the following location to release my records

Dr/Facility _____

Address _____

Phone _____ Fax _____

To

Ocotillo Internal Medicine
245 S. Dobson Rd.
Chandler, AZ 85224
480-895-5870 480-895-0573 Fax

I understand that the information used or disclosed may be subject to re-disclosure by the person receiving it and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notification in writing of my desire to revoke it. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the provider to whom this authorization is furnished may not condition its treatment or me on whether or not I sign the authorization.

This authorization expires two (2) years from the date of execution.

Dated this _____ day of _____, 20__.

Patient's signature



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
Office's Notice of Privacy Practices.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
Acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

03/06/2015