Patient Information

Last Name	First Name	MI

Address	City	State	Zip

Phone (H)	Phone (C)	Email Address

DOB	Gender	Insurance Policy Holder	DOB	Relationship

Emergency Contact	Relationship	Emergency Phone

Provider Information

Referring Physician	Primary Care Physician
☐ **None**	☐ **None**

How did you hear about us? ☐ Doctor ☐ Family/Friend ☐ Google ☐ Internet ☐ Newspaper
. ☐ Article ☐ Magazine ☐ Other _____

Race		Ethnicity	Marital Status		Language
African American ☐	Other Race ☐	Hispanic/Latino ☐	Single ☐	Widowed ☐	English ☐
American Indian ☐	White ☐	Not Hispanic/Latino ☐	Married ☐	Divorced ☐	Spanish ☐
Asian ☐	Decline to Specify ☐	Decline to Specify ☐			Other ☐

Pharmacy Information

Pharmacy Name	Phone	Pharmacy Cross Streets/Address

Medications - Please list ALL medications, Dose, Frequency, Reason **NONE** ☐

Medication	Dose	Frequency	Reason

Medical History - Please List ALL Current Medical Problems & Treating Physician **NONE** ☐

Problem	Doctor	Problem	Doctor

Allergies - Please List ALL Allergies and Reaction **NONE** ☐

Allergy	Reaction	Allergy	Date

Surgical History - Please List ALL Past Surgeries and Year Performed **NONE** ☐

Procedure	Date	Procedure	Date

Family Medical History

Mother: Alive ☐ Deceased ☐

Father: Alive ☐ Deceased ☐

Sibling: Alive ☐ Deceased ☐

Other: Alive ☐ Deceased ☐

Tobacco Usage	Alcohol Consumption	Illicit Drug Use	Medical Marijuana
Every day ☐ Age Started _____	Every day ☐ Never ☐	Every day ☐	Every day ☐
Some days ☐ Never ☐	Some days ☐ Former ☐	Some days ☐	Some days ☐
Former ☐ Age Stopped _____	Amount used: _____	Former ☐	Former ☐
Amount used/day:_____	Day ☐ Week ☐ Month ☐	Never ☐	Never ☐

Last Name:	First Name:	DOB:

Acknowledgement - Receipt of Patient Rights & Responsibilities and Notice of Privacy Practices

By signing on this form, I acknowledge receipt of CiC's Patient Rights & Responsibilities and Notice of Privacy Practices (HIPAA), and have been given the opportunity to read it. I understand these policies are available to me by request.

Appointment Policy

Please call by 2:00 pm on the day (Friday for Monday appointment) prior to your scheduled appointment to notify us of any changes or cancellations.

Acknowledgement - Medical Record Request

By signing this form, I hereby authorize CIC to obtain and/or disclose my medical records for medical treatment purposes only to my physician(s), clinic, hospital, or insurance without further written permission for continuation of care.

General Consent and Right to Refuse Treatment

General Consent to Treatment: By signing this form I (or my authorized representative on my behalf) authorize CIC and staff to conduct any diagnostic exams, tests, and procedures and to provide any medications, treatment to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reason(s) for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and benefits associated with these options as well as alternative courses of treatment. Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, or medication recommended or deemed medically necessary as prescribed by my referring physician. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of my evaluation and/or treatment. Unless otherwise revoked, this authorization will expire in 1 year from date of signature.

Advanced Directives

You have the right to information on CIC's policy regarding Advanced Directives. Advanced Directives will not be honored within the center. In the event of a life- threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR- Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. IMPORTANT: Under Arizona law a Prehospital Medical Directive or DNR must be on letter sized paper or wallet sized paper of orange background to be valid. If you have any questions, please talk to your physician or anesthesiologist.Visit https://www.caringinfo.org/ for more info.

I have an Advanced Directive ☐ I do not have an Advanced Directive ☐ Copy given to CIC ☐

Payment Policy

Insurance: CiC participates with Medicare and most insurances. I understand during the check-in process, if I do not have my referral and/or insurance card, I will be responsible for any payment due at time of service. If we are not contracted with your plan, payment in full is due at time of service. If you do not provide your insurance information for contracted plans, payment in full is due at the time of service. We can bill your plan upon receipt of insurance details and refund your payment after the claim has been paid in full. Co-Payments, Deductible, & Co-Insurance: All co-payments, deductibles and co-insurance must be paid at time of service per your contract with your insurance. I assume and agree to pay all applicable deductibles and co-pays. Non-Covered Services: Some services may not be covered or not considered medically necessary by Medicare or other insurances. In case, you will be required to pay for these services in full at time of service. I agree to pay for all non-covered services (preventative or routine) not covered by my insurance. Proof of Insurance: We may require a copy of your driver's license and valid insurance card to provide proof of insurance. If we are not provided with the correct information, you will be held responsible for all outstanding balances. Coverage Changes: You must notify us immediately of any changes to your insurance coverage to avoid problems with payment. Non-insured patients: I agree that I am responsible for payment at the time of service unless prior arrangements have been made. Collections: Patient/Guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.Once an account is placed in collection status, all future services must be paid in full at time of service. I understand that there will be a $25.00 fee for any returned checks. I hereby assign all insurance benefits to CIC for services performed. By signing this form, I acknowledge CIC's Payment Policy.

Patient or Authorized Representative Signature: _____ Date: _____

Authorization to Communicate Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Last Name: First Name: DOB:

In the event that I am unavailable, I hereby authorize CIC to communicate my protected health information, including information regarding my billing, condition, treatment and diagnosis to the following individual(s) or entity:

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

If your records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, mental health information, drug/alcohol abuse or sexually transmitted diseases, you are hereby authorizing the disclosure of this information.

Text Message Communication – Duty to Warn: By providing my e-mail or telephone number, I agree that Comprehensive Integrated Care (CiC) may contact me by e-mail or text. I understand that an e-mail or text may not be secure and that there is some risk that it may be read by third parties.

To the extent consent is required the Telephone Consumer Protection Act (TCPA), I hereby authorize delivery of messages containing non-health care communications like appointment reminders, patient satisfaction surveys, account calls, etc. through the use of an automatic/artificial telephone dialing system, pre-recorded voice messages, or e-mail. I am not required to agree to receive such communications and my agreement is not a condition of receiving items or services. Notwithstanding the foregoing, CiC does not waive and expressly reserves the right to contact me by any means for any purposes as otherwise permitted by law. By signing below, I have consented to receive e-mails or non-healthcare pre-recorded communications to the e-mail address or telephone number I have provided. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from date of signature.

Patient or Authorized Representative Signature: _____ Date: _____