NORTHWEST ALLIED PHYSICIANS

Northwest Allied Physicians Patient Registration

(ADULT)

Date of Birth: ____/____/____ **Date of Visit:** ____/____/____

PLEASE PRINT

Patient First Name	Patient Middle Name	Patient Last Name

Sex:	☐ Male ☐ Female ☐ Intersex ☐ MtF Female ☐ FtM Male	Social Security #:	

Street Address (Arizona)	Apt/Space	City	State	Zip Code

Street Address (Out of State)	Apt/Space	City	State	Zip Code

Primary Phone	Secondary Phone

Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Domestic Partner ☐ Other

Insurance Information

Is patient the insurance policy holder?	☐ Yes ☐ No	If NO, indicate patient's relationship to policyholder:	☐ Spouse ☐ Domestic Partner ☐ Other

Policyholder's Name (if different from patient)	Policyholder's Date of Birth

Person Legally Responsible for Payment (if not the patient)	☐ Parent ☐ Other_____

Name of Responsible Party	Social Security #	Date Of Birth

Address	City-State-Zip	Phone

Emergency Contact Information

Contact is: ☐ Spouse ☐ Parent ☐ Guardian ☐ Friend ☐ Domestic Partner ☐ Other

First Name	Middle Name	Last Name

Home Phone	Cell Phone	Other Phone

Continued On Back

Patient's Full Name: _____ **Date of Birth:** _____
(Please print)

Who referred you to Northwest Allied Physicians?	
☐ Primary Care Provider ☐ Other Provider(Name): _____	☐ Advertising ☐ Internet ☐ Family or Friend ☐ Health Fair ☐ Hospital or Urgent Care ☐ Insurance

Name of Patient's Primary Care Provider	Phone Number

Are there any other family members in this household with a Northwest Allied Physician primary care provider?
☐ **Yes** ☐ **No**
If yes, would you like information on Combined Family Billing? ☐ **Yes** ☐ **No**

Language, Race and Ethnicity

If your preferred language is other than English, we can arrange for an interpreter when you visit our doctors. Please inform clinic staff if you will be requiring an interpreter at your appointment.

Studies show that our racial and ethnic backgrounds may place us at different risks for certain diseases. By knowing more about your background, we can get a better idea of health risks you may have and better meet your medical needs.

Preferred Language: (check one)		Race: (check one)	Ethnicity: (check one)
☐ English	☐ Spanish	☐ American Indian	☐ Central American
☐ Arabic	☐ Chinese (all types)	☐ Asian	☐ Cuban
☐ French	☐ German	☐ Black	☐ Dominican
☐ Greek	☐ Italian	☐ Black or African American	☐ Hispanic or Latino/Spanish
☐ Japanese	☐ Korean	☐ Chinese	☐ Latin American/Latin, Latino
☐ Navajo	☐ Polish	☐ European	☐ Mexican
☐ Russian	☐ Tagalog	☐ Other Pacific Islander	☐ Not Hispanic or Latino
☐ Ukrainian	☐ Vietnamese	☐ White	☐ Puerto Rican
☐ Other _____		☐ Other Race	☐ South American
			☐ Spaniard

I certify the information provided in this form is true and accurate.

_____ _____
Patient's Signature or Legal Representative **Date**

NORTHWEST ALLIED PHYSICIANS

Patient's Full Name:_____

Date of Birth: _____ Date of Service: _____

Preferred Method of Communication

HIPAA privacy rules give you the right to request a restriction on uses and disclosures of your protected health information (PHI). By signing this document, you agree, restrict or object to providing PHI to family members, friends or caregivers. Your preferences indicated on this document will remain effective until you further notify us of any changes.

Northwest Allied Physicians usually sends lab, radiology, test or procedure results to your home address by mail. Sometimes we will call you about your results or to set an appointment to discuss them with your provider. If we call, we will make an attempt to get in touch with you according to your request as indicated on the second page of this document.

Financial Responsibility

Each time you come to see your doctor, we will ask to see your personal identification and proof of insurance so that we can properly bill your insurance company(ies) and charge you the correct amount.

Payment: Any amount you owe is due when you arrive to see your provider. Cash, personal checks and credit cards are accepted as payment. If your bank returns your check to our office as unpayable, there will be a $35 return check fee charged to you. A collection agency will be used to collect on delinquent accounts.

Insurance: If your visit with our provider is not covered for any reason by your insurance company, you are responsible for paying for the entire visit based on our fee schedule.

No Insurance: If you do not have insurance, you will need to pay the full cost of your visit at the time of service. A discount of 30% is given for payment in full at the time of the visit.

Appointment Cancellation: We want to make sure our patients have access to their providers when they need them, so we pay close attention to how we schedule appointments. If you arrive late for your appointment, you may be asked to reschedule for another time. Please give our office at least 24 hours advance notice (not including weekends) when you need to change or cancel an appointment, **otherwise a $27 cancellation fee may be charged**. Repeatedly not showing for your appointment may lead to termination of the relationship between you and your medical care provider.

Contact Preferences

Please indicate below the contact phone numbers that you authorize Northwest Allied Physicians to leave a phone message at, **or** indicate that you do not want phone messages left at any contact phone number.

☐ Ok to leave a phone message with detailed health information at following phone number:
( ) _____

☐ Ok to leave a phone message with callback phone number only at the following phone number:
( ) _____

☐ Do NOT leave a phone message at any number.

If we have permission to share your information with anyone else, in case we cannot reach you by phone, please fill in their name and phone number below:

☐ OK to disclose lab, radiology, test, or procedure results info **only**
☐ OK to discuss & disclose any/all clinical information

Name	Relationship to Patient	Contact Phone Number
Contact #1		
Contact #2		

I have read this document, indicated my preferred method of communication and agree to the terms for financial responsibility.

- **I understand it is my responsibility to notify Northwest Allied Physicians of <u>any</u> changes to the communication permissions I have given in this document.**
- **I understand my responsibility for payment to Northwest Allied Physicians and have been given the opportunity to ask questions about it. If additional information is needed to ensure insurance coverage, I will provide it in an accurate and timely basis.**

_____ _____
Patient or Legal Representative - *Printed Name* Date of Birth

_____ _____
Patient or Legal Representative-*Signature* Date

ADM

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to the check-in desk.

All of the communication accessibility aids and/or services that you need are **free of charge to you** by staff or contracted vendors.

Do you think you need any of the following aids and/or services?*	**YES**	**NO**
American Sign Language interpreter (must be requested at least 5 business days in advance of appointment)		
Foreign language		
Reading aloud of written materials		

*Please note that these services may only be necessary in certain situations.

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own.*

I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

X Primary Spoken Language: _____

Patient's preferred language for discussing healthcare: _____

Interpreter services are available during regular business hours.

Some Limited English Proficiency (LEP) persons may prefer or request to use a family member or friend as an interpreter. However, family members of friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services using the applicable CyraCom services will be provided to the LEP person.

Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.

Call 1-XXX-XXX-XXXX (TTY: 1-XXX-XXX-XXXX).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 1-XXX-XXX-XXXX (TTY: 1-XXX-XXX-XXXX).

Kwe'é ats' íís baa áháyánígi éí Wáashindoon bibeehaz'áanii bíla'ashdla'ii ninánonílíjdjį ha'át'íida doo bąąh doot'įįłda bíla'ashdla'ii łahgo át'éhígíí biniinaa, bikágí ánoolnininígíí biniinaa, náánáłahdęę' kéyahdęę' yigáálígíí biniinaa, binááhaiígíí, bąąh dahaz'ánígíí,éí doodago asdzání éí doodago hastįį nílínígíí biniinaa t'áá sahdii at'égo bina'anishígíí doo beehaz'ánígíí yik'eh hól'į dóó yidísin.

DÍÍ BAA AKÓNÍNÍZIN: Diné Bizaad bee yáníłti'go, t'áá jíík'e saad bee áká aná'álwo'jí ata hane', bee níká i'doolwoł. Kojį'hódíílnih 1-XXX-XXX-XXXX (TTY: 1-XXX-XXX-XXXX).

X Patient/Family Member/Companion Signature	Date/Time
Signature of person, *if any,* who filled out this form on behalf of the patient, family member, or companion:	Date/Time
Witness	Date/Time

Patient Label

NORTHWEST ALLIED PHYSICIANS

Patient Portal Access Form

The Patient Portal is an easy way to go online to request prescription refills; ask your doctor questions; and see your medications, laboratory and radiology reports, vitals, allergies, diagnoses and procedures.

Sign me up!

Patient's Full Name _____ Date of Birth _____
(Please Print)

E-mail Address _____ Last Four #s SSN _____

Mailing Address _____

City _____ State _____ Zipcode _____

Patient's Signature (Patients 16 yrs old and above): _____ Date: _____
(If patient is under 16 yrs. only parent has to sign this form; if patient is 16-17 yrs. both child and parent must sign)

Signature of Parent/Guardian (for patients under 18 yrs old): _____

You can designate a relative, friend or caregiver to see your info or use the portal on your behalf.
I also authorize the following person/people to access my patient portal:

Full Name: _____ *(Print Please)*	Full Name: _____ *(Print Please)*
Relationship to Patient: _____	Relationship to Patient: _____
E-mail Address: _____	E-mail Address: _____
Mailing Address: _____	Mailing Address: _____
City, State: _____	City, State: _____
Zip code: _____	Zip code: _____
Telephone: _____	Telephone: _____

Patient Signature: _____ Date: _____
(Parent/Guardian if patient is under 18 years)

Check off **one** category below:

_____ View Only Access: allows person to see the patient's information.

_____ Full Access: allows person to see patient's information, plus request prescription refills and ask questions of the patient's provider.

*Completed document should be scanned into Cerner and placed under **Consents** with an internal note of Patient Portal User Agreement in the Cerner EMR.

Rev 07/2018

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice.

3. **NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

4. **GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

I hereby consent to engaging in virtual health/telemedicine services, where available, as part of my treatment. I understand that "virtual health" or telemedicine services includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications.

5. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advance health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision made for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Physician Clinic.

Please check one:

- ☐ I have executed an advance directive and have supplied a copy to the Physician Clinic.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Physician Clinic.
- ☐ I have reviewed the directive(s) on file with this Physician Clinic and it is/they are my current directive(s).

Patient Label

☐ I have not executed an advance directive. I have received information about advance directives from this Physician Clinic.

☐ I have not executed any advance directives, and I do not wish to receive information about advance directives from this Physician Clinic

6. RESEARCH STUDIES:

Are you currently a participant in any research study or project: *(If yes, please briefly describe what is being studied (drug, medical device or other)* _____

Who can the Physician Clinic contact with questions about the Study? _____.

7. CONSENT TO PHOTO/VIDEO:

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

8. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

9. E-MAIL:

I hereby consent to provide my e-mail address, so that representatives from the Physician Clinic can e-mail information to me about health education or disease prevention and up-to-date information about the Physician Clinic, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

Email Address:

10. CELL PHONES:

I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Physician Clinic, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

11. VIDEOTAPING/RECORDING:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative				Date	Time
Relationship to Patient			Interpreter, if Utilized	Date	Time
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label

NORTHWEST ALLIED PHYSICIANS

Patient Acknowledgement

- I acknowledge as the patient or patient's representative that I have already signed the Consent to Medical Treatment form for Northwest Allied Physicians, and that my signed Consent applies to my treatment today at this clinic.
- I acknowledge as the patient or patient's representative that I have received a copy of the Patient Rights and Responsibilities for Northwest Allied Physicians.

_____

Patient's Signature (or Legal Representative's signature)
If you are a patient's Legal Representative, please indicate your relationship to the patient below:
☐ Parent ☐ Guardian ☐ Spouse ☐ Domestic Partner ☐ Other

_____ _____
Name of Interpreter, if utilized Date

_____ _____
Signature of Witness Date

FOR STAFF USE ONLY

Patient's Name: _____
(Please Print)

Patient's Date of Birth: _____ **Date of Service:** _____

Clinic Name: _____

If patient received copy of Rights and Responsibilities but is declining acknowledgement, a staff member must sign below:

_____
Staff Signature

Patient Rights and Responsibilities

In caring for our patients, Northwest Allied Physicians strives at all times to respect the patient's individuality, privacy and other rights. Patients may request a copy of these Patient Rights and Responsibilities at any time.

A PATIENT HAS THE FOLLOWING RIGHTS:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnosis.
2. To receive treatment that supports and respects the patient's individuality, choices, strengths and ability.
3. To receive privacy in treatment and care for personal needs.
4. To review, upon written request, the patient's own medical record.
5. To receive a referral to another provider or healthcare facility, if the physician is unable to provide physical health services or behavioral health services for the patient.

6. To participate or have the patient's representative participate in the development of, or decisions concerning treatment.
7. To participate or refuse to participate in research or experimental treatment.
8. To receive assistance from a family member, representative, or other individual in understanding, protecting or exercising the patient's rights.
9. To be treated with dignity, respect and consideration.
10. Is not subject to: abuse, sexual abuse, sexual assault, neglect, exploitation, coercion, manipulation, restraint or seclusion, retaliation for submitting a complaint to the Health Department or another entity, misappropriation of personal and private property by an employee, volunteer or student.
11. A patient or patient's representative:
    a. Except in an emergency either consents to or refuses treatment
    b. May refuse or withdraw consent for treatment before treatment is initiated
    c. Except in an emergency is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure
    d. Is informed of the following;
        i. Health care directives
        ii. Patient complaint process
    e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to a clinic for identification and administrative purposes
    f. Except as otherwise permitted by law, provides written consent to the release of information in the patients;
        i. Medical record or Financial records.

PATIENT RESPONSIBILITIES:

1. **Provision of Information:** A patient has the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, existing advanced directives, and other matters relating to their health. The patient has the responsibility to report changes in their condition and whether they clearly understand instructions.
2. **Refusal of Treatment:** The patient is responsible for the outcome of their actions if they refuse treatment or do not follow medical instructions.
3. **Physician Practice Charges:** The patient is responsible for assuring that the financial obligations of their health care are fulfilled promptly.
4. **Physician Practice Rules and Regulations:** The patient is responsible for following clinic rules concerning patient care and conduct.
5. **Respect and Consideration:** The patient is responsible for being considerate of the rights of other patients and providers and other clinic staff.

RATE SCHEDULE:

A copy of the fee schedule is available upon request from the front desk.

COMPLAINTS AND GRIEVENCES:

We strive to provide the best possible care during your visit. If you have any concerns, questions or complaints about your care or treatment, please let your Provider or the Practice Manager know. If you have a complaint we want to resolve it as soon as possible. If you believe your concern has not been addressed you may also lodge a complaint directly with the Department of Health Services without first filing an internal complaint by contacting:

Arizona Department of Health Services
150 N. 18th Avenue, Suite 450; Phoenix AZ 85007
Phone: (602) 364-3030, Fax (602) 792-0466

STATE INSPECTIONS:

As part of our ongoing commitment to providing quality care, our office has been surveyed by the Arizona Department of Health. A state inspection report is available upon request from our front desk: