A-P Medical Group

Patient Information

Thank you for selecting our practice, so that we may best serve you, please fill out this form as accurately as possible and return it to our receptionist. If you have any question or need assistance, please ask us- we will be happy to help. Thank you!

Today's Date: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Gender: M F T Marital Status: _____ Race: _____ Ethnicity: _____

Phone Number: _____ Cell Home Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

OCCUPATION

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

INS Address: _____ City: _____ ST: _____ Zip: _____

Phone Number: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ Relation to Patient: _____

INS Address: _____ City: _____ ST: _____ Zip: _____

Phone Number: _____

PREFERRED PHARMACY

Pharmacy: _____ Cross Streets: _____/_____

A-P Medical Group

Medical History

Name: _____ **DOB:** _____

ALLERGIES

Do you have any allergies to medication: YES NO if yes, please list:

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

MEDICATIONS

Name of Medication	Dose	How Frequent

SURGICAL HISTORY

Have you had any surgeries? YES NO If yes, please list:

Type of Surgery	Reason for Surgery	Year

A-P Medical Group

Medical History

Name: _____ **DOB:** _____

Please indicate if you have or had any of the following:

YES	NO		YES	NO	
		Hepatitis			Swollen Ankles
		High Blood Pressure			Bleed or Bruise Easily
		Anemia			Chest Pain
		Kidney or Bladder Disease			Cough : Persistent or with blood
		Arthritis			Diarrhea, Constipation, Blood In Stool
		Psychiatric Illness			Dizziness
		Asthma or Emphysema			Fever
		Cancer			Fainting
		Diabetes or Gestational Diabetes			Headaches
		Eye Problems			Jaundice (yellow skin)
		Ear- Nose- Throat Problem			Joint Pain or Stiffness
		Skin Disease			Dry Mouth
		Stomach Problems, Gastritis or Ulcers			Thyroid Problems
		Stroke			Vomiting
		Heart Problems			Rash
		Artificial Joint			Seizures
		Heart Valve or Pacemaker			Difficulty Breathing
		Blood Transfusion			Excessive Thirst
		Chemotherapy / Radiation			Frequent Urination
		Glasses or Contacts			Blurry Vision
		Sexual Disease			Increase or Loss of Weight recently
		Domestic Violence			Other:

Do you use any of the Following?

Yes	NO		YES	NO	
		Alcohol How Frequent:			**Tobacco** How Frequent:
		Caffeine How Frequent:			**Recreational Drugs** How Frequent:

Name: _____ **DOB:** _____

WOMEN ONLY

YES	NO		YES	NO	
		Are You Pregnant or Breastfeeding?			When was your last Pap Smear?
		Are you on any Birth Control?			Have you had any abnormal Pap Smears?
		Is your Menstrual Cycle abnormal?			When was your last mammogram?
		Have you had any miscarriages or abortions?			Have you had any abnormal mammogram?
		Have you had more than one sexual partner recently?			Have you had a hysterectomy? Complete or Partial?
		Do you have pain during intercourse?	What age did you start your period?		

FAMILY HISTORY

Are you adopted? YES NO

Alive	Deceased		Health Problems
		Father	
		Mother	
		Sister/Brother	
		Sister/Brother	
		Sister/Brother	
		Sister/Brother	

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____

Todays Date: _____

Emergency Contact Form

Ensure that the information is valid and updated periodically.

Personal Information

Name: _____ DOB: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

Primary Person to be Notified in Case of an Emergency

Name: _____ DOB: _____
Relationship: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

Secondary Person to be Notified in Case of an Emergency

Name: _____ DOB: _____
Relationship: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this form will be used by A-P Medical Group Staff and/or Emergency Personnel.

Please ensure that the form has the most updated and accurate information.

In case of an emergency, I give permission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this form may be notified as needed.

Signature: _____ Date: _____

A-P Medical Group
2110 E. Flamingo Rd Suite 213
P: 702-971-3400 F: 702-971-3401

Authorization to Release Medical Records

Patient Name: _____ DOB: _____

Authorizes Release TO/FROM Office:

Name of Healthcare Provider/Office: _____
Phone #: _____ Fax #: _____

Information to be released:

- ☐ Office Visits
- ☐ Procedure Reports
- ☐ Billing
- ☐ In office X-rays images
- ☐ Laboratory Results
- ☐ Medications
- ☐ Diagnostic Results
- ☐ ENTIRE RECORD
- ☐ Other(specify): _____

Purpose of Disclosure:

I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans or healthcare clearinghouses, which must follow the federal privacy standards, the health information disclosed because of this authorization may no longer be protected by the federal privacy standards and my health information may be disclosed without obtaining my authorization.

You're Rights with Respect to this Authorization:

I understand this consent may be revoked at any time with the exception and to the extent that disclosure of this information has already occurred prior to receipt of revocation by the above-named provider. I understand if written revocation is not received, the authorization will be considered valid for a period not to exceed 12 months from the date signed. To initiate of this authorization, I must submit my request in writing to the "Authorizes" entity above. I understand a photocopy of this information is to be considered as valid as the original. I understand the information used or disclosed pursuant to this authorization may be transmitted electronically and may be subject to re-disclosure by the recipient and may no longer be protected by Federal law. J understand that I have the right to refuse to sign this authorization, am signing this authorization voluntarily, and that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining the authorization. I have the right to receive a copy of this authorization and any records obtained with its use. I understand this consent includes disclosures of Alcohol, Drug Abuse and/or Psychiatric records, Sexually Transmitted Disease and HIV/AIDS Information. I have the right to inspect or copy the health information I authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information, obtain copies of my health information, by contacting the privacy officer.

Expiration Date:

This authorization if good for 12 months from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing, this authorization, I am confirming that it accurately reflects my wishes.

Patient Signature: _____ Date.: _____

A-P Medical Group

Financial/Collection Policy

The goal of A-P Medical Group is to provide you with the best quality care at a responsible cost. In order to achieve these goals, your assistance is needed in understanding your insurance policy and benefits. Although, we do verify eligibility and get a brief summary from your insurance company, it is very important that you read and understand your benefits. Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Our relationship is with you and you are ultimately responsible for any service provided, regardless of your insurance coverage. We bill your insurance as a courtesy, not all services are covered by your insurance company. It is your responsibility to know what it covered and what is not. Fees for non-covered services are due at the time service is rendered. If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly and that you contact your insurance carrier.

If your insurance company cannot be contacted to verify eligibility, you will be asked to pay for the visit via cash, credit or debit at the time of service, until eligibility can be verified.

Payment is due at the time of service and includes all co-pays and deductibles per your insurance company and their contract with our facility.

- ✓ A charge of $ 50 will be applied to your account for FMLA, disability forms and any other forms requiring a provider's signature but not completed at the time of scheduled appointment, 72 Hour turnaround.
- ✓ A charge of $ 100 will be applied to your account for FMLA, disability forms and any other forms requiring a provider's signature, completed at the time of scheduled appointment..
- ✓ **No-shows will be charged a $50 no-show fee. No show fees are not covered by insurance companies and will be the responsibility of the guarantor. A patient who has excessive no-shows in a calendar year may subject to dismissal from the practice.**

Accounts will be considered delinquent after 90 days. Delinquent accounts will be placed with a private collection agency. All accounts placed with a collection agency will be subjected to all reasonable collections and court costs.

Patient's refund will be released once insurance claim has been paid by your insurance carrier. We want to make sure we deduct any co-pays, coinsurance, deductibles or any other charges your insurance carrier may apply toward your responsibility. Timeframe is usually 6 to 8 weeks.

We do understand that temporary hardships may affect timely payments of your balance. We encourage you to communicate any problems so that we can assist you n the management of your account. We also offer payment arrangements. You may speak with your billing department for further assistance.

I authorize A-P Medical Group to provide any emergency care deemed by medical staff on the event of a medical emergency while on the A-P Medical Group property.

_____ _____

Patient/Parent/Guardian Signature Date

A-P Medical Group

Informed Consent to use Patient Portal

A-P Medical Group is offering this secure, HIPAA compliant patient portal as a courtesy to our patients. It is an optional service that we reserve the right to suspend or terminate at anytime. We will alert you to any changes as promptly as possible. This consent is intended to inform you of the facts and risks surrounding the use of the web portal. You also agree not to hold A-P Medical Group or any of their staff liable for network infractions beyond their control.

The web portal has a tunnel connection with our clinic that uses encryption to keep unauthorized persons from being able to access and read your health information or communications from us. To help insure that this system remains secure, we need to have your current PRIVATE email address and be informed if it ever changes. Keep your portal user ID and password secure only you can or someone authorized by you can gain access to your patient information. If you think someone has learned your password, immediately go to the portal site and change it. It is your responsibility to protect your password and log in.

If you gave any questions regarding this Patient Portal please contact the office to discuss.

Confidential EMAIL, please print clearly: _____

- ☐ I wish to gain access to the Patient Portal
- ☐ I do not wish to gain access to Patient Portal
- ☐ I do not want to disclose my email

Late and No-Show Policy

No-shows and late shows unnecessarily delay the delivery healthcare to other patients and some of whom may be quite ill

NO SHOW POLICY:

- ✓ A no-show is defined as missing a scheduled appointment without calling us at least 24-hours in advance to cancel the appointment
- ✓ Appointments scheduled for the same day you call will require at least one hour notice of cancellation
- ✓ After the first no-show, a letter will be sent clarifying this policy and consequences
- ✓ Subsequent no-shows will be charged a $25 no-show fee. No show fees are not covered by insurance companies and will be the responsibility of the guarantor. A patient who has excessive no-shows in a calendar year may subject to dismissal from the practice.

LATE-SHOW POLICY:

A patient who is more than 15 minutes late to his/her appointment may be asked to reschedule their appointment. Every effort will be made to see the patient the same day but on time patient will be seen first.

I have read and understand the above policies and agree to abide as outlined.

Print Patient Name: _____ DOB: _____

Patient/Parent/Guardian Signature: _____ Date: _____