Patient Name: _____ **DOB:** _____

DMG
DISTRICT MEDICAL GROUP

Patient Identification Acknowledgement

Patient Name: _____ Date of Birth: _____

_____
Street Address Apt # City State Zip

Phone: _____ Parent/Legal Guardian (if applicable) _____

Email Address: _____

Gender: Male ☐ Female☐ Other (Specify) _____ Decline to Answer ☐

Race: American Indian ☐ Alaska Native ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Caucasian ☐

Ethnicity (check one) Hispanic or Latino ☐ Not Hispanic or Latino☐ Decline ☐

Language(s): _____

Primary Care Physician: _____ Phone: _____

Behavioral Health Provider: _____ Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____
Street Address City State Zip

If 18 years of age or older do you have a **medical advance directive**? Yes ☐ No ☐
If yes, please provide our office with copy. If no, would you like information on **medical advance directives**? Y☐ N☐
If 18 years or older do you have a **psychiatric advance directive**? Yes ☐ No ☐
If yes, please provide our office with copy. If no, would you like information on **psychiatric advance directives**? Y☐ N☐
In case of a medical emergency or any other emergency, please list one emergency contact below. By listing this contact below, you are authorizing DMG to contact these individuals and share your relevant Protected Health Information with them for the purpose of ensuring your safety during a medical emergency or any other emergency.

Name _____ Relationship _____ Phone _____

FOR MINORS ONLY: *If biological parents are divorced/ co-parenting and share medical decision-making, please list the following demographic information for the non-custodial parent (or the parent who is not completing these forms):*

Name _____ Phone _____

Address: _____
Street Address Apt # (if applicable) City State Zip

If under the age of eighteen (18) please list the name(s) of the individuals to whom the child may be released: (If names are present, please ask for a medical release form to fill out and sign).

_____ _____
Name Relationship Name Relationship

I certify that this information is true to the best of my knowledge. _____
Signature Patient/Parent/Guardian

Revised 9/2/2020

Patient Name: _____ **DOB:** _____

DMG
DISTRICT MEDICAL GROUP

Financial Responsibility Acknowledgment

Primary Insurance Information:			
Primary Insurance Co. Name	Identification Number	Group Number	
Address of Primary Insurance	City	State	Zip Code
Policyholder Name (if Different from Patient)	Phone Number of Policyholder	Relationship to Patient	
Policyholder's Social Security No.	Policyholder's Date of Birth	Relationship to Patient	
Policyholder's Employer	Home Phone	Cell Phone	

Is there a secondary insurance company? ☐Yes ☐No if yes, please provide additional information to staff.

Financial Responsibility Acknowledgement – Please initial each paragraph:

_____ I acknowledge full financial responsibility for services rendered by DMG. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to DMG.

_____ I understand that DMG verifies my health benefits through my insurance as a courtesy to me. I further understand that it is my responsibility to ensure services are covered and/or what my exact benefits are. DMG will assist me in this process to the best of its ability. I understand that I am ultimately responsible for payment of all services rendered. I understand that any co-pays, deductibles, or any other payments of outstanding balances are due prior to services being rendered. I understand that it is my responsibility to update DMG of any insurance changes.

_____ I understand that health insurance is a contract between me and the insurance company and/or my employer, not DMG. If there are any disputes of benefit coverage I understand that I need to contact my insurance company.

_____ I have read and fully understand the above financial responsibility and insurance authorization.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Print Name of Patient/Parent/Legal Guardian

Patient Name: _____ **DOB:** _____

Consent for Purpose of Information, Payment, and Healthcare Operations

I consent to the use and disclosure of _____'s Protected Health
Print Patient Name
Information by District Medical Group (DMG) for the purpose of diagnosing, providing treatment, obtaining payment for health care bills, or to conduct health care operations of the DMG clinic. I understand that the diagnosis or treatment by the DMG clinic providers may be conditioned upon the consent as evidenced by the authorizing signature and initials on this document.

Please initial each paragraph:

_____ By initialing and signing this consent form I am agreeing that this DMG clinic can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ I understand that all information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law. Examples of such disclosures include medical emergency cases; situations of an emergency involving a serious an imminent threat to a person or the public; the reporting of child or adult abuse or neglect, court ordered disclosures. I understand that my treatment information may be discussed by other members of my clinical team, and other professionals at DMG clinics.

_____ I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the DMG clinical practice and that the DMG clinical practice is not required to agree to the restriction. However if the DMG clinic agrees to the restriction that I request, the restriction is binding on the DMG clinic. I have the right to revoke this consent, in writing at any time, except to the extent that the DMG clinic has taken action in reliance on this consent.

_____ My "Protected Health Information" means health information, including demographic information, collected from me and created or received by the DMG provider, another heath care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to past, present or future physical or mental health or condition and identifying information, or there is a reasonable basis to believe the information may personally identify the patient named above.

_____ I understand I have a right to review the DMG clinic Notice of Privacy Practices prior to signing this document. DMG clinic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information that will occur in treatment, payment of bills, or in the performance of healthcare operations of the DMG clinic. This notice of Privacy Practices also describes client rights and DMG Clinic duties with respect to protected health information.

_____ The DMG Clinic reserves the right to change the Privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Printed Name of Patient/Parent/Legal Guardian

Patient Name: _____ **DOB:** _____

Patient Record of Disclosures

In general the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home/Mobile Telephone: _____

_____ OK to leave message with detailed info

_____ Leave message with call-back number only

_____ Decline personal phone messages

Work Telephone: _____ Work Fax: _____

_____ OK to fax to this number

_____ OK to leave message with detailed info

_____ Leave message with call back number only

_____ Decline work phone messages

Written Communications:

Email: _____

_____ OK to send detailed email to this address

_____ OK to mail to my work/office address

_____ OK to mail to my home address

Patient Representative to whom information may be given:

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Privacy and Disclosure of Medical information:

Our Notice of Privacy Practices ("NPP") provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our NPP.

_____ _____

Patient/Parent/Guardian Signature Printed Name

_____

Date

Revised 9/2/2020

Patient Name: _____ **DOB:** _____

General Consent for Treatment

Please initial each paragraph:

_____ General consent: I consent to medical care at this facility, including telephonic evaluation and management if medical services are not performed in-person. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.

_____ I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.

_____ In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Arizona law.

_____ I understand that District Medical Group utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.

_____ I understand that District Medical Group utilizes an electronic prescribing mechanism for electronic transmission of prescriptions to local pharmacies and mail order pharmacies.

_____ I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician or provider.

By signing this document, I agree that photocopies of this document are as legally binding as the original.

I have read and understand and agree to the above terms.

_____	_____	_____	_____
Patient or Guardian signature	Printed Name	Relationship to Patient	Date

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION

Our notice of Privacy Practices provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our use and disclosure form.

_____	_____	_____	_____
Patient or Guardian signature	Printed Name	Relationship to Patient	Date

Patient Name: _____ **DOB:** _____

DMG
DISTRICT MEDICAL GROUP

AUTHORIZATION/ AGREEMENT FOR NONPARENT CAREGIVER

I, _____Parent/ Legal Guardian of_____
Printed Name of Parent/Legal Guardian Child's Name
am the Parent or legal guardian of the above named patient. For a variety of reasons, there may be occasions when I will be unable to personally accompany child named above to his/her appointments. Adults listed below are 18 years of age or older and are authorized to discuss care and treatment needs with appropriate clinic staff, and are authorized by me to give consent to the performance of only routine procedures such as lab and x-ray. I understand these individuals must have knowledge of my child's diagnosis and treatment so that care may be discussed with the physicians. If these individuals cannot provide an adequate history as required by the physician then I understand that the appointment may be rescheduled. I have read and understand and agree to the terms above._____(Initials)

Do hereby authorize and appoint (please print):

Name:_____Relationship:_____Contact Number:_____

Name:_____Relationship:_____Contact Number:_____

Name:_____Relationship:_____Contact Number:_____

AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End date_____ or Event Name_____

COPY RECEIVED. I acknowledge receipt of a signed copy of this authorization._____(Initials)

Any questions or concerns regarding this authorization may be directed to me at:

(Please select preferred method of contact)

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Parent/Legal Guardian Signature: _____ Date: _____

Employee Witness: _____ Date: _____

Patient Name: _____ **DOB:** _____

DMG Outpatient Clinics

Acknowledgment of Receipt

At the time of admission, I have been provided with the following information:

1. Patient Identification Acknowledgement;
2. Financial Responsibility Acknowledgement;
3. Consent for Purpose of Information, Payment, and Healthcare Operations;
4. Patient Record of Disclosures;
5. General Consent for Treatment;
6. Authorization/ Agreement For Nonparent Caregiver;
7. Notice of Privacy Practices;
8. Patient Rights;
9. DMG Patient Handbook of Administrative Policies, which includes:
    a. A copy of the Billing Policy and Procedure;
    b. Notice of fees: Each Employee Completed Form may be assessed a $60 fee; that includes, but not limited to:
        i. FMLA Forms
        ii. Disability Forms
        iii. Adoption Forms
        iv. Other forms requiring manual completion
        Please note: Forms may or may not be completed upon the first visit.
    c. Any ancillary forms may be assessed a $30 fee.
    d. Notice of fees: Medical records requests may be assessed a $ 25.00 clerical fee, $0.25 per page, and postage (except for requests exempt under Arizona Statutes). Allow 7-10 business days for completion.
    e. Complaints and Grievance process;
    f. A copy of the No-Show/Cancellation Policy and Procedure that applies to no shows and/or late cancellations (less than 24 hours-notice). <u>No-Show (NS) fees will only be assessed if allowable under patients identified insurance carrier</u>:
        i. NS fee of $ 25 for medical appointments (non-psychiatry);
        ii. NS fee of $ 60 will apply for psychiatry appointments/ medication management;
        iii. NS fee of $ 70 for therapy appointments;
    g. A copy of the Termination Policy and Procedure.
    h. A copy of the Medication Policy.
10. Notice of Health Information Practices with Health Information Exchange (As appropriate)

I acknowledge receipt of all documents listed above by my signature set forth below. I understand that it is my responsibility to read all policies and procedures provided to me.

_____ _____ _____/_____/_____

Signature of Patient/Parent/Legal Guardian Printed Name Date