

Thank you for choosing Gilbert Primary Care for your medical needs. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to ask us. Regular informational updates are needed yearly. Please complete this form. Thank you for your cooperation.

**PATIENT REGISTRATION**

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_ APT. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Social Security # \_\_\_\_\_

Marital Status, please check one: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

(Someone not living with you)

May we speak with your spouse? \_\_\_\_\_ Yes \_\_\_\_\_ No      May we call you at work? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you a student? \_\_\_\_\_ No \_\_\_\_\_ Yes    If yes, are you \_\_\_\_\_ Part Time \_\_\_\_\_ Full Time

Employment Status: \_\_\_\_\_ Full-Time \_\_\_\_\_ Part-Time \_\_\_\_\_ Retired \_\_\_\_\_ Self \_\_\_\_\_ Active Duty \_\_\_\_\_ Not Employed

Please provide us with your insurance information. Completed information is necessary to bill your insurance.

**PRIMARY INSURANCE INFORMATION**

Name Of Policy Holder: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

Date of Birth: \_\_\_\_\_ Social Security # of the policy holder \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name Of Policy Holder: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other

Date of Birth: \_\_\_\_\_ Social Security # of the policy holder \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Member ID # \_\_\_\_\_ Group # \_\_\_\_\_ Plan # \_\_\_\_\_

**Authorization for Treatment and Assignment of Benefits**

I authorize treatment for the person named on this information form. I authorize all insurance benefits to be paid directly to Gilbert Primary Care. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependants and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Gilbert Primary Care**  
**FINANCIAL POLICY**

- **Insurance** - Your insurance policy is a contract between you and your insurance company. The doctor is not involved in this contract. You are contractually responsible for your co-payment, co-insurance or any balance unpaid at the time of service. We accept Cash, Check, or Visa/MasterCard.
- **No Insurance** – Patients who are self-pay are responsible for the entire balance at the time of service.
- **Regarding Insurance**- We may accept assignment of insurance benefits. We will bill your insurance company upon receipt of your current insurance information. If your insurance company has not paid your account in full within 45 days, the balance may automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Non-covered services will be billed to the patient.
- **Medicare Medical Necessity** -Medicare will pay only for services that it determines to be “reasonable and necessary” under the Medicare laws. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary, Medicare will deny payment for that service. If Medicare denies payment, you are personally and fully responsible for payment.
- **FMLA Forms, Disability Forms and Insurance Forms** - Form completion is not a covered benefit under any plan. There will be a charge for completion of all FMLA, Short-term and Long-term Disability forms. Completion of insurance forms is not a covered benefit; there will be a charge for completion of insurance forms.
- **No-Show/Late Cancellation**- If you must cancel your appointment, you will be required to cancel 24 hours before your appointment time. “No show” patients and cancellations with less than 24 hour notice will be charged a \$25 fee.
- **Children** – The parent seeking medical attention of a child/children is responsible for their co-payment and/or coinsurance at the time of service. The financial arrangement between you and the child/children’s parent does not include our practice.
- **Returned checks** – There is a \$25.00 fee if your check is returned unpaid. In addition, any future services will require cash or credit card payments.
- **Statements** – Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date.
- **Collections** – Should it be necessary to place your unpaid account with our outside collection agency, you must communicate directly with them.

*I have read, understand and agree to abide by the financial policy of Gilbert Primary Care.*

X \_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

## **Acknowledgment of Receipt of Privacy Practices**

**GILBERT PRIMARY CARE**

I, \_\_\_\_\_ am aware of Gilbert Primary Care's Notice of Privacy Practices Policies which went into effect on April 14, 2003. I understand that I may request and receive a copy of these policies.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

## **Designated Recipient of Confidential Information**

Because of HIPAA Privacy Rules, Gilbert Primary Care will not share confidential medical information with any other individuals without the express consent of the patient. **(Please review Privacy Practices for complete text)**. Parents or guardians of unemancipated minor children (under the age of 18 years) may be given information regarding that patient however; this does not require a signature.

I do \_\_\_\_\_ authorize Gilbert Primary Care to share confidential medical information with the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I do NOT \_\_\_\_\_ authorize Gilbert Primary Care to share confidential medical information.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_



## Policies and Protocol of Gilbert Primary Care

I have received the information regarding the policies and protocol of Gilbert Primary Care.

I am aware that failing to comply with these policies and/or protocol may result in termination from the medical practice.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



Gilbert Primary Care  
Family Practice & Internal Medicine

## No-Show Policy of Gilbert Primary Care

I have received the information regarding the changes in the No-Show policy of Gilbert Primary Care.

I am aware that failing to comply with the policy may result in a fee and /or termination from the medical practice.

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Patient Name (print

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Date

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Patient Signature

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Date

## PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained will not be released to anyone without your authorization to do so.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_

### REVIEW OF SYMPTOMS

Do you now or have you had any problems related to the following systems?

<b>Constitutional Symptoms</b>	<b>(Comments)</b>	<b>Genitourinary</b>	<b>(Comments)</b>
Weight change	Y N	Change in stream	Y N
Chills/Fever	Y N	Nocturia (getting up at night)	Y N
Sleep Disorder	Y N	Urinary frequency > 8 times/day	Y N
Other		Burning with urination	Y N
		Other:	
<b>Eyes</b>		<b>Musculoskeletal</b>	
Double vision	Y N	Bone pain	Y N
Glaucoma	Y N	Muscle pain	Y N
Cataracts	Y N	Joint pain	Y N
Other:		Other	
<b>Ear/Nose/Throat/Mouth</b>		<b>Integumentary (Skin)</b>	
Hearing changes	Y N	Rash	Y N
Sore throat	Y N	Lumps or bumps	Y N
Sinus problems	Y N	Moles, skin tags	Y N
Other		Other	
<b>Cardiovascular</b>		<b>Neurological</b>	
Chest pain	Y N	Tremors	Y N
Irregular heartbeat	Y N	Dizzy spells	Y N
Swelling in ankles	Y N	Numbness/tingling	Y N
Other		Do you have difficulty falling?	Y N
		Asleep or wake without cause?	Y N
		Other	
<b>Psychologic</b>		<b>Respiratory</b>	
Are you generally happy?	Y N	Wheezing	Y N
Do you feel depressed?	Y N	Frequent cough	Y N
Do you feel anxious?	Y N	Shortness of breath	Y N
Do you feel safe in your home?	Y N	Other	
<b>Endocrine</b>		<b>Gastrointestinal</b>	
Excessive thirst	Y N	Abdominal pain	Y N
Too hot/cold	Y N	Nausea/vomiting	Y N
Tired/sluggish	Y N	Indigestion/heartburn	Y N
Other		Constipation/Diarrhea	Y N
		Other	
<b>Hematologic/Lymphatic</b>		<b>Sexual History</b>	
Swollen glands	Y N	Change in sex drive	Y N
Blood clotting problem	Y N	Sexual performance	
Bruising	Y N	Satisfactory?	Y N
Other		Other (ie. Sexual trauma)	Y N
<b>Allergic/Immunologic</b>		<b>Last Eye &amp; Dental Exam</b>	
Hay Fever	Y N	Date: Last Dental Exam:	_____
Drug allergies	Y N	Date: Last Eye Exam:	_____
Food allergies	Y N		
Other			

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Gilbert Primary Care  
Family Practice & Internal Medicine

JUNE 1<sup>ST</sup>, 2008

ATTENTION ALL PATIENTS OF GILBERT PRIMARY CARE:

EFFECTIVE AS OF JUNE 1<sup>ST</sup>, 2008 WE WILL BE ENFORCING OUR NO-SHOW POLICY THAT WE CURRENTLY HAVE IN EFFECT. IF YOU HAVE A SCHEDULED APPOINTMENT AND YOU NO-SHOW, WHICH MEANS YOU DO NOT CALL TO CANCEL OR YOU SHOW UP LATE AND WE ARE FORCED TO CANCEL THE APPOINTMENT, YOU WILL BE CHARGED A FEE. THE FEES FOR A NO-SHOW ARE \$35 AND \$45, DEPENDING ON THE LENGTH OF THE SCHEDULED APPOINTMENT. ALSO BE AWARE THAT IF THIS OCCURS 3 OR MORE TIMES YOU MAY BE TERMINATED FROM THE PRACTICE. THE REASON FOR THIS IS BECAUSE WE ARE HAVING A HIGH VOLUME OF NO-SHOWS.

ALSO, PLEASE BE AWARE THAT OUR AUTOMATED REMINDER CALLS IS OUR COURTESY TO PATIENTS, BUT YOU CANNOT RELY ON THIS SYSTEM. JUST LIKE ANY OTHER SYSTEM...THEY DO HAVE THEIR DEFAULTS. IT IS UP TO YOU, AS THE PATIENT, TO REMEMBER WHEN YOUR SCHEDULED APPOINTMENT IS.

OUR FRONT OFFICE STAFF WILL GIVE YOU A REMINDER CARD ON THE DAY THAT YOU SCHEDULE YOUR APPOINTMENT. IF YOU CALL IN TO MAKE AN APPOINTMENT IT IS UP TO YOU TO WRITE IT ON YOUR CALENDAR.

THANK YOU SO MUCH FOR UNDERSTANDING AND WE APOLOGIZE FOR ANY INCONVENIENCE THIS MAY BRING.

SINCERELY,

  
DR. CYNTHIA JORDAN

  
DR. BRIAN ANDREWS

  
DR. MARIE PIMENTEL

## Gilbert Primary Care

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include referrals to specialists or diagnostic services or treatment facilities.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your health care insurance plan for your medical services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION TO ORGANIZATIONS that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED

HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

**Gilbert Primary Care** Practice Administrator  
**3048 East Baseline Road**  
**Suite #120**  
**Mesa, Arizona 85204**

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
877-696-6775 (toll-free)