COMPREHENSIVE INTEGRATED CARE
Passionate People • Compassionate Care

Patient Demographic Information and Policy Acknowledgement

Patient Information – Please Print

First Name: ______________________________Last Name:_____________________________ Middle Initial:_________

Date of Birth:____________ Sex:________ Race:_______________ Are you of Hispanic/Latino Decent?(Yes/No):_______

Permanent Address: _______________________________________ City: ____________ State: _______ Zip: ________
Temporary Address: ____ City: ____________ State: _______ Zip: ________

Contact Information – *Check the box next to the best contact number*

☐ Home Phone: (______)____________ ☐ Work Phone: (______)____________ ☐ Cell Phone: (______)____________
Email Address: ___________________________________ Please contact me by: ☐ Phone ☐ Email ☐ Mail
Emergency Contact Name: __________________________Relationship: _______Phone: (_____)______________

Preferred Pharmacy

Pharmacy Name: ____ Phone Number: (______)_____________

Approximate Location (cross streets, city, etc.):____

Provider Information

Referring Physician: _______________________________ Primary Care Physician: _______________________________

Responsible Party Insurance / Billing Information

Primary/Secondary Insurance Company: ____

Responsible Party: _____________________ DOB:____________________ Relationship to Patient: _________________

Address (if different than above): ______________________________________ Phone Number: (______)____________

Reproductive History

Is there a possibility you may be pregnant? ☐ Yes ☐ No Date of LMP: _______________________________

Medical History - Please List ALL Current Medical Problems and the Physician Treating Them:

____ ____
____ ____
____ ____

Surgical History - Please List ALL Past Surgeries & What Year Performed:

____ ____
____ ____
____ ____

Allergies – Please List all Allergies and Reaction:

____ ____
____ ____
____ ____

First Name:_______________________ Last Name:__________________ Middle Initial:_____ Date of Birth:_____________________

Medications- Please List ALL Medications, Dose, Frequency and Reason:

____ ____
____ ____
____ ____
____ ____

Family Medical History:

Mother: __Alive __Deceased

____
____

Father: __Alive __Deceased

____
____

Sibling(s): __Alive __Deceased

____
____

Other (please list): ______________________________

____
____

Social History

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Occupation(s): *Please be specific about any occupations where you may have been exposed to hazardous materials*

____
____

Tobacco Usage: ☐ **Currently, Every Day** ☐ **Currently, Some Days** ☐ **Former** ☐ **Never**

Tobacco Amount Used/Day: ______________ Age Started: ___________ Age Stopped:_______

Alcohol Consumption: ☐ **Currently, Every Day** ☐ **Currently, Some Days** ☐ **Former** ☐ **Never**

Alcohol Amount Used: __________________, per ☐ **Day** ☐ **Week** ☐ **Month**

Type of Alcohol: ☐ **Beer** ☐ **Wine** ☐ **Liquor** ☐ **Multiple**

Illicit Drug Use: ☐ **Currently, Every Day** ☐ **Currently, Some Days** ☐ **Former** ☐ **Never**

Medicinal Marijuana: ☐ **Currently, Every Day** ☐ **Currently, Some Days** ☐ **Former** ☐ **Never**

Patient Policy Acknowledgement

Acknowledgement – Receipt of Patient Rights and Responsibilities

By my signature on page 3, I acknowledge receipt of the Patient Rights and Responsibilities, and have been given the opportunity to read it. I understand that this information is available to me upon my request.

Acknowledgement- Notice of Privacy Practices Receipt

By my signature on page 3, I acknowledge receipt of CiCC's Notice of Privacy Practices (HIPAA) and have been given the opportunity to read it. I understand that this information is available to me upon my request.

Appointment Policy

Please call us at (480) 374-7354 by 2:00 pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 pm on Friday. If prior notification is not given, you will be charged $50 for the missed appointment.

First Name:_______________________ Last Name:__________________ Middle Initial:_____ Date of Birth:______________________

Payment Policy

CICC is committed to providing you with the highest quality care. Please review our Payment Policy, should you have questions we will discuss prior to your exam. **Insurance:** We participate with plans, most insurance plans including Medicare. If you are not insured by a plan we are contracted with, payment in full is due at the time of your exam is performed. If you are insured by a plan we are contracted with, but do not have your insurance information, payment in full is due at the time your exam is performed. Once we obtain your insurance information, we will bill the insurance company 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 the time your exams are performed per your contract with your insurance company.

Non-Covered Services: In some instances, the services you receive may not be covered or not considered medically necessary by Medicare or other insurance companies. In these instances, you will be required to pay for these services in full at the time of your exam.

Proof of Insurance: We may require that we obtain 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 the balance of the claim.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get the claim paid.

Coverage Changes: If your insurance changes, notify us immediately to avoid problems with your claim being paid. By my signature below, I acknowledge CICC's Payment Policy. I hereby assign all insurance benefits to CICC for services performed

Non-insured patients: I agree that I am responsible for payment at the time of service, unless prior arrangements have been made.

Referral & Insurance Card Responsibility: I understand that during the check in process, if I do not have my referral and/or insurance card, I will be responsible for any payment rendered at the time of service.

Deductible/Coinsurance: I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible has been met, my coinsurance amount may be collected at time of service.

Non-covered procedures: I agree to pay for all non-covered services (preventative or routine) not covered by my insurance. **Collections:** Once an account is placed in collection status, all future services must be paid in full at the time of service. I understand that there will be a $25.00 fee for any returned checks.

Acknowledgement – Medical Record Request

By my signature below, I hereby authorize CICC to **obtain** and/or **disclose** my medical records for medical treatment purposes only to my physician(s), clinic, hospital, or to my insurance company without further written permission for continuation of care. Medical records request(s) up to 10 pages will be provided at no charge to the patient, request(s) larger than 10 pages may incur a fee.

General Consent and Right to Refuse Treatment

General Consent to Treatment: By my signature below, I (or my authorized representative on my behalf) authorize CICC and their staff to conduct any diagnostic examinations, 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 CICC'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 an orange background to be valid.

Patient or Authorized Representative Signature:____Date:_______