ALLIANCE MEDICAL CLINIC, LLC

NEW PATIENT REGISTRATION

Please circle one: Memory care Assisted living Independent living

Patient Name: _____ SSN#: _____
First Name MI Last Name

Date of Birth: ____/____/____ Male ___ Female ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Street Address with Apt/Unit # where the patient is living:

_____

City: _____ State: _____ Zip Code: _____ Home Phone: _____-_____-_____

Cell Phone: _____-_____-_____ Email for patient portal sign up: _____

Alternate Address with Apt/Unit # where statements should be sent:

_____

City: _____ State: _____ Zip Code: _____

POWER OF ATTORNEY:

Medical:_____Phone:_____

Financial:_____Phone:_____

PLEASE COMPLETE THE REQUESTED INFORMATION AND PRESENT INSURANCE CARD(S) FOR COPYING

Insurance Company: _____ Phone Number: _____-_____-_____

Primary Insured's Name: _____ Date of Birth: ____/____/____ Relationship: _____

Policy #: _____Group #: _____

Secondary Insurance Company: _____ Phone Number: _____-_____-_____

Primary Insured's Name: _____ Date of Birth: ____/____/____ Relationship: _____

Policy #: _____Group #: _____

Assignment of Benefits

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted. My signature below will bind me as though I personally signed the claim. **I understand that I am responsible for all charges not covered by my insurance.** If this account should be referred to a collection agency, I will be responsible for all collection and legal fees. I authorize the release of any medical or other information necessary to process my medical claims. I also authorize payment of government benefits either to myself or to the party who accepts assignment. I have read and understand the office policies and procedures.

_____ Date: _____

Patient or Responsible Party's Signature

ALLIANCE MEDICAL CLINIC, LLC

PATIENT AUTHORIZATION OF DISCLOSURE

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 of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that applies):

Home Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only

Cell Telephone: _____

- O.K. to leave message with detailed information
- Leave message with call-back number only
- Do not call me at my cell phone

_____ _____

Patient Signature/ MPOA **Date**

____ Patient refused to sign

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the physicians and staff at Ternion Physician Group may discuss your healthcare and scheduling needs as well as billing issues that may arise.

____ Only disclose information to myself

Name Relationship Phone Number(s)

_____

_____

_____

_____ _____

Patient Signature/ MPOA **Date**

Effective Date: April 14, 2005
Updated: March 20, 2009

ALLIANCE MEDICAL CLINIC LLC

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES NOTICE

I have had the opportunity to receive and/or review a copy of Alliance Medical Clinic, LLC's Notice of Privacy Practices that outlines how a patient's confidential information will be used, disclosed, and protected.

_____
Printed Patient Name or Responsible Party's Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but could not because:

- o Individual refused to sign
- o Communication barrier
- o Care Provided was emergent
- o Other

_____

_____

_____

_____ _____
Employee Name Date

Alliance Medical Clinic, LLC

CONSENT AGREEMENT
FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to _____ (referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

CCM Services include 24-hours-a-day, 7-days-a-week access to a healthcare provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.
When providing CCM Services, the Provider must:
• Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
• Provide to you a written or electronic copy of your care plan.
• If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Beneficiary Acknowledgment and Authorization.
By signing this Agreement, you agree to the following:
• You consent to the Provider providing CCM Services to you.
• You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
• You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
• You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights.
You have the following rights with respect to CCM Services:
• The Provider will provide you with a written or electronic copy of your care plan.
• You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally (by calling 623-271-8704) or in writing (to 42104 N. Venture Drive, Suite D118 Anthem, AZ 85086). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Beneficiary

Signature:_____

Print Name:_____

Date:_____

Beneficiary's Representative and/or Caregiver (if applicable)

Signature:_____

Print Name:_____

Date:_____

ALLIANCE MEDICAL CLINIC LLC
42104 N. Venture Drive
Suite D118
Anthem, AZ 85086
Tel: 623-505-6565
Fax: 623-551-5567

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient: _____

Date of birth: _____

Address: _____

I hereby authorize (physician/facility name) _____

Phone Number: _____

Fax Number: _____

Address: _____

to release the ***last three years*** of medical records (*no CD's*) via FAX/MAIL to Alliance Medical Clinic at 42104 N. Venture Dr., Ste. D118 Anthem, AZ. Fax 623-551-5567

*I hereby authorize the provider to release my protected health information to Alliance Medical Clinic, LLC. I understand that this authorization may cover information related to AIDS, HIV and other communicable diseases; genetic testing; psychiatric, mental and behavioral health and treatment; alcohol, drug and substance abuse treatment. I understand that I may revoke this authorization at any time by notifying the provider in writing. I understand that any disclosure made pursuant to this authorization before revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire 180 days following the date of my signature. I understand that a photocopy of this authorization is valid in lieu of the original. I understand I may refuse to sign this authorization and that my provider will not condition or deny treatment because of my decision.

Signed: _____ Date: _____

Health History Questionnaire

Social history:

Relationship status:_____

Exercise level:_____

Smoking status:_____ If yes how many years:_____ what year did you quit:____

Live alone or with others?_____

Able to care for self? YES / NO

Advanced Directive/ Living will? YES / NO

Alcohol intake: YES / NO How many drinks a week?_____

Caffeine intake? YES / NO How many cups daily? _____

Hard of hearing or uses hearing aids daily? YES / NO

Difficulty walking or climbing stairs? YES / NO

Uses a walker, cane or wheelchair? YES / NO

Family History: (Please list what family member had each condition**)**

Alcohol Abuse:_____

Alzheimer's Disease:_____

Cancer (which type):_____

Dementia:_____

Diabetes:_____

Heart Disease:_____

Hypertension:_____

Kidney Disease:_____

Osteoporosis:_____

Surgical history:

Please list all surgeries with approximate dates here:

_____

_____

_____

_____

Past Medical History: Please check all that apply

- ⬜ Allergies
- ⬜ Anemia
- ⬜ Anxiety disorder
- ⬜ Arthritis-Osteo
- ⬜ Arthritis- Rheumatoid
- ⬜ Asthma
- ⬜ Bladder/ kidney problems
- ⬜ Blood diseases
- ⬜ Breast cancer
- ⬜ COPD
- ⬜ Cancer
- ⬜ Chronic constipation/ IBS
- ⬜ Chronic headaches
- ⬜ Congestive heart failure (CHF)
- ⬜ Coronary artery disease
- ⬜ Depression
- ⬜ Diabetes
- ⬜ Ear/ hearing problems
- ⬜ Fibromyalgia
- ⬜ Heart disease
- ⬜ High cholesterol
- ⬜ Hypertension
- ⬜ Kidney disease
- ⬜ Kidney stones
- ⬜ Liver disease
- ⬜ Lung disease
- ⬜ Mental disorder/ Illness
- ⬜ Osteoporosis
- ⬜ Pulmonary embolism/ DVT
- ⬜ Reflux/Gerd
- ⬜ Seizures/ Epilepsy
- ⬜ Stroke
- ⬜ Hypothyroidism(underactive thyroid)
- ⬜ Hyperthyroidism (overactive thyroid)
- ⬜ Vision or eye problems

Please list any other past medical history here:

_____

_____

_____

_____

_____

Please list most recent immunizations:

TETANUS_____ Shingles/Zoster_____

INFLUENZA _____ TB skin test _____

Pneumonia_____ COVID-19_____

Routine screen checks:

Diabetic? YES/ NO

When was your last A1c?_____

When was your last foot exam?_____

When was your last eye exam?_____

Who was your eye exam done by?_____

When was your last mammogram?_____

When was your last colonoscopy?_____

When was your last Bone Density test?_____

When was your last Physical?_____

When was your last EKG?_____

Anything else we should know about you?

_____

_____

_____

Allergies to medications? Please list the medication and reaction:

_____

_____

_____

_____

_____

_____

Please list all medications, strengths, and how you take them daily. Please include all over the counter medications as well:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list what pharmacy you'd like for us to use:

_____