The Wellness Medical Clinic
1880 W Frye Road, Suite #1
Chandler, AZ 85224
Phone (480) 821-5500 -- Fax (480) 821-5502
www.primarycarechandler.com

Ammar Alsheikh, MD
Melissa L. Brown, FNP

Patient Information Sheet

Patient's Name : _____ **Today's Date**: _____
LAST **FIRST** **MIDDLE**

Social Security #: _____ - _____ - _____ **Date of Birth**: ____ / ____ / ____

Sex: Male / Female **Marital Status**: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Address:_____
STREET **CITY** **STATE** **ZIP CODE**

Primary Phone Number: (_____) _____- _____ **Alternative Phone**: (_____) _____-_____

E-mail Address: _____ **Student**: Yes / No **If YES**: Full-time/Part-time

How did you hear about our CLINIC?
( ) By Friend ( ) Insurance Company ( ) Doctor: _____ ( ) Advertisement ( ) Other : _____

Do you have a Primary Care Physician? Yes / No, **If YES**, which Dr? _____

Dr's Address: _____ Phone# _____

Fax# _____

Emergency Contact Information: In Case of Emergency please contact ……

Name: _____ **Phone:** _____

Address: _____**Relation to Patient:** _____

Employment Information:

Employer Name: _____ **Employer Phone #:** _____

Employer Address: _____**Position:** _____

Insurance Information:

Insurance Company's Name: _____ **Phone #:** _____

Policy Holder's Name: _____ **SSN:** _____

Policy # / Ins ID#: _____ **Group#:** _____

Insurance Address:_____

Policy Holder's Relation to Patient: ( ) Self ( ) Spouse ( ) Dependent ( ) Other

Do you have a SECONDARY insurance? Yes / No **If YES**, please fill out the following:

Insurance Company's Name: _____ **Phone#:** _____

Policy # / Ins ID#: _____ **Group#:** _____

Please provide your preferred pharmacy name and location

_____

_____

Name of Person Completing this Form: _____

Relation to Patient: _____

Signature of Person Completing this Form: _____

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I hereby authorize **The Wellness Medical Clinic** to leave a detailed voice message on my answering machine regarding any medical information they may have. The number (s) acceptable to leave a voicemail are:

Home Phone: _____

Cell Phone: _____

Alternative Phone: _____

Please provide us with the names of any person or persons are allowed to share your medical information with, otherwise we may not do so even with a spouse or relative without this authorization.

I hereby authorize:

_____

_____

_____

To receive any information concerning my medical condition or treatment at The Wellness Medical Clinic.

Patient Signature: _____

Date: _____

Patient's Printed Name: _____

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Appointment and Payment Policies

Thank you for choosing us as your Primary Care Provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1 **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have up-to-date insurance card, payment in full for each visit is required until we can verify you coverage. Knowing your insurance benefit is **YOUR** responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – off the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insures. You must pay for these services in full at the time of the visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **45 days**, the balance will automatically be billed to you.

7. Nonpayment. If your account is over **90 days** past due, you will receive a letter stating that you have **20 days** to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. The collection agency we work with has their own surcharges that would be added to your account balance if this were to happen, those charges would be the sole responsibility of the patient. You and your immediate family members may be discharged from this practice as well for nonpayment. If this is to occur, you will be notified by regular and certified mail that you have **30 days** to find alternative medical care. During that **30-day** period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge **$50.00** for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our areas.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guideline.

_____ _____

Signature of patient or responsible party **Date**

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2.It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, or U.S. mail; or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3.The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI, but must agree to abide by the confidentiality rules of HIPAA.

4.You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5.You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6.Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7.We agree to provider patients with access to their records in accordance with state and federal laws.

8.We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.

9.You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and an subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Patient Name	**Guardian / Support Role (if appropriate)**
_____	**Name**: _____
Date of Birth	**Relationship**: _____
_____	**Role: __ Next of Kin __ Guardian __ Caregiver**

Please provide as much detail as you are able so that we can give you the safest and best care possible.

What is the primary reason for your visit today?

_____

MEDICATIONS

Please list any medications you are taking, with dose and frequency.

Medication	**Dosage**	**#per Day**	**Do you need refills?**
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____
_____	_____	_____	Yes _____

Please list Vitamins, Supplements and Over the Counter Medicines

_____

_____

_____

ALLERGIES

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Please list any allergies and intolerances to medications.

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

Do you have an Egg, Neomycin or Gelatin allergy? **No**_____ **Yes** _____
Do you have an allergy to intravenous contrast? **No**_____ **Yes** _____

Please list any allergies to food or the environment.

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

___ Allergies	___ Blood Clots	___Gallbladder Disease	___ Heart Attack
___ Anemia	___ Cancer (type) _____	___ GERD – reflux	___ Osteoarthritis
___ Angina	___ Stroke	___ Hepatitis C	___ Ulcers
___ Anxiety	___ COPD	___ High Cholesterol	___ Thyroid Disease
___ Arthritis	___ Heart Disease	___ Hypertension	___ Kidney Disease
___ Asthma	___ Crohn's Disease	___ Irritable Bowel	___ Seizure Disease
___ Atrial Fibrillation	___ Depression	___ Liver Disease	___ Migraines
___ Prostate Enlargement		___ Diabetes (Type) ___	

Other medical problems:

_____

_____

_____

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SURGICAL HISTORY

What **surgeries** have you had? Please mark **all** that apply and include the year that were performed, if possible.

_____ Angioplasty _____
_____ Angio w/ Stent_____
_____ Appendectomy _____
_____ Arthroscopic Knee _____
_____ Back Surgery _____
_____ Heart Bypass _____
_____ Carpal Tunnel _____
_____ Cataract Extraction _____
_____ Gallbladder Removal _____
_____ Gastric Bypass _____
_____ Hernia Repair _____
_____ Knee Replacement _____
_____ LASIK _____
_____ Liver Biopsy_____
_____ Pacemaker _____
_____ Bowel Resection _____
_____ Thyroidectomy _____
_____ Tonsillectomy_____

Men Only:

_____ Prostate Biopsy _____
_____ Transurethral Resection _____
_____ Vasectomy _____

Women Only:

_____ Augmentation Mammoplasty _____
_____ Bilateral Tubal Ligation _____
_____ Breast Biopsy _____
_____ Cesarean Section _____
_____ Dilation and Curettage _____
_____ Hysterectomy _____
_____ Mastectomy _____
_____ Myomectomy_____
_____ Reduction Mammoplasty_____
_____ TAH/BSO _____
_____ Vaginal Hysterectomy_____
_____ Last Menstrual Cycle_____

Other surgeries:

_____

_____

Have you had any recent hospitalizations or ER visits?

_____

_____

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FAMILY HISTORY

Mother:
__ **Alive** __ **Deceased** (age at death) ____ **Cause of Death**_____

Medical Problems _____

Father:
__ **Alive** __ **Deceased** (age at death) ____ **Cause of Death**_____

Medical Problems _____

Siblings:
Number of Brothers ___ Medical Problems _____

Number of Sisters ___ Medical Problems _____

Children:
Number of Sons ___ Medical Problems _____

Number of Daughters ___ Medical Problem _____

Have any of the women in your family had a heart attack/heart disease at age 65 or younger?
No ____ **Yes** _____
Hany any of the men in your family had a heart attack/heart disease at age 55 or younger?

No ____ **Yes** ____
Any additional pertinent family history:

_____

_____

SOCIAL HISTORY

Marital Status _____ **Occupation** _____

Employer _____

Exercise? _____ No _____ Yes Type _____

Hours per Week _____

How many people other than you reside in your household?
_____ Spouse _____ Children _____ Grandparents _____ Other

Do you have advance directives?

_____

Do you have any religious beliefs that could affect your medical care?

_____

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TOBACCO/ALCOHOL/CAFFEINE/DRUGS

Please check your **current Tobacco** status. _____ **Current** _____ **Never** _____ **Former**

Do you use **Alcohol**? ___ **No** ___ **Yes**

Type _____ **Amount** _____ **Frequency** _____

Do you use **Caffeine**? ___ **No** ___ **Yes**

Type _____ **Amount** _____ **Frequency** _____

Do you use **Illicit Drugs**? ___ **No** ___ **Yes**

Type _____ **Amount** _____ **Frequency** _____

OTHER

Do you use contraceptives?
___ No ___ Yes Type: _____

Who is your **dentist**? _____

Telephone: _____

Do you have any dental/oral problems? _____

PREVENTIVE CARE HISTORY

INDICATE DATE OF YOUR LAST:

Tetanus Vaccine: _____ Colonoscopy: _____

Influenza Vaccine: _____ Stool Check for Blood: _____

Pneumonia Vaccine: _____ Prostate Check: _____

Shingles Vaccine: _____ Mammogram: _____

EKG/Heart Stress Test: _____ Pap Smear: _____

Chest Xray: _____ Bone Density/DEXA: _____

Visit with Eye Doctor: _____ Visit with Dentist: _____

In the past 2 weeks, have you had little interest or pleasure in doing things?
__ (0) Not at all __ (1) Several days __ (2) More than half the days __ (3) Nearly every day

In the past 2 weeks, have you been feeling down, depressed, or hopeless?
__ (0) Not at all __ (1) Several days __ (2) More than half the days __ (3) Nearly every day

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Consent for Release of Patient Medical Records

Upon change of physician we recommend that you have copies of your medical records transferred to our new provider of medical services. Having you complete medical history and pertinent records will be very valuable to your primary physician.

Please fill out the following:

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient/Parent/Guardian Signature: _____

Relationship to Patient: _____ **Next of Kin** _____ **Guardian** _____ **Caregiver**

_____ **Self**

Date: _____

This is a formal request for the following records (in regards to the patient above):

( ) All Available medical records

( ) Any records pertaining to the following information only:

_____

Clinic Name: _____

Physician's Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Please send records to:
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Fax: 480-821-5502