CHILDREN (0-17yrs)

PATIENT REGISTRATION FORM

Last First MI

Patient Name: _____

Ethnicity (circle): Hispanic or Latino | African American | White | Asian | Native American | Hawaiian | Other

Address: _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ SSN ____-____-____ Male or Female

DOB ____/____/____ Marital Status S M W D Preferred Pronouns _____

E-mail address _____ Driver's License _____

Preferred method of communication (circle one, two, or all three): Text | Phone | Email

Employer Name: _____ Phone (____) _____

Primary Insurance Information

Policy Holder Name _____ DOB ___/___/___ Relationship to holder _____

Address _____ City _____ State _____ Zip _____

Insurance Name _____ Policy# _____ Group# _____

Secondary Insurance Information

Policy Holder Name _____ DOB ___/___/___ Relationship to holder _____

Address _____ City _____ State _____ Zip _____

Insurance Name _____ Policy# _____ Group# _____

Emergency Contact

Name _____ Relationship _____ Phone (____) _____

If patient is a child, who may authorize treatment? _____ Phone (____) _____

I assign all medical and/or surgical benefits to which I am entitled, under any and all insurance, or any other health plan to Ponderosa Family Care. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, co-payments and annual deductibles. I have received my Medical Treatment Agreement. This includes my email and phone communication preferences as well as the Consent to Treat Agreement.

_____ _____

Signature of patient, parent, or legal guardian Date

How did you hear about us? _____ Friend _____ Internet _____ Facebook

Medical Treatment Agreement

Patient Name_____DOB_____

Patient or the patient's legal representative agrees to the follow terms of clinic encounters:

1. **MEDICAL TREATMENT**
   The patient consents to the treatment, services, and procedures which may include but are not limited to laboratory procedures, X-ray examinations, medical and surgical treatments, procedures, or anesthesia.
2. **TELEMEDICINE**
   The patient consents to medical visits via electronic platforms including but not limited to video and/or verbal communication using smart phones, tablets, laptops, computers, Teams, Google Meets, and all/any other types of electronic formats to communicate the patient's healthcare services.
3. **LEGAL RELATIONSHIP BETWEEN CLINIC AND HEALTHCARE PROVIDERS**
   The patient will be treated by his/her attending physician or health care provider and be under their supervision. Physicians and other healthcare providers providing services to the patient may include but are not limited to radiologists and pathologists who are generally not employees of the clinic. These providers may bill separately for their services. Questions about whether a healthcare provider is an agent or employee of the clinic should be directed to administration during normal business hours.
4. **TEACHING PROGRAM**
   The clinic participates in training programs for physicians and healthcare personnel. Some patient services may be provided by persons in training under the supervision and instruction of physicians or clinic employees.
5. **RELEASE OF INFORMATION**
   The patient acknowledges and agrees that medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED HEALTH INFORMATION) may be released to the following:
   a. Healthcare providers or their agents who are providing or have provided healthcare to the patient, any individual accrediting the facility or conducting utilization review quality assurance, or peer review and to the clinics and providers legal representatives and professional liability carriers.
   b. Individuals and organizations engaged in medical education and research, provided that information may only be released for the use in medical studies and research without patient identifying information.
   c. Individuals and entities as specified by federal and state laws and/or in the clinic's notice of privacy practices.
   d. Patient records of services provided at any time may be exchanged among these facilities where necessary to provide appropriate patient care. This release shall continue for so long as the medical and/or financial records are needed for any of the above stated purposes.
   e. This is an assignment of benefits and rights under my insurance. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company.
   f. Individual visit summary available upon request.
   g. Staff will return patient phone calls within 24 hours, Mon-Fri 8am-5pm. After hours and weekends contact the on-call provider.
   h. Refill requests take 3 business days. Please contact your pharmacy to request refills.

6. **CONTRABAND**
   Drugs, alcohol, weapons and other articles specified as contraband by the Clinic may not be brought onto clinic premises. Any illegal substances will be confiscated and turned over to Law Enforcement authorities.
7. **COMMUNICATION**
   _____OK to call my home and leave a message
   _____ call my home phone but DO NOT leave a message
   _____ DO NOT CALL MY PHONE, call only this number: _____
   _____ DO NOT speak to a family member
   _____ OK to send me my health information by encrypted email.
   I authorize the following individuals to inquire and receive verbal information regarding my care:

1. _____Relationship_____Phone_____
2. _____Relationship_____Phone_____
3. _____Relationship_____Phone_____

I have received the notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign the agreement.

Signature of Patient/Representative/Parent of a minor child **Date**

PATIENT NAME_____ DATE_____ DOB_____

Adolescent History (birth to 17 years of age)

Mother/Guardian:_____ Occupation:_____

Cell number_____ Work_____ Other_____

Father/Guardian:_____ Occupation:_____

Cell number_____ Work_____ Other_____

Child resides with/custody arrangement: _____

_____

Childcare:_____ Hours/day _____

Primary language:_____ Language spoken at home:_____

School:_____ Grade:_____ Do you like school?_____

Overall performance in school (circle one) Below grade level At grade level Above grade level

Any concerns with education or ability to learn? _____

_____

Does the child use/consume: ___ Tobacco Type:_____ Amount_____ Frequency_____

___ Alcohol Type:_____ Amount_____ Frequency_____

___ Caffeine Type:_____ Amount_____ Frequency_____

Are there smokers in the home? _____

Circle all that apply

Takes nap Sleeps with parents Sleeps through the night Minimum 8 hours of sleep Nightmares

Uses bike/skating helmet Car restraints (car seat, booster, seat belt)

Exercise/sports:_____ hours/day TV/computer games:_____ hours/day

Anything else you would like us to know about your child?

_____

_____

_____

_____

Ponderosa Family Care
Whole Person Family Care
Best of Care Regardless of Where
928-468-8603

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality health care. Please take your time to read our office policies and procedures. If you would like a copy one 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 an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments: All co-payments 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 from patients can terminate our contract with your insurance company, which will force you, the patient, to find a different doctor.

3. Non-Covered services: Please be aware that some - and perhaps all- of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurance companies. Take the time to review what your insurance policy will cover before making an appointment. You will be asked to sign a medical waiver before each procedure is done, regardless of your insurance coverage.

4. Proof of insurance: All patients must complete our patient information form before seeing the doctor; this must be filled out completely. We must obtain a copy of your current insurance card. Our new system will verify your insurance benefits, but it is your responsibility to verify that your insurance has eligible benefits to see your physician. If you fail to provide us with the correct insurance information, you will be responsible for the balance on your 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.

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 patient remainder balance is over 90 days past due, it will go to our collection agency, and you will be discharged as a patient from the practice. If this is to occur, you will be notified by 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 only.

8. Missed appointments: Our policy is to charge for missed appointments not cancelled within a 24 hour period before your scheduled appointment time. These charges will be your responsibility and billed directly to you. This office is very busy and has a high patient volume, when you miss your appointment without letting us know, it prevents us from giving your appointment time to another patient that is in need of a physician. Please help us to serve you better by keeping your regularly scheduled appointment. From time to time our office is forced to reschedule patient appointments, due to emergencies. We ask our patients to show compassion and understanding, when these situations arise.

9. New Software: We have made changes to our practice by changing medical software. The new software allows us to setup a patient portal. If you have an e-mail address, please provide this information to our front desk receptionist. She will set up a temporary password for you to join our patient portal. The patient portal will give you the opportunity to fill in your demographics, insurance information, and provide the doctor with your complete medical history, along with providing you the opportunity to view your labs, x-ray results, and visit summary, and see your latest statements and make payments. The patient portal is a vital tool, as it will provide you with a complete medical history. The information that you provide is imported into your medical chart, so your doctor can understand your medical problems. This also helps expedite the time you spend in the waiting room. You can update your demographics, insurance information and medical history at any time should any information change. When doing this you are providing your doctor with useful information regarding your medical health. Contact the front desk to have your patient portal enabled.

10. Prescriptions: We require a 72 hour window to fill all prescriptions. Make sure that when calling in to refill a prescription, you leave one clear and slowly spoken message with your name, the medication name, the pharmacy you prefer and your phone number. Be sure that you have at least one week of your medication left when you call in for refills. To expedite this process, please call your pharmacy and request the refill through them; if you do not receive your refill within the 72 hours, then please call our office.

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

Patient Name:_____ **Date:**_____

ALLERGY HISTORY

NAME_____DOB_____DATE _____

COMPLAINTS:
Please circle the appropriate number 0 to 3 according to severity: **0 = absent** (no symptoms evident) **2 = moderate** (tolerable)

1 = mild (symptoms present, but minimal awareness), **3 = severe**

Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Itching ears	0	1	2	3
Watery eyes	0	1	2	3	Sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Sensitivity to pet hair	0	1	2	3
Cough	0	1	2	3,	Itchy throat	0	1	2	3
Wheezing	0	1	2	3	Sinus pressure	0	1	2	3
Difficulty breathing	0	1	2	3	Sinus pain	0	1	2	3

Other symptoms causing you problems?
_____

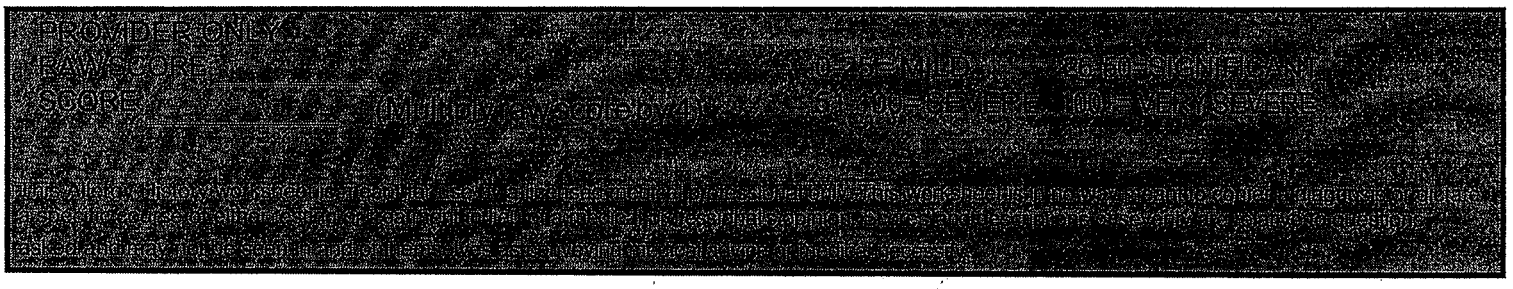
MEDICATIONS:
How often do you take medications for your allergy symptoms?
0 = never 1 = occasionally (several times a month or less) 2 = frequently (several times a week)
3 = daily

Antihistamines	0	1	2	3	Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids	0	1	2	3	Asthma medication (Inhaler, Singulair, Advair)	0	1	2	3
Eye drops	0	1	2	3	Other allergy-related medications _____				

Does any medication give you complete relief of symptoms? _____

GENERAL ALLERGY HISTORY:
How many months of the year do you have allergies?_____ How many years? _____

In what season are they worse (check all that apply): O Spring O Summer O Fall O Winter
Have you been allergy tested before? O Yes O No
If yes, which type: O Skin prick/Puncture O Blood draw
Have you previously received allergy shots?_____Allergy drops?_____If yes, when? _____
Do you smoke or use tobacco products? _____
List any animals you have in or around the home _____
Who else in your family has allergies? _____



Ponderosa Family Care

Patient Name:_____

DOB: _____

Advanced Allergy Care Questionnaire

Please Check Any Box That Applies

- ☐ History of anaphylaxis during allergy immunotherapy (allergy shots)
- ☐ Failed allergy immunotherapy in the past
- ☐ Hospitalized for allergies in the past year
- ☐ Steroid injection for allergies in the past 3 months
- ☐ Uncontrolled, severe asthma
- ☐ Heart failure
- ☐ Renal disease
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Untreated anxiety
- ☐ Severe, untreated depression
- ☐ Currently undergoing cancer treatment
- ☐ Pregnant
- ☐ Actively trying to get pregnant
- ☐ Taking immunosuppressant medication

For Office Use Only

☐ Referral to Specialist ☐ In-Office Treatment

Ponderosa Family Care

Rural Health Clinic

* Internal Medicine
* Pediatrics
* Family Practice
* Behavioral Health
* Wellness Center
* Nephrology
* Neurology

Alan P. Michels, MD
Medical Director and CEO

127 E. Main St, Ste D
and 806 South Ponderosa St.
Payson, Arizona 85541
ph. (928) 468-8603
fax. (928) 468-8625

ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

By reviewing and signing this form, you acknowledge that Ponderosa Family Care has given you the right to review and obtain a copy of the HIPAA privacy policies, which explain how your health information will be handled in various situations; if you would like to review the detailed form or obtain a copy, please see the receptionist.

"I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I choose to Opt Out."

If you want to Opt out, please see the receptionist for the paperwork to do so, otherwise you are automatically enrolled, which is a good thing!!!

Patient Signature

_____

Print name

_____

Date

_____