DATE:_____

PATIENT INFORMATION

Patient Name: First_____MI_____ Last_____

DOB:_____ Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated □ Life Partner

Parent / Legal Guardian Name if patient is a minor Name_____ DOB_____

Race: □ White □ Black/African American □ Asian □ American Indian/Alaska Native □ Native Hawaiian/Pacific Islander □ Declined
Ethnicity: □ Not Hispanic/Latino □ Hispanic/Latino □ Declined

Preferred Language: English_____ Spanish_____

Address: _____Apt # _____ City_____St_____Zip _____

Phone: Home_____Cell_____ Work_____

E-Mail_____

Is it ok to leave detailed results on voicemail? Yes or No

Employment Status: □ Full-Time □ Part-Time □ Unemployed □ Student □ Disabled □ Retired

Employer/School:_____

EMERGENCY NOTIFICATION

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

Name: _____ Relationship to Patient: _____

Phone: Home_____ Cell_____ Work_____

MEDICATION REFILL

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the physician will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request. **Initials** _____

Pharmacy Name_____ Address or Cross Street_____

Phone number_____

PRIVACY PRACTICES

Our office, physicians and staff, are committed to securing the privacy of your health making available to you a copy of our Notice of Privacy information.

Signature_____ Date: _____

FINANCIAL AND PAYMENT GUIDELINES

Notice: Our office does NOT file Auto Insurance claims for visits relating to motor vehicle accidents.

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance. If your insurance company requires a referral, it is the patient's responsibility (or guarantor) to obtain the referral prior to your appointment.

I understand that in the event I do not cancel my appointment within twenty-four hours of the scheduled appointment that the clinic may charge a cancellation fee. I authorize direct payment of my insurance benefits to Dr. Patricia R. Reiff for services rendered to myself or dependents.
Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information. Out of
Network services not paid by the health insurance company will be the responsibility of the patient or his/her guardian.
Dr. Patricia Reiff will provide medical information to the insurance company as required for payment of claims for services rendered.

Lab / Diagnostic Services:

I understand that I may receive a separate bill if my medical care includes lab, or other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance.

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

I consent to treatment necessary to the care which has been discussed and directed by the provider.
I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its intermediaries, its carriers, or any other insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
I further authorize and request that insurance payments be directed to Dr. Patricia R. Reiff

Authorization to Treat a Minor

☐ **Not Applicable (patient is an adult)**

(Ages 0-18th Birthday)

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize Dr. Patricia R. Reiff to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Dr. Patricia R. Reiff of changes or update. I authorize Dr. Patricia R. Reiff to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

I have read, fully understand and agree to the above **medication refill guidelines, financial responsibility statement, payment guidelines, consent for treatment** and release of **medical information & insurance authorization**. I also certify that all of the information, provided is complete and accurate.

Patient Name _____ Signature _____ Date_____

NAME:

PATIENT INFORMATION SHEET

ALLERGIES AND REACTIONS : _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____

_____

PERSONAL MEDICAL HISTORY:

_____

_____

Last Menstrual Date:
Period _____
Colonoscopy Yes/No Date:____ Results: _____
Dexa Bone Density Yes/No Date:____ Results: _____
Mammogram Yes/No Date:____ Results: _____
Pap Yes/No Date:___Results: _____

Surgical History: Please list all prior surgeries **WITH DATES**

_____

_____

Hospital Stays: Please only list if you stayed 2 or more days. **WITH DATES**

_____

_____

SOCIAL / CULTURAL HISTORY:

Education Level: □GED □ High School □ Some college □ Associates □ Bachelors □ Masters

Smoking/ Tobacco Use: □ Never □ Past □ Current (if current please fill out 1,2,3)

1. □ Everyday □ Some days How many a day? □ 5 or less □ 6-10 □ 11-20 □ 21-30

2. How soon after you wake up do you smoke? □ within 5 minutes □ 6-30 minutes □ 31-60 minutes □ after 60 minutes

3. Ready to quit ? □ YES □ THINKING ABOUT IT □ NO

Alcohol: □ Never □ Past □ Current Drinks/week: _____ How often did you have 6 or more drinks on one occasion in the past year_____

Recreational Drug Use: □ Current □ Past □ Never Type: _____

Are you sexually active? □Yes □ No With who? □ Men □ Women □ Both

Exposure to any chemical at work or home? □Yes □ No Where do you work? _____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Medical History:

_____

MOTHER: Living: Age _____ Deceased: Age _____

Medical History:

_____

NUMBER OF SIBLINGS:

___BROTHERS ____ SISTERS _____ ARE THEY HEALTHY?

NUMBER OF CHILDREN:

___SONS ____ DAUGHTER _____ ARE THEY HEALTHY? _____

PATRICIA R. REIFF, M.D., P.C.
1101 W. McDOWELL RD.
PHOENIX, AZ 85007

healthcurrent

Patient Notification Process

Date: _____

1. The Notice of Health Information Practices (The Notice) is very similar to the HIPAA Notice that is provided to every patient and should be provided to the patient at the same time.

2. Patient acknowledgment language: The following sample language in English or Spanish can be added to a provider's HIPAA Notice of Privacy Practices acknowledgement form, conditions of admission/treatment form, or a separate form that acknowledges the Provider participates in Health Current, Arizona's health information exchange (HIE).

   "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 complete and return an Opt Out Form to my healthcare provider."

   "Reconozco que recibí y leí el Aviso de Prácticas de Información de Salud. Entiendo que mi proveedor de salud participa en Health Current, el intercambio de información sobre la salud de Arizona (HIE – por sus siglas en inglés). Entiendo que mi información de salud puede ser compartida de forma segura a través del HIE, a menos que complete y regrese una Forma (Opt Out) sobre la opción de no participar del paciente a mi proveedor de salud."

3. The three forms that should be available to capture a patient request regarding The Notice are:
   a. **Opt Out Form** – documents a patient's decision to opt out of having his or her health information available in the health information exchange (HIE).
   b. **Opt Back In Form** – documents a patient's decision to opt back in to having his or her health information available in the HIE.
   c. **Health Information Request Form** – documents a patient's request to receive a copy sent via certified mail of his or her health information that is available in the HIE and/or a list of providers who have viewed the patient's information in the HIE.

4. Health Current can provide fillable PDF Forms and an instruction sheet to Providers to prefill the Provider Office Only section. It is essential the **Provider Office Only** section is completed at the bottom of these forms prior to sending via secure fax to ensure compliance with the patient's decision or request.
   Secure fax numbers: (602) 324-5596 or (520) 300-8364.

If you have questions, please see the FAQ's available at healthcurrent.org or email hiesupport@healthcurrent.org.

If you wish to opt out check this box ☐

Name: _____

X _____