

FINANCIAL POLICY

Please initial next to each paragraph to acknowledge that you have read and agree to the terms discussed

_____ I understand it is my responsibility to know my insurance coverage and network. I understand I am responsible to pay for any charges that could be denied or not covered by my policy. Any dispute for unpaid charges will be billed to the member. I understand in the event I'm entitled to health insurance benefits relating to my medical treatment, I hereby assign those benefits to this office and apply to my bill.

_____ I understand filing a claim is time sensitive (90 days) and it's my responsibility to provide the office with updated policy information, including keeping my Coordination of Benefits up to date or claims will be denied and I will be responsible. *The practice doesn't become involved in any disputes between the patient and the insurance company.*

_____ I understand I'm required to pay at the time of visit my portion according to my insurance, including co-pays, deductibles or co-insurance. Account balances, Aesthetic Services, B-12 injections, and Self-Pay visits are to be paid in full at time of service. *Returned checks will result in a fee of \$25.*

_____ I understand invoices are due immediately upon receipt. *Three statements will be mailed before being considered delinquent. After 60 Days the delinquent account will be turned over to an outside collection agency of our choice with or without notice. The patient/guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35% of the delinquent balance, such contingency fee to be added and collected by the collection agency immediately upon our referral of your account to them.*

_____ I understand it is my responsibility to arrive on time for my appointment and I may be asked to reschedule if more than 15 minutes late. If more than 3 appointments are missed without proper notice, you can be dismissed from our practice and/or charged \$25 for the missed appointment. *Please notify us 24 business hours in advance to cancel and/or reschedule your appointment.*

_____ I understand the Annual Wellness Physical is a preventative well visit, allowed once a year. This visit code does not cover being seen for a sickness, injury, etc. A separate visit charge will apply if time is spent outside the insurance guidelines of prevention.

_____ I understand my provider may order blood work or diagnostic images from an outside facility. I understand they are separate entities and billing is not associated with DC Ranch Family Medicine, PLLC. Nor does the practice have access to those billing statements.

I have read the Financial Policies and I understand these terms and agree to pay this account in accordance with the rates and payment terms of DC Ranch Family Medicine, PLLC.

Printed Guarantor Name

Patient Name if different

****Guarantor Signature:** _____

Date: _____

Acknowledgement Re: Notice of Privacy Practices AND Financial Policy:

I have been offered a copy of the Notice of Privacy Practices. I understand that DC Ranch Family Medicine, PLLC has the right to change its Notice of Privacy Practices and that I may contact DC Ranch Family Medicine, PLLC at any time to obtain a current copy. I have also read, understand, and agree to the provisions of the Financial Policy.

****Patient Signature:** _____ **Date:** _____

Authorization for Release of Health Information:

I hereby authorize the release any medical or incidental information to my referring physician or any other provider(s) who have been or may become involved with my care.

I hereby authorize the release of health information and record(s) of my visit(s) to my insurance company If needed in the processing of any insurance claim and/or other third parties responsible for payment of my medical charges.

I hereby authorize DC Ranch Family Medicine, PLLC and its Employees permission to discuss, send and/or receive my personal health information to/with the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand it is my responsibility to update any changes with the office about the above individuals

****Patient Signature:** _____ **Date:** _____

Please initial next to each paragraph to acknowledge that you have read and understand the following Office Policies:

_____ I understand medication refills are handled during normal business hours and not prescribed or refilled after hours.

_____ I understand the practice does not treat pain management or ADD and will refer me to another provider.

_____ I understand verbal abuse towards the office staff or providers will not be tolerated and I will be dismissed from the practice.

_____ I understand if I have a medical need after hours and can't wait until the next business day to immediately contact the E.R. or Urgent Care of my choice for immediate medical attention.

****Patient Signature:** _____ **Date:** _____

****Printed Signature Name:** _____



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Phone 480.800.3550 Fax 480.800.3551

Authorization for Request of Medical Information

TO: Provider/Facility _____

Street _____ City _____ State _____ Zip _____

Phone #: _____ Fax #: _____

I, _____, hereby request that you release the indicated medical records to DC Ranch Family Medicine, PLLC. The office of Dr. Arneyo Perez.

INFORMATION TO BE RELEASED: ***Do not send CD's larger than 3 MB**

Complete Records Other: _____

Patient Name (please print)

Date of Birth

Street _____ City _____ State _____ Zip _____

Patient/Guardian Signature _____

Date _____

MEDICAL HISTORY

Patient Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____ Hispanic or Latino Ethnicity? Yes No

Date of **Last Annual Physical**: _____

Do you have an **advance directive**? (Legal document specifying actions to be taken if you are no longer able to make those decisions due to illness or incapacity) Yes No

Drug Allergies: Yes No Drug: _____ Reaction: _____
 Drug: _____ Reaction: _____

Daily Medications: (include pain, herbal, vitamins, supplements & any over the counter medication)

Name	Dosage/Strength	Times/day	Month and Year Start Date

Have you had a **colonoscopy** or alternative test? Yes No Year _____ Results _____ Provider _____

Do you have **Diabetes**? Yes No Last A1C # _____ Monitoring Provider _____

Date of last **eye exam** _____ from the office of _____

Do you **use tobacco**? Yes No Quit Date _____ Use **e-cigarettes**? Yes No Quit Date _____

If Yes, how many per day? _____ How many years? _____ Interested in **Quitting**: Yes No

Do you **exercise**? Yes No How Often? _____ What type? _____

Do you drink **alcohol**? Yes No If yes, average consumption is _____ drinks per day week month

Do you experience **sadness** or have been **depressed** the past year? Yes No

Are you currently on any **hormonal** therapy? Yes No What type? _____

Are you **currently** sexually active? Yes No Birth Control Method _____

Do you have **children**? Yes No If yes, gender & age(s) _____

Do you have urinary **urgency**? None Mild Moderate Severe

Have you received the following **immunizations**?

Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Tetanus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
HPV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
MMR	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____
Hepatitis A/B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	DTaP/Tdap	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____

Surgical History including Cosmetic: (Type and date)

Please specify your current and past medical conditions:

- ADHD/ADD AIDS/HIV Anemia Arthritis Autoimmune Disorder
- Asthma Bladder Issues Blood Clots Cancer of _____ year _____
- Depression Diabetes Eating Disorder Fibromyalgia Gastro conditions
- Gout Heart Disease Hepatitis _____ High Cholesterol High Blood Pressure
- Hypertension Kidney Trouble Neurological Seizures Stroke
- Substance Abuse of _____ STD(s) _____ Thyroid Disorder Ulcers
- Stomach issues _____ Other _____

Family medical conditions; example - Diabetes, Hypertension, Heart Disease, Stroke, Mental Illness, Cancer

OF Father: _____ Alive Deceased

OF Mother: _____ Alive Deceased

OF Sibling: M F _____ Alive Deceased

OF Sibling: M F _____ Alive Deceased

OF Children: M F _____ Alive Deceased

OF Children: M F _____ Alive Deceased

Genetic Cancer Preliminary Screening:

Have you or a relative **aged 50 and under** been diagnosed with breast or ovarian cancer? Yes No

Has a family member been known to have the BRCA mutation? Yes No Unknown

Have you or a relative **aged 50 and under** been diagnosed with colon or uterine cancer? Yes No

Has a family member been known to have Lynch Syndrome Mutation? Yes No Unknown

FEMALES

When was your last Mammogram? Date _____ Imaging Facility _____ Results _____

What was the first day of your last period? Date _____ or _____ > 1 year

Are you pregnant and/or nursing? Yes No

Do you leak urine when you cough, sneeze, and/or laugh? Always Sometimes Never

Have you had vaginal rejuvenation treatments? Yes No What type? _____ How many? _____

Do you have a history of recurrent vaginal bacterial or yeast infections? Yes No How often? _____

Do you have a history of recurrent urinary tract infections? Yes No How often? _____

The last time you had sexual intercourse did you experience vaginal dryness, internal/external pain? Yes No