Westview Family Medicine
"We Care For Your Family"

Date _____ Name _____

Date of Birth _____ Sex: M F

Allergies	Reaction
1)	
2)	
3)	
4)	
5)	

Medications taken presently	Dose	Times/day
1)		
2)		
3)		
4)		
5)		

Past Medical History

- ☐ Diabetes
- ☐ Cancer _____
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Other heart trouble
- ☐ Asthma
- ☐ Pneumonia
- ☐ Stroke
- ☐ Epilepsy
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Chicken pox
- ☐ Valley fever
- ☐ Tuberculosis / (+) skin test
- ☐ Depression/anxiety
- ☐ Glaucoma
- ☐ Sexually transmitted disease
- ☐ Fractures _____

- ☐ Headaches
- ☐ Neck problems
- ☐ Back problems
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Esphogeal reflux (GERD)
- ☐ Kidney/bladder disease
- ☐ Hepatitis
- ☐ Peptic ulcer
- ☐ Appendicitis
- ☐ Other stomach/bowel disease

Immunizations:

- ☐ Polio vac (year) _____
- ☐ MMR vac (year) _____
- ☐ DPT vac (year) _____
- ☐ Chicken Pox Vaccine
- ☐ Flu Shot in last 12 months
- ☐ Pneumovax (year) _____
- ☐ Tetanus (year) _____
- ☐ Hep B vac (year) _____

- ☐ Pap (mo./yr.) _____
- ☐ Mammogram (mo./yr.) _____
- ☐ Prostate exam (mo./yr.) _____
- ☐ Colonoscopy (mo./yr.) _____

Specialists (seen regularly)

- ☐ Cardiologist _____
- ☐ Chiropractor _____
- ☐ Allergist _____
- ☐ Other _____
- ☐ Pulmonologist _____
- ☐ Other _____

(Females only) ☐ Menopause ☐ Tubal Ligation

full term pregnancies ____ # of premature deliveries ____

Cesarean sections ____ # vaginal deliveries ____

miscarriages/abortions ____

During pregnancy did you have: *(Circle all that apply)*
High Blood Pressure Diabetes
Pre-Eclampsia or Eclampsia

Current Method of Birth Control: *(Circle all that apply)*
Oral Contraceptives Condoms
Vasectomy (Male Partner)
Intrauterine Device (IUD) Abstinence

Surgical History

- ☐ Tonsillectomy
- ☐ Knee / hip surgery
- ☐ Shoulder surgery
- ☐ Heart bypass
- ☐ Back surgery
- ☐ Appendectomy
- ☐ Thyroid surgery
- ☐ Prostate surgery
- ☐ Cataract R(___) L(___)
- ☐ Breast surgery / biopsy
- ☐ Gallbladder surgery
- ☐ Hysterectomy
- ☐ Vasectomy
- ☐ Hernia repair
- ☐ C-section
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Family History

(Circle all that apply)

Mother	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Father	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Brothers	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Sisters	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Children	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Grandmothers	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Grandfathers	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____

Social History

Occupation _____ **Hobbies/Activities** _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Tobacco ☐ never ☐ now ☐ quit # per day_____ Year quit _____ Age started_____

Alcohol use: ☐ never or ☐ Liquor _____ per day / week / month
☐ Beer _____ per day / week / month
☐ Wine _____ per day / week / month

Rec. Drugs: ☐ never ☐ now ☐ in past

Have you had sex within the last twelve months (vaginal, oral, or anal)? Yes No **If yes, with:** Men Only Woman Only Both Men and Woman

Have you ever had a Sexually Transmitted Disease (STD)? Yes No **Are you currently using protection?** Yes No

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13065 W McDowell Rd, Ste #A105 Avondale, AZ 85392
8811 N 51st Ave, Suite 107 Glendale, AZ 85302
5133 N Central Ave, Suite 101 Phoenix, AZ 85012

PATIENT INFORMATION:

Last Name: _____

First Name: _____

Middle Name: _____

Address: _____

_____

City: _____

State, Zip: _____

Email: _____

[ ] Employed [ ] Retired [ ] Unemployed

Employer: _____

Employer Phone_____

Date of Birth: _____ Age: _____

Sex: [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Single [ ] Divorced

Social Security #: _____

Please Mark Phone Number to Contact First:

Phone: _____ [ ]

Phone: _____ [ ]

Pharmacy Name & Address: _____

_____

Pharmacy Phone: _____

Previous Primary Care:_____

INSURANCE INFORMATION:

Policy Holder:

[ ] Patient [ ] Other

Insurance Name: _____

Insurance Phone: _____

Claims Address: _____

Policy ID: _____

Relationship to Patient: _____

Policy Holder's Name: _____

Date of Birth: _____

Social Security #: _____

Policy Group: _____

Release of Benefits and Information: *I authorize direct payment of all benefits to Westview Family Medicine. I further acknowledge and understand that I am responsible for payment of all services rendered within a reasonable time. I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or the above information. Any portion not paid by the insurance; I agree to make payment arrangements for prompt payment. In the event my account is turned over for collections, I understand that I will be responsible for all collection costs.*

Patient Print Name: _____

Signature: _____ Date: _____ / _____ / _____

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Patient Financial Responsibility

As a courtesy to our patients, Westview Family Medicine, P.C. has enrolled in numerous managed-care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to notify our practice of any changes to name, address or phone number. It is the responsibility of each patient to know the details of his or her insurance plan in addition to any lapses in insurance coverage. Any charges that occur as a result of insurance plan restrictions or lapses in coverage are ultimately that patient's responsibility. If you do not inform us of special provisions that may be required by your plan and we order medically necessary services, such as lab work or supplies that are not covered by your plan; we may bill you directly for those charges. If current coverage cannot be verified prior to each appointment, payment will be due at the time of service. Payments of co-pay's are required prior to services being rendered and are not refundable. Any patient responsibility that is not paid within 90 days from the date billed may be assessed an interest charge of ***10%monthly***, for the total amount due until paid in full.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines, whenever possible. With your cooperation you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

To confirm your appointment, we will routinely attempt to contact you the day prior to any scheduled appointment. In return, we ask that you notify us of any cancellation. Westview Family Medicine, P.C. reserves the right to charge patients a ***$40.00 NO SHOW*** fee for any appointment broken without prior notification.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES AND I ACCEPT THE RIGHTS AND RESPONSIBILITIES AS DISCLOSED THEREIN:

- **Notice of Privacy Practice for Protected Health Information**
- **Patients' Rights Regarding Health Information**
- **Patient Financial Responsibility**
- **Cancellation Policy**

I hereby authorize this practice to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to this practice for any services rendered that are not paid for directly by me.

_____ _____

Patient Print Name Date

_____ _____

Signature Name/Relationship (If other than patient)

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Referral, Lab/Imaging result, and Refill Policy

Dear Valued Patients,

Your safety, treatment plan, and care are our greatest concern. In order to ensure you receive good quality care, please review the following:

Referrals:Your provider has determined that your medical condition requires a consultation with a specialist. We will process your referral within 24-72 hours. However, please note that some insurance companies require referrals to be submitted through the insurance companies and this process can take between **7-21 business days**.

Labs/Imaging: Upon receiving the results from the Laboratory and Radiology facilities, our office will review and inform you of your test results within 14 business days. If you **DO NOT** hear from our office within 14 business days after you have had labs or radiology performed, please call our office immediately. Laboratory and Radiology results can be lost during transmissions, mishandled by outside facilities, or not sent to our office at all. Please **DO NOT** assume that "everything is normal" if you do not hear from our office about your test results.

Prescription Refills: Please allow our office between 24-72 hours to complete all prescription refill requests. Refills of any narcotic prescriptions require an office visit based on federal guidelines. Please contact your pharmacy to send us an electronic request if you need medication refills. To provide you with high quality care, your provider may require you to have a physical examination yearly and follow up every **3 to 6 months** to manage your chronic conditions and to ensure that your current therapy continues to be appropriate.

By signing below, you are in agreement with the above policy.

Name: _____ Date of birth: _____
Signature: _____ Date: _____

Thank you to our valued patients and we look forward to caring for you and your family.

Regards,

Westview Family Medicine, P.C.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. You also have a right to restrict certain disclosures of your PHI to a health plan if you have paid in full out-of-pocket for the health care item or service.

Your health care provider is not required to agree to a restriction that you may request. If your health care provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare provider. If your health care provider does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for general notification purposes. You have the right to receive specific information regarding these disclosures that occurred after June 13, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this Notice of Privacy Practices from us. You have a right to obtain a paper copy of this Notice from us, upon request, even if you have agreed to accept this Notice electronically.

The signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Patient Print Name: _____

Signature: _____ **Date**_____

If the Personal Representative's signature appears above, please describe the Personal Representative's relationship to the patient.

Health current- Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care? In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current? The following types of health information may be available: • Hospital records • Medical history • Medications • Allergies • Lab test results • Radiology reports • Clinic and doctor visit information • Health plan enrollment and eligibility • Other information helpful for your treatment

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and declined another copy.

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)

Tôi đã nhận và đọc nội dung về trao đổi thông tin sức khỏe. Tôi hiểu rằng bác sĩ gia đình của tôi tham gia vào chương trình trao đổi thông tin sức khỏe của Arizona (HIE). Tôi hiểu rằng thông tin sức khỏe của tôi được chia sẽ bảo mật qua hệ thống (HIE), ngoại trừ trường hợp tôi ký giấy yêu cầu không chia sẻ thông tin.

Patient Print Name: _____

Signature: _____ **Date**_____

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Annual Wellness Exams and Copay Agreement:

While most plans do offer a zero co-pay on all Wellness and Preventive Exams, any services intended to diagnose, treat or monitor an illness or injury is not considered preventive. Therefore, I understand I will be held responsible for my insurance carrier's copay, coinsurance, and deductible.

By signing, I fully understand that if I choose to discuss other issues in my annual wellness office visit, I will be subject to my copay set forth by my insurance carrier.

Patient Print Name: _____

DOB:_____

Signature: _____

Date: _____

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Patient Name: _____ **Date of Birth**: _____

TEST RESULTS RELEASE AND CONSENT

[ ] I give consent to Westview Family Medicine, P.C. to release any lab or radiological test results or any imperative information to:

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

Should we contact the above-named person(s) instead of calling you directly? [ ] Yes [ ] No

[ ] I prefer a message on my phone #: _____

[ ] I give consent to WVFM to release pertinent information to me via US mail to my address on file.

[ ] I DO NOT consent to have my test results given to anyone other than myself.

ADVANCED DIRECTIVE

[ ] Yes, I do have an advanced directive, and I have a copy of it.

[ ] Yes, I do have an advanced directive, but I do not have a copy of it.

[ ] No, I do not have an advanced directive, and I would like more information.

[ ] No, I do not have an advanced directive, but I do not need information.

EMERGENCY CONTACTS

First Name: _____ Last Name: _____ Relation: _____

Home Phone #: _____ Cell Phone: _____ Work Phone: _____

First Name: _____ Last Name: _____ Relation: _____

Home Phone #: _____ Cell Phone: _____ Work Phone: _____

Signature: _____ Date: _____

Patient Portal Authorization Form

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Update your contact information
- Request an appointment
- View and Request a Referral
- Request prescription refills
- View your visit summary, medication list, treatment history and visitation dates
- Receive education material pertaining to your last office visit
- View and pay your bill

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when you are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill on medication not currently being prescribed by a **Westview Family Medicine**

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 10 failed log-in attempts before the account is locked
- You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, and when your visit summary is available to view.
- You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
- If you forget your password you may request another one through Patient Portal by clicking on the **"Forgot Password" link**.
- After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However, if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
- Our hours of operation are 7:00 am - 5:00 pm Monday-Friday. We encourage you to use the web site at any time; however, messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- We reserve the right to suspend or terminate the patient portal at any time and for any reason.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer. Our Patient Portal site may be accessed by two different URL's:

Our Website: **www.westviewfamilymedicine.com**

Patient Portal site: *https://mycw45.eclinicalweb.com/portal5126/jsp/100mp/login_otp.jsp*

Patient Portal Authorization Form

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years.

Name of Parent/Guardian requesting access:

_____

Last Name Middle Initial First Name

_____

Relationship to the Patient Date

WESTVIEW FAMILY MEDICINE POLICIES

APPOINTMENT NO-SHOW, SAME DAY CANCELLATIONS, LATE APPOINTMENTS

- There will be a **$40.00 fee** for each no-show appointment.
- Appointments that **are not** canceled within 24 hours **will** be charged a **$40.00 fee.**

LATE APPOINTMENTS- EACH PROVIDER SCHEDULE VARIES

- If your appointment is scheduled within the first 3 hours of the morning or the afternoon **(depending on each provider's schedule)**, you will have a **15–25-minute** grace period. **Past** the **15–25-minute grace period**, your appointment will be rescheduled if you are late for your appointment.
- If your appointment is scheduled for the ***last*** appointment of the morning or the afternoon there will **not** be a grace period allowed, and your appointment **will** be rescheduled if you are late for your appointment.
- If you have any questions regarding these policies, please feel free to ask our front office staff.

ACCOUNT BALANCES & COLLECTIONS

- Balances on accounts will be collected at the time of service.
- **Reminder: all copays and deductibles are due at the time of service. No exception.**
- There will be a **25%** collection fee **(on top of balance)** on all accounts that have been sent to collections. **The total balance will be collected at the time of service. No exception.**

ONSITE LABORATORY SERVICE

- As a courtesy to our patients, each of our office locations is provided with an onsite laboratory, performed by a third-party vendor, such as Sonora Quest or LabCorp. Westview Family Medicine is not related to Sonora Quest or LabCorp and does not submit claims or collect fees on their behalf. Any questions regarding laboratory billings must be directed to either Sonora Quest or LabCorp.

DIAGNOSTIC IMAGING/ LABORATORY ORDERS

- To properly diagnose and treat your health conditions, our Providers may give you orders for diagnostic imaging or laboratory studies to be performed by a 3rd party vendors such as Simon Med Imaging, Banner Medical Imaging, Sonora Quest or LabCorp. Westview Family Medicine **does not** verify coverage, submit claims or collect payments on imaging and laboratory studies provided by third party vendors. If you have any billing questions regarding these imaging and laboratory studies, please contact the 3rd party vendors directly.

Patient Print Name: _____

DOB:_____

Signature: _____Date: _____

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize:

Facility Name: _____

Facility Phone: _____

Facility Fax: _____

to disclose the following information from the health record of:

Patient Name: _____ DOB: _____

Phone: _____

Dates of service (if applicable) from: _____To: _____

Information requested**:**

○ Entire Medical/Clinical Record ○ Assessments/Visit Notes ○ Discharge Summary ○ Lab Reports	○ X-ray Reports ○ Operative Report ○ Specify, if not listed:

Release to: WESTVIEW FAMILY MEDICINE, P.C. FAX 623-536-9288

I understand the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes the release of photocopies of all medical records, unless otherwise indicated in writing.

I understand that I may revoke this authorization at any time except to the extent that actions based on this authorization have already been taken. The Notice of Privacy Practices explains the process of revocation, which includes a request in writing. This authorization will expire automatically six months from the date signed. I understand that there is no charge when medical records are mailed directly to a medical provider for continuation of care. I also understand that there is a charge when records are mailed to any party other than a medical provider.

Signature of Patient or Guardian: _____ Date: _____