Thank you for choosing me as your primary care physician. I am Board Certified in Internal Medicine and Pediatrics. I see my own patients at Banner Baywood Medical Center and Banner Heart Hospital. I work closely with several home health agencies, have privileges at Mi Casa Skilled Nursing Facility, and am a Medical Director at AdvisaCare Hospice. I take Medicare, most Medicare Advantage Plans, supplemental plans, commercial plans and AHCCCS plans.

I have a full-time Physician Assistant on staff and patients are expected to see the PA when I am not available. However, all patients must be seen by me every third visit, or a minimum of once a year.

RUNNING LATE – I RUN LATE. While I understand your time is valuable, this is something that cannot be helped in an internal medicine practice where I see my own hospital patients. I will never rush a patient to stay on schedule. While I may run late, the staff must stay on schedule when rooming patients. If you arrive late and I have moved past your appointment time, you will need to be rescheduled.

PATIENT PORTAL – We offer a patient portal for communicating with office staff. If you need assistance setting up the portal, our front office staff will be able to help.

INSURANCE – You must present your insurance card at each visit and pay any copay or remaining deductible at the time of your visit.

PATIENT PHOTO – Patient photos are required to have a photo taken for your chart.

MEDICATION PRIOR AUTHORIZATIONS - Depending upon your insurance, certain medications may require prior authorization. If an appropriate alternate medication is available, it will be substituted; if not, and a prior authorization is needed, an appointment will be necessary to document its medical necessity and submit the prior authorization.

TESTING RESULTS – Any labs or testing ordered will require a follow-up appointment to discuss results.

REFERRALS – Requests for new referrals require an appointment. We use a centralized referral system to locate specialists who take your insurance. If a referral is rejected by the specialist, you must contact your insurance company for the name of an in-network specialist, and a new referral will be processed. Please allow 3 days for a referral to be submitted.

PRESCRIPTION REFILLS – All prescriptions are sent electronically. We do not respond to faxed requests. All patients on chronic medications require an appointment a minimum of every six months.

CONTROLLED SUBSTANCES – All Schedule 1, 2 and 3 controlled substances require an in-office monthly appointment. At the time of your appointment your next monthly appointment must be scheduled. Failure to schedule your next appointment will not guarantee that you can be seen before you run out of your medication. A maximum of two telehealth appointments will be allowed each year to accommodate special circumstances.

MEDICAL RECORDS – There is a $25 fee for copying medical records unless the request is made by another physician for continuity of care. All records will be supplied in CD format and will be completed within 7-10 business days.

FORMS – Forms to return to work, FMLA paperwork, school physicals, disability paperwork, etc. Requires a separate visit to address the paperwork and cannot be combined with other appointments. Please allow 7 business days for final completion of the form. If an exception is made and the form is completed outside of a visit, the charge for simple forms is $25 fee and for more complicated forms (more than 3 pages) the fee is $60.

BILLING – We use a third-party billing service. For billing questions please call 602-314-3836.

TELEPHONE – All messages are triaged throughout the day and returned in order of importance. Any message left before 4P will be returned before close of business. Calling multiple times without leaving a message or leaving multiple messages will only delay our response time. Our on-call physician can be reached after hours for emergent clinical matters only.

Patient Signature: _____ Date:_____

NEW PATIENT PACKET

PERSONAL INFORMATION

Name	DOB
Address	Social Security #
City State Zip	Marital Status
Phone	Race
Winter Visitor ☐ Yes ☐ No	Ethnicity
Address #2	Is Interpreter Needed ☐ Yes ☐ No
City State Zip	Language
Phone #2	Occupation
Emergency Contact:	
Name	Phone
Relationship to Patient	

INSURANCE INFORMATION

☐ I DO NOT HAVE INSURANCE. I understand that all fees must be paid at the time of service.

PRIMARY INSURANCE	MEMBER ID	GROUP ID	POLICYHOLDER	POLICYHOLDER DOB
SECONDARY INSURANCE				
RX (PART D) INSURANCE				
MEDICARE (Required if on Medicare Advantage Plan)				

Patient Name _____ DOB _____

PERSONAL HEALTH HISTORY AND HEALTH RISK ASSESSMENT

Primary Concern for this appointment: _____

Allergies/Medication Reactions

Type of Allergy or Medication	Describe Reaction

Current Medications – or attach copy of current med list

Medication/Strength (ex: lisinopril 10 mg)	*Dosing (ex: 1 tablet daily)*	*Reason (ex: high blood pressure)*

Other Healthcare Providers – List all healthcare providers who have treated you in the last 3 years:

Name of Provider	*Specialty*	*City, State & Phone*	*Condition Treated & When*

Previous Hospitalizations and Surgeries:

Name of Provider	*Hospital*	*City, State & Phone*	*Condition Treated & When*

Family History – Please check all that apply and give the relationship to family member

☐Osteoarthritis	☐Heart Attack
☐Rheumatoid Arthritis	☐Hypertension
☐Asthma	☐High Cholesterol
☐Blood Clots	☐Lupus
☐Breast Cancer	☐Stroke
☐Colon Cancer	☐Thyroid Problems
☐Skin Cancer	☐Cystic Fibrosis
☐Depression	☐Other
☐Diabetes	☐Other

Patient Name _____ **DOB** _____

Caffeine, Alcohol, Tobacco and Drug Use **– *Do you use any of the following:***

Caffeine ☐Yes ☐No If yes, how many caffeinated beverages to you drink daily? _____
(example: 2 regular cups of coffee daily)

Alcohol ☐Yes ☐No If yes, how much and how often do you drink alcohol? _____
(example: 2 4-oz glasses of wine weekly)

Tobacco ☐Yes ☐No ☐Former tobacco user If yes, or former tobacco user, please answer the following:

When did you quit using tobacco and for how long did you use?	
Type of tobacco (cigarettes, cigars, snuff, chew)	
How long have you been smoking?	
How much and how often do you smoke? (example: one pack/day)	

Drugs ☐Yes ☐No ☐Former drug user If yes, or former drug user, please answer the following:

When did you stop using drugs and for how long did you use?	
Type of drug (IV, marijuana, cocaine, crystal meth, opioids)	
How long have you been using drugs?	
How much and how often do you use drugs?	

HIV/AIDS Risk **– *Please answer the following questions:***

Have you ever had a blood transfusion?	☐YES	☐NO
Have you used intravenous drugs within the last 10 years?	☐YES	☐NO
Have you engaged in unprotected sex within the last 10 years?	☐YES	☐NO
Have you had multiple sexual partners in the last 10 years?	☐YES	☐NO

Patient Name _____ **DOB** _____

Other Health Behaviors

Do you do self-breast/testicular exams?	☐YES	☐NO
Do you wear your seatbelt regularly?	☐YES	☐NO
Do you wear sun protection regularly?	☐YES	☐NO
Do you have annual vision exams?	☐YES	☐NO
Do you have regular dental exams?	☐YES	☐NO
Do you exercise regularly?	☐YES	☐NO
Do you have a smoke detector in your home?	☐YES	☐NO

Psychological History **- *Please indicate if you now have, or in the past have ever, experienced the following:***

C = CURRENT P = PAST N = NEVER

Depression _____ Mania/Psychosis _____ Sexual Abuse _____ Physical Abuse _____
Suicidal/Homicidal Thoughts _____

Patient Name _____ DOB _____

System Review *– Please check any symptom you currently have or that has been a recurring problem*

General	Skin/Integument	Head and Neck	Gastrointestinal
☐Dizziness	☐Bruising	☐Blurred Vision	☐Abdominal Pain
☐Excessive Thirst	☐Eczema	☐Dental Pain	☐Black/Tarry Stools
☐Fainting	☐Hives	☐Double Vision	☐Bloating/Gas
☐Fatigue	☐Itchiness	☐Ear Ringing	☐Blood in Stool
☐Fever	☐Rash	☐Eye Infections	☐Change in Bowels
☐Sleep Problems	☐Moles	☐Eye Pain/Floaters	☐Constipation
☐Weight Gain	☐Psoriasis	☐Jaw Pain	☐Diarrhea
☐Weight Loss	Cardiac/Circulation	☐Hay fever	☐Difficulty Swallowing
☐Mood Swings	☐Angina	☐Head Injury	☐Heartburn
Nervous System	☐Chest Pain	☐Hearing Loss	☐Loss of Appetite
☐Anxiety/Nervousness	☐Chest Pressure	☐Hoarseness	☐Painful Swallowing
☐Chronic Pain	☐Chest Tightness	☐Mouth Sores	☐Persistent Nausea
☐Depression	☐Irregular Pulse	☐Neck Pain	☐Vomiting
☐Knocked Unconscious	☐Leg Pain (Walking)	☐Swollen Lymph Nodes	
☐Memory Loss	☐Murmur	☐Neck Swelling	Muscular Skeletal
☐Mental Illness	☐Palpitations	☐Nosebleeds	Joint Pain
☐Numbness/Tingling	☐Swollen Ankles	☐Sinus Infections	Muscle Weakness
☐Phobias	☐Varicose Veins	☐Sore Throat	Joint Swelling
☐Seizures	Genitourinary	Do You Wear/Use	Joint Deformity
☐Tics	☐Blood in Urine	☐Dentures	Muscle Wasting
Pulmonary	☐Genital Discharge	☐Glasses/Contacts	Muscle Pain
☐Blood in Sputum	☐Sexual Dysfunction	☐Hearing Aid	
☐Cough	☐Decrease urine control	☐Cane	Other
☐Wheezing	☐Painful Urination	☐Walker	
☐Shortness of Breath (Lying)	☐Decrease Urine Stream	☐Wheelchair	
☐Shortness of Breath (Exertion)	☐Blood in Urine		
☐Shortness of Breath (Resting)	☐Increased urinary frequency		

Patient Name _____ DOB _____

Past Medical History – Please check all that apply and give date condition began

☐Allergies	☐Bleeding Disorder	☐Constipation
☐Anemia	☐Blood Clots	☐Crohn's Disease
☐Anxiety/Depression	☐Cancer: Type	☐Diabetes
☐Arthritis - Osteo	☐Cataracts	☐Eating Disorder
☐Arthritis - Rheumatoid	☐Chronic Back Pain	☐Emphysema
☐Asthma	☐Chronic Bronchitis	☐Fibromyalgia
☐Atrial Fibrillation	☐Chronic Diarrhea	☐Gallstones
☐Angina	☐Colon Polyps	☐Gout
☐Headaches	☐Hearing Loss	☐Heart Failure
☐Heart Attack	☐Heartburn	☐Hemorrhoids
☐Hepatitis	☐High Cholesterol	☐HIV/AIDS
☐Hypertension	☐Kidney Stones	☐Kidney Failure
☐Lupus	☐Mental Illness	☐Ovary Problems
☐Pancreatitis	☐Pneumonia	☐Poor Circulation
☐Prostate Problems	☐Psoriasis	☐Rheumatic Fever
☐Seizures	☐Sexual Dysfunction	☐Shingles
☐Skin Lesions	☐Stomach Ulcers	☐Stroke
☐Testicular Problems	☐Thyroid Disease	☐Tuberculosis
☐Ulcerative Colitis	☐Valley Fever	☐Vision Problems
☐Other:	☐Other:	☐Other:

FOR FEMALES ONLY – Gynecologic History

Age at onset of menses	Miscarriages
Length of monthly cycle	Abortions
Length of menstruation	Menopause was ☐natural ☐surgical
Date of last menstrual period	Date of last pap smear
Cycle is regular irregular	Was pap normal abnormal
Flow is light moderate heavy	Date of last mammogram
Number of pregnancies Live Births	Was mammogram normal abnormal

Patient Name _____ **DOB** _____

PREVENTATIVE SCREENING

Type of Screening	*Location*	*Date of*
Colonoscopy		
Cologuard		
FOBT		
Mammogram		
DEXA (Bone Density)		
PAP		
PSA & digital rectal exam		
ECHO		
CT cancer screening		
Diabetic eye exam		
PFT (Spirometry) (for patients with COPD)		
NIOX (for patients with asthma)		
Cognitive Testing (for patients with memory concerns)		
Chest x-ray		
EKG		
AAA		
Treadmill Stress Test		
ABI		
Cardiac Catherization		
Cholesterol Lab		

IMMUNIZATIONS

Vaccine	*Date(s) Given*	*Where Given*
Flu		
Pneumonia PPSV23		
Pneumonia PCV13		
Pneumonia PCV15		
Pneumonia PCV20		
Tdap (Tetanus)		
Shingles		
RSV		
COVID-19 (last date received)		
Hep A		
Hep B		

HIPAA & Privacy Guidelines

Patient Name: _____ Patient Date of Birth: _____

What is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) was passed to protect the confidential medical and billing records of our patients. A particularly important element of HIPAA regulation pertains to the patients' rights related to access and control of their medical information. We count on all members of Gerard B Chamberlin, MD MPH PC to incorporate the HIPAA rules into their daily activities. Our patients have a right to privacy. We are committed to complying with HIPAA, not only because it is the law, but also because we value our patients and their privacy.

The Privacy Rule (45 CFR Part 160 and Subparts A & E of Part 164) provides the first comprehensive Federal protection for the privacy of health information. All segments of the health care industry have expressed support for the objective of enhanced patient privacy in the health care system. The Privacy Rule, as modified, is carefully balanced to provide strong privacy protections that do not interfere with the patients access to, or the quality of, health care delivery.

Acknowledgment of Notice of Privacy Practices:

I acknowledge, by signing below, that a copy of this office's Notice of Privacy Practices is available to me that outlines how a patient's confidential information will be used, disclosed, and protected.

Acknowledgement of Notice of Health Information Practices:

I acknowledge receipt and have read and understand the Notice of Health Information Practice regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Consent For Electronic Medication History Download

I give Gerard B Chamberlin, MD MPH PC, the PLC and its employees' permission to download my electronic prescribing history, into our electronic health record, when available, for the purpose of improved clinical care. This information will be included in the permanent medical record and will only be shared with the persons, groups, or affiliations that have legal access to the patient's medical record. This information will help us avoid potential drug-drug interactions, prescribe appropriate medications and take better care of our patients. Policies and Procedures related Health Insurance Portability and Accountability Act (HIPAA), which safeguards medical information, will be maintained.

Is this patient a Minor (under 18 years of age)? [ ] YES [ ] NO

Is the patient a legal dependent (over 18 years of age, however, legally a dependent)? [ ] YES [ ] NO

_____ _____

Patient Signature (if minor or adult dependent – Parent Legal Guardian) Date

_____ _____

Relationship to Patient if patient is a minor or adult dependent (documentation may be requested) Date

Patient Name _____ DOB _____

PROTECTED HEALTH INFORMATION (PHI) COMMUNICATION AUTHORIZATION

I hereby give permission to receive voicemail messages containing the following information:

☐Appointments/Scheduling ☐Notification that test results are available ☐Test results

I hereby revoke all prior PHI authorizations and give permission to the person(s) listed below to discuss my protected health information (PHI) as it relates to my care or treatment. NOTE: This permission does not authorize the person(s) listed below to make health care decisions for the patient or entitle them to paper or electronic copies of the patient's medical records.

We will NOT release via telephone or other means of communication any information to friends or family members that are not listed below, unless the patient has been given the opportunity to object to such release of PHI, unless it is reasonable to infer that patient does not object (as when patient brings a spouse or others into the exam room when treatment is being discussed). The only EXCEPTION is when the provider deems it necessary in an emergency.

Name	Phone Number	Relationship

_____ DATED _____

Signature of Patient or Guardian

Patient Signature: _____ **DOB:** _____

MEDICAL RECORDS REQUEST

(this section to be completed by provider as needed)

Patient: _____ **DOB:** _____

To: _____ **FAX:** _____

Complete Medical Records	Progress Notes
Last 3 Visit Notes	Imaging/X-Results
Lab Results	Other

Notes:

Please FAX or mail records to:

FAX: 480-930-4615
Gerard B Chamberlin, MD MPH PC
6242 E Arbor Avenue, Suite 123
Mesa, AZ 85206
Phone: 480-930-4600

(Patient Authorization – to be signed by patient)
(to be signed by patient – a copy is as valid as an original)

Patient or Guardian Signature: _____
If Guardian, relationship to patient _____