Dear Patient,

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

Below is a list of office policies that are mandatory for me to be able to meet your healthcare needs.

RUNNING LATE. I run late. While I understand your time is valuable, this is something that cannot be helped in an internal medicine practice. I will never rush a patient to stay on schedule.

PATIENT PORTAL. We offer a patient portal for communicating directly with me. Our front office will assist you in setting up this portal.

PATIENT PHOTO. A current photo (not a driver's license photo) must be on file.

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

MEDICATION PRIOR AUTHORIZATIONS. If a prior authorization is submitted for a medication and is denied, an appointment is necessary to discuss alternative medications.

TESTING RESULTS. Any labs or testing that is ordered requires a follow up appointment to discuss results.

REFERRALS. Requests for referrals require an appointment. While we use a centralized referral system, sometimes the information has not been updated by the specialist(s). When scheduling, please confirm that the specialist is on your plan and if not, please contact your insurance for the name of a specialist that is on your plan and a new referral will be processed.

PRESCRIPTION REFILLS. All patients on chronic medications require monitoring every 6 months. All refills other than short-term prescriptions and controlled substances are refilled for 180 days so you should not run out of medications before your next appointment. All prescriptions are sent electronically, and we do not respond to faxed requests from your pharmacy. All controlled substances require an appointment every 30 days without exception.

MEDICAL RECORDS. Please allow 7-10 days for medical records requests. There is a $25 fee for copying medical records unless they are requested by another physician for continuity of care.

FORMS. Completion of forms to return to work, FMLA paperwork, school physicals, disability paperwork, etc. require a clinical visit to address the paperwork and cannot be combined with other appointments. The paperwork will then be completed within 7 business day. The charge for simple forms is $25 and more complicated forms (more than 3 pages) is $60.

TELEPHONE. Phone calls made to the office before 4P are returned by close of business. All calls are triaged throughout the day so please leave a message rather than calling multiple times. Our on-call physician can be reached after hours for emergent clinical matters only.

BILLING. Please be aware that we use a third-party biller and any questions regarding your bill should be directed to Unislink at 602-314-3836.

Thank you for your cooperation.

_____ DATED: _____

Signature of Patient/Guardian

NEW PATIENT PACKET

PERSONAL INFORMATION

Name	DOB Social Security #
Address	☐Married ☐Single ☐ Divorced ☐Widowed
City State Zip	Gender ☐Male ☐ Female
Primary Phone	Race Ethnicity
Secondary Phone	Occupation
Email	Emergency Contact Name
Secondary Address Winter Visitor ☐YES ☐NO	Relationship ☐Spouse ☐Child ☐Other:
City State Zip	Phone

INSURANCE INFORMATION

☐**I do not have insurance.** I am a self-pay patient and understand that ALL fees are due at the time of service.

Primary Insurance	**Secondary Insurance**	**Prescription Insurance**
Company	Company	Company
Policy #	Policy #	Policy #
Group #	Group #	BIN #

If you are not the policy holder, please provide the policy holder's information below:

Name	DOB
Social Security #	Relationship ☐Spouse ☐Child ☐Other:

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 _____

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

Year of Last Vaccine/Test

Bone Scan (DEXA)	Chest X-ray	Flu Vaccine
Colonoscopy	EKG	Pneumonia Vaccine #1
Cologuard	Treadmill Stress Test	Pneumonia Vaccine #2
FOBT	ECHO	Tetanus Booster
PSA	Cardiac Catherization	TB Screening
Cholesterol Lab	AAA	Hep A Vaccine
PFT or Spirometry	ABI	Hep B Vaccine

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		

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 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.**

***The above authorization(s) may be revoked at any time by submitting written notice to the Practice Manager.**

We will NOT release via telephone or other means of communication any information to friends or family members that re 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.

_____ DATE _____

Signature of Patient/Guardian

If Guardian, relationship to patient: _____

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 _____