Patient name: ____ DOB:___________

Notice of Privacy

A. Ideal Self LLC shall disclose medical records or payment records, or the information contained in medical records or payment records, without the patient's written authorization as otherwise required by law or when ordered by a court or tribunal of competent jurisdiction.

B. Ideal Self LLC may disclose medical records or payment records, or the information contained in medical records or payment records, pursuant to written authorization signed by the patient or the patient's health care decision maker.

C. Ideal Self LLC may disclose medical records or payment records or the information contained in medical records or payment records and a clinical laboratory may disclose clinical laboratory results without the written authorization of the patient or the patient's health care decision maker as otherwise authorized by state or federal law, including the health insurance portability and accountability act privacy standards (45 Code of Federal Regulations part 160 and part 164, subpart E), or as follows:

1. To health care providers who are currently providing health care to the patient for the purpose of diagnosis or treatment of the patient.
2. To health care providers who have previously provided treatment to the patient, to the extent that the records pertain to the provided treatment.
3. To ambulance attendants as defined in section 36-2201 for the purpose of providing care to or transferring the patient whose records are requested.
4. To a private agency that accredits health care providers and with whom the health care provider has an agreement requiring the agency to protect the confidentiality of patient information.
5. To a health profession regulatory board as defined in section 32-3201.
6. To health care providers for the purpose of conducting utilization review, peer review and quality assurance pursuant to section 36-441, 36-445, 36-2402 or 36-2917.
7. To a person or entity that provides services to the patient's health care providers or clinical laboratories and with whom the health care provider or clinical laboratory has an agreement requiring the person or entity to protect the confidentiality of patient information and as required by the health insurance portability and accountability act privacy standards, 45 Code of Federal Regulations part 164, subpart E.
8. To the legal representative of Ideal Self LLC in possession of the medical records or payment records for the purpose of securing legal advice.
9. To the patient's third-party payor or the payor's contractor.
10. To the industrial commission of Arizona or parties to an industrial commission claim pursuant to title 23, chapter 6.

D. Ideal Self LLC may disclose a deceased patient's medical records or payment records or the information contained in medical records or payment records to the patient's health care decision maker at the time of the patient's death. Ideal Self LLC also may disclose a deceased patient's medical records or payment records or the information contained in medical records or payment records to the personal representative or administrator of the estate of a deceased patient, or if a personal representative or administrator has not been appointed, to the following persons in the following order of priority, unless the deceased patient during the deceased patient's lifetime or a

Initial ______

person in a higher order of priority has notified the health care provider in writing that the deceased patient opposed the release of the medical records or payment records:

1. The deceased patient's spouse, unless the patient and the patient's spouse were legally separated at the time of the patient's death.
2. The acting trustee of a trust created by the deceased patient either alone or with the deceased patient's spouse if the trust was a revocable inter vivos trust during the deceased patient's lifetime and the deceased patient was a beneficiary of the trust during the deceased patient's lifetime.
3. An adult child of the deceased patient.
4. A parent of the deceased patient.
5. An adult brother or sister of the deceased patient.
6. A guardian or conservator of the deceased patient at the time of the patient's death.

E. A person who receives medical records or payment records pursuant to this section shall not disclose those records without the written authorization of the patient or the patient's health care decision maker, unless otherwise authorized by law.

F. If Ideal Self LLC releases a patient's medical records or payment records to a contractor for the purpose of duplicating or disclosing the records on behalf of Ideal Self LLC, the contractor shall not disclose any part or all of a patient's medical records or payment records in its custody except as provided in this article. After duplicating or disclosing a patient's medical records or payment records on behalf of a health care provider, a contractor must return the records to the health care provider who released the medical records or payment records to the contractor.

STATEMENT of PATIENT'S RIGHTS

You have the right to receive individualized, considerate and respectful care in a safe setting. Care is delivered in a manner and setting intended to preserve your personal dignity. Care is provided without discrimination as to your race, color, religion, gender, age, sexual orientation, familial status, national origin, genetic information, physical or mental disability, veteran status or how your bill is paid.

You have the right to be involved in decisions about your care.
- Before and during treatment, whenever medically possible
- To receive information about your diagnosis and help make the plan for your care
- To refuse treatment to the extent permitted by law and to be informed of the medical consequences of your refusal.

You have the right to privacy and confidentiality.
- Your personal information is treated in a confidential manner and in accordance with applicable law.
- You may refuse to allow observation by anyone not directly involved in your care.

You have the right to agree to your care. Before agreeing to your care, you will understand:
- Why the treatment is suggested.
- What its possible benefits, risks and side effects are, including what could happen if refused.
- What other treatments could be used.
- What the outcomes are, including those that are unexpected.
- What limitations on protecting your confidential information are, if any.

Patient name: ______________________________ DOB:__________

If you do not agree to the recommended treatment, Ideal Self LLC may do one of these things:

- Suggest other ways of treating you and continue to see you.
- Refer you to another place to get care
- In special emergency cases, seek a court order to allow the treatment

You have the right to review or obtain a copy of your medical record.

- Your provider may review it with you.
- You may request copies of records used to make decisions in your health care, including the medical chart and billing records.
  - Our office may charge a fee for copies of records
  - All requests must be submitted in writing on provided ROI form
- If you do not agree with something in your record, you may ask for the record to be changed in the way allowed by law.
- You have the right to access, to request amendment and to receive an accounting of disclosures of your health information as permitted by law.

You have the right to contact Arizona Department of Health Services if you feel your rights have not been upheld.

You have the responsibility to:

- Provide complete and accurate information about your health and any other requested information.
- Ask questions when you do not understand what your doctor or other caregivers tell you about your medications and treatment. Express your concerns if you anticipate problems in following prescribed treatment and if you are considering alternative therapies.
- Follow the instructions related to your care plan and be responsible for the outcomes if you do not follow your care plan.
- Show respect and consideration for the Ideal Self staff, other patients and their families and their property.
- Meet any obligations for payment.
- Keep appointments, be on time for your appointments and call as soon as possible if you cannot keep your appointments.
- Keep confidential any information regarding another patient that you may hear or see.

Financial Policy

INSURANCE

- Your insurance policy is a contract between you and your insurance company. You are contractually responsible for your co-payment, co-insurance or any balance unpaid at the time of service. We recommend you become familiar with your health insurance policy, its coverage, limitations, payments and regulations concerning visits, referrals and pre-authorizations. Because all insurance contracts are between the patient and the insurance company, you are ultimately responsible for payment.
- All Co-pays are to be paid during check-in prior to the visit through the patient portal or by calling (623) 303-6777

NO INSURANCE

- Patients who are self-pay are responsible for the entire balance at the time of service.

Initial ________

Patient name: ____ DOB:____________

- Patients can pay for services with credit, debit, FSA or HSA through the patient portal www.idealself.org, or by phone by calling (303) 303-6777.
- If I have any questions regarding fees for service I can call (623) 303-6777 prior to my appointment.

USUAL AND CUSTOMARY RATES

- Ideal Self is committed to providing the best treatment for our patients and we charge what is usual, reasonable and customary in our geographical area.

MEDICARE MEDICAL NECESSITY

- Medicare will only pay for services that it deems to be "reasonable and necessary" under the Medicare laws. If Medicare determines that a particular service, although recommended by your provider, is not "reasonable and necessary," Medicare will deny payment for that service. If Medicare denies payment for services rendered, you are personally and fully responsible for payment in full.

CHILDREN

- The parent or guardian seeking medical attention of a child is responsible for their co-payment and/or co-insurance at the time of service.

STATEMENTS

- Charges shown on statements are agreed to be correct and reasonable unless protested in writing within 30 days of the billing date.

COLLECTIONS

- Should it be necessary to place your unpaid account with our outside collection agency, you must communicate directly with them.

If balances are unpaid my appointment may be cancelled and I will not be permitted to reschedule until balance is paid. Medication refills will not be approved unless prior arrangements have been made with the provider.

NO SHOW AND LATE ARRIVALS POLICIES

Please be aware that we require a 24-hour advance notice of appointment cancellation. A $30.00 fee will be applied to your account for short-notice cancellations or missed appointments.

Patients who miss 3 or more appointments without calling may be discharged from our practice.

If you arrive late for your appointment you may not be able to be seen and you may be charged a short-notice cancellation fee. We are sorry for any inconvenience. However, that time slot was reserved specifically for you and other patients are scheduled following your appointment. This decision is made on a case-by-case basis depending on the schedule for that day.

I have received and understand the information regarding the No Show and Late Arrivals Policies of Presidio Primary Care. I am aware that failing to comply with these policies may results in a fee and/or discharge from the medical practice.

FMLA, DISABILITY FORMS, INSURANCE FORMS AND OTHER PAPERWORK

- Completion of paperwork is not a covered benefit under medical insurance plans.

Initial ____

Patient name: Type text here ______________________ DOB: ____________

- A fee of $30 will be charged for the completion of FMLA, Disability, Insurance or other paperwork.
- Please discuss all paperwork with your provider prior to sending.
- The provider may decline completion of paperwork if they do not have evidence of need.
- Paperwork will not be completed for new patients at an initial visit. Patients must be under care of the provider for a minimum of 90 days.

Patient or Legal guardian: ______________________________

Signature: ______________________________ Date: ______________

Patient name: ______________________________ DOB:____________

Medical History

List any **ALLERGIES TO MEDICATIONS** with reactions ☐ No Known Drug Allergies

Past Medical History:

1)Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes please explain:

	YES	NO			YES	NO	
Diabetes	☐	☐	________	**Bleeding Disorder**	☐	☐	________
Hypertension	☐	☐	________	**Urinary Problems**	☐	☐	________
Thyroid problems	☐	☐	________	**Kidney problems**	☐	☐	________
Heart disease/cholesterol	☐	☐	________	**Neurological problems**	☐	☐	________
Respiratory prob/Asthma	☐	☐	________	**Skin Problems**	☐	☐	________
Stomach/intestinal prob	☐	☐	________	**Hepatitis**	☐	☐	________
Arthritis	☐	☐	________	**Chronic Pain**	☐	☐	________
Seizures	☐	☐	________	**HIV**	☐	☐	________
Autoimmune Disorder	☐	☐	________	**Liver Disease**	☐	☐	________
Tuberculosis	☐	☐	________	**Valley Fever**	☐	☐	________

OTHER MEDICAL DIAGNOSIS: ____

2)Please list any **operations/surgical procedures (and dates)** you have ever had (including tonsils & adenoids):

3)Please list any **current medications (including dosage, times per day)**:

(Include aspirin, antacids, hormone replacement, birth control, herbal supplements, OTC nasal sprays/cold/sinus/allergy meds)

Patient name: ______________________________ DOB:__________

Social History: **YES** **NO** **Please list details below**

Question	YES	NO	Details
Do you smoke or chew tobacco?	☐	☐	**How much?** __________**For how long?** __________
If no, did you use tobacco in the past?	☐	☐	______________________________
Do you have pets in your home?	☐	☐	______________________________

How often do you drink alcohol? ____________ **What type?** ____________**How Much**____________

Other drug use? ____________________ **How Often?** ________________________

Highest level of education completed? ______________________________

Employment? ______________**What is your occupation?** ______________________

Marital status? ____________________ **Children?** __________ **How many?** ____________

Stable Housing? ____________**Who do you live with?** ________________________

Can you care for yourself? ____________**Trouble Walking?** ____________**Trouble Bathing?** ____________

Legal Issues? ____

Family History: Please check the "Yes" or "No" box to indicate whether any relatives have/had any of the following:

	YES	NO			YES	NO	
High Blood Pressure	☐	☐	__________	Bleeding disorders	☐	☐	__________
High Cholesterol	☐	☐	__________	Psychiatric	☐	☐	__________
Diabetes	☐	☐	__________	Heart problems	☐	☐	__________
Cancer	☐	☐	__________	Other	☐	☐	__________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ DATE ______________

Patient name: ______________________________ DOB:____________

Review of Systems

Category		Yes		Yes		Yes
General	Fever		Weight change		No Appetite	
	Chills		Night sweats		Insomnia	
Allergy/Immunology	Sneezing fits		Environmental Allergy		Hives	
Eye	Blurry Vision		Eye pain		Dry eyes	
ENT	Snoring/Apnea		Difficulty swallowing		Sore throat	
	Sinus pressure		Difficulty smelling		Nose bleeds	
	Difficulty hearing		Ear pain		Ringing	
Endocrine	Cold intolerance		Excessive sweating		Fatigue	
Respiratory	Shortness of breath		Wheezing		Orthopnea	
	Cough		Pain w/ breathing		Mucus	
Cardiovascular	Chest pain		Exercise intolerance		Murmur	
	SOB w/ exertion		Racing heart		Palpitations	
GI	Diarrhea		Reflux/Heartburn		Abdominal pain	
	Constipation		Nausea		Vomiting	
Hem/Lym	Bleeding problems		Swollen glands		Bruising	
Urinary	Blood in urine		Pain with urination		Frequency	
	Flank pain		Foul smell		Slow stream	
Musculoskeletal	Muscle aches		Joint aches		Back pain	
	Muscle spasms		Joint stiffness		Swelling	
Skin	Itching		Rash		Yellowing	
	Dry Skin/patches		Abnormal moles		Redness	
Neuro	Weakness		Memory problems		Headaches	
	Tremors		Nerve pain		Numbness	
	Dizziness		Balance problems		Seizures	
Psychiatric	Anxiety		Depression		Mood Swings	
	Social Anxiety		Auditory hallucinations		Paranoia	
	Trauma		Trouble concentrating		Compulsions	
	Nightmares		Obsessions		Dissociation	
	Addictions		Substance Abuse		Self-Harm	
	Mania		Excessive energy		Psychosis	
	Grief/loss		Anhedonia		Confusion	
	Low self esteem		Suicidal ideations		Eating DO	
	Visual hallucinations		Panic attacks		Specific Phobia	