PRIORITY
FAMILY MEDICAL CLINIC

Patient's Name: Date of Birth:

Mailing Address: Gender: ☐ Male ☐ Female

City: State: Zip:

Street Address: ☐ Same as mailing

City: State: Zip:

Home #: Cell #: Work #:

E-Mail Address: Patient Portal Access? ☐ Yes ☐ No

Preferred method of contact? ☐ Home ☐ Cell ☐ Work Message Content: ☐ Brief ☐ Extended

Appointment reminder: ☐ Voice message ☐ Text message Lab results: ☐ Voice message ☐ Text message Marital

Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Employment Status: ☐ Retired ☐ Employed full-time ☐ Employed part-time ☐ Self-employed

Employer: _____Occupation: _____

Emergency Contact: _____Relationship: _____Phone: _____

Primary Insurance Company:	ID#:	Group No./ Name:	Insurance Phone:
Address:		City, State, Zip:	
Subscriber's Name (Policy Holder):	Date of Birth:	Gender:	Relationship to Patient:
Social Security Number:	Employer:	Employment Status: □ Full Time □ Part Time □ Retired	
Secondary Insurance Company:	ID#:	Group No./ Name:	Insurance Phone:
Address:		City, State, Zip:	
Subscriber's Name (Policy Holder):	Date of Birth:	Gender:	Relationship to Patient:
Social Security Number:	Employer:	Employment Status: □ Full Time □ Part Time □ Retired	

PRIORITY
FAMILY MEDICAL CLINIC

Authorization to release information to family/friends or others:

I authorize Priority Family Medical Clinic to release any information regarding my treatment; including lab results, imaging, medical conditions and medications to the following individuals/entities:

Name: Relationship:

Name: Relationship:

Signature: Date:

Preferred Local Pharmacy:

Mail Order Pharmacy:

PATIENT RIGHTS AND RESPONSIBILITIES

We respect your rights as a patient and recognize that you as an individual have unique healthcare needs. Therefore, we respect your personal dignity and want to provide care based upon your individual needs. Not only do you have rights and responsibilities, but these rights and responsibilities also apply to the people who are legally responsible for making your healthcare decisions. These people may include parents of patients under the age of 18, legal guardians, and those you have given decision-making responsibility in a Durable Power of Attorney for Health Care.

PATIENT RIGHTS

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients have the right to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients have the right to access care easily and in a timely fashion.
- Patients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the right to share in developing their plan of care.
- Patients have the right to the delivery of services in a culturally competent manner.
- Patients have the right to information about the organization, its providers, services, and role in the treatment process.
- Patients have the right to information about provider work history and training.
- Patients have the right to information about clinical guidelines used in providing and managing their care.
- Patients have a right to know about advocacy and community groups and prevention services.
- Patients have a right to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients have the right to know about laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

PATIENT RESPONSIBILITIES

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to give providers the information they need, in order to provide the best possible care.
- Patients have the responsibility to ask their providers questions about their care.
- Patients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to let their provider know about their insurance coverage, and any changes to it.
- Patients have the responsibility to let their provider know about problems with paying fees.
- Patients have the responsibility not to take actions that could harm others.
- Patients have the responsibility to report fraud and abuse.
- Patients have the responsibility to openly report concerns about quality of care.
- Patients have the responsibility to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients have the right and the responsibility to understand and help develop plans and goals to improve their health.

I have read and understood my rights and responsibilities.

Patient Signature Printed Name Date

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Priority Family Medical Clinic (PFMC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Priority Family Medical Clinic Notice of Privacy Practices provides a more complete description of such uses and disclosures). I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Additionally, I give my consent for Priority Family Medical Clinic to access information on my prescription history from pharmacy networks, if needed, to reconcile strengths, dosages, or medications I have taken.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Priority Family Medical Clinic reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Priority Family Medical Clinic, Attn: Privacy Officer at 3625 Crossings Dr. Ste B, Prescott, AZ 86305

I have the right to request that Priority Family Medical Clinic restrict how Priority Family Medical Clinic uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT BILL OF RIGHTS

I have received a copy of the Priority Family Medical Clinic Patient Bill of Rights & Responsibilities.

PERMISSION TO RENDER SERVICES/ACKNOWLEDGEMENT OF FINANCIAL POLICY

By presenting for treatment, I hereby employ Priority Family Medical Clinic to provide medical services to me. I agree to pay for all services rendered on my behalf at the rates established by Priority Family Medical Clinic or those rates as established by Priority Family Medical Clinic and my insurance carrier if such a contractual relationship exists. I remain fully responsible for all treatments, services and out-of-pocket expenses incurred on my behalf. I have been given a copy of Priority Family Medical Clinic Financial Policy and Procedures and acknowledge my responsibility to notify Priority Family Medical Clinic of any changes in my insurance plan or status.

I also understand and acknowledge that I am personally responsible to pay Priority Family Medical Clinic in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

I have received a copy of Priority Family Medical Clinic's Financial Policy and Procedures and understand that all bills are due and payable upon presentation. PFMC reserves the right to charge interest on any bills not paid when due from the date thereof at the rate of up to 18% per annum. If a check is not honored upon presentation to the bank for payment, I agree to pay a $30.00 handling fee, which may be charged to my account. If legal action is instituted to collect any amount due, I agree to pay all court costs and reasonable attorney’s fees. If my immediate family and I are discharged due to nonpayment on our account, I agree to pay all delinquent balances along with a $30.00 reinstatement fee before being seen again in the clinic.

I understand that Priority Family Medical Clinic requests 24 hours’ notice of cancellation, whenever possible. I agree to notify in advance of my scheduled appointment whenever I am unable to keep it.

INSURANCE ASSIGNMENT OF BENEFITS AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to Priority Family Medical Clinic at: 3625 Crossings Dr. Ste B, Prescott, AZ 86305 for any or all medical services furnished which were not paid by me in full at the time services were rendered. I further authorize the release of medical information about me or my insured dependents to my health insurance carrier (s), if applicable, as needed to determine this benefits payable for related services.

If I do not sign this consent, or later revoke it, Priority Family Medical Clinic reserves the right to deny medical treatment to me.

Patient Signature | Printed Name | Date

HEALTH HISTORY
(Confidential)

Patient Name: _____

CURRENT MEDICATIONS

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications:

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4) _____ 9) _____

5) _____ 10) _____

ALLERGIES

Are you allergic to any prescription medications? ☐ Yes ☐ No

Are you allergic to food/products? ☐ Yes ☐ No

List medications/foods/products to which you are allergic:

What kind of reaction did you have?

1) _____

2) _____

3) _____

4) _____

5) _____

HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

☐ Anemia or blood disorder
☐ Asthma or COPD
☐ Diabetes Type I or Type II
☐ Heart Disease/Heart Attach
☐ Kidney Disease
☐ Cancer Type: _____
☐ Hepatitis Type: _____
☐ Arthritis/Joint Pain
☐ Liver Disease
☐ Pneumonia
☐ Thyroid Disease
☐ GERD/Stomach Ulcers
☐ Stroke or CVA
☐ Hypertension/High Blood Pressure
☐ Rash/Skin Problems
☐ Depression and/or Anxiety
☐ Mental Illness/Dementia
☐ Seizures/Epilepsy
☐ Sexually Transmitted Disease
☐ Other_____

GYN HISTORY (Females Only)

At what age did you begin menstruation? _____

Date of your last menstrual period: _____ How long was your last menstrual period? ____ (# of days)

Are your menstrual periods: ☐ Regular ☐ Irregular How many days between your periods? _____ (# of days)

What was the severity of your last menstrual period? ☐ Average ☐ Light ☐ Heavy

SURGICAL HISTORY (include dates)

☐ Tonsillectomy _____ ☐ Appendectomy ____ ☐ Heart Bypass/Heart Surgery ____

☐ Gallbladder Surgery ____ ☐ Back/Neck Surgery ____ ☐ Angiogram/Pacemaker/Stent Placement ____

☐ Hernia Repair ____ ☐ Breast Surgery ____ ☐ Skin Cancer Removal ____

☐ Orthopedic Surgery _____ Type: _____ ☐ Other: _____

☐ Hysterectomy/D&C/Uterine Ablation/Tubal Ligation ☐ Other: _____

☐ Colonoscopy/Upper GI ____

HOSPITALIZATIONS HISTORY

Recent hospitalization and reason for admitting: _____

PREVENTIVE SCREENINGS AND IMMUNIZATION HISTORY (most recent date)

Colonoscopy: _____ Flu Shot: _____

Mammogram: _____ Pneumonia Shot: _____

Prostate Exam: _____ Tetanus/Pertussis: _____

Diabetic Eye Exam: _____ Zostavax (shingles): _____

DEXA Scan: _____ Other: _____

DEPRESSION SCREENING: (PHQ2)

Little Interest or pleasure in doing things ☐ No ☐ Yes

Feeling down, depressed or hopeless ☐ No ☐ Yes

HEALTH HISTORY Cont'd

Patient Name: (Confidential)

FAMILY HISTORY

	Alive or Deceased	Year of Death	Alzheimers/ Dementia	Alcoholism/ Drug Addiction	Arthritis	Asthma	Cancer: _____ Type	Diabetes	Heart Disease	High blood pressure	Kidney Disease	Liver Disease	Mental Illness	Stroke	Unknown
Father															
Mother															
Siblings															
Siblings															
Paternal Grandfather															
Paternal Grandmother															
Paternal Uncle															
Paternal Aunt															
Maternal Grandfather															
Maternal Grandmother															
Maternal Uncle															
Maternal Aunt															

SOCIAL HISTORY

Tobacco Use/Smoking	☐ Never ☐ Former (year quit): _____ ☐ Current (year and/ or age started): _____ ☐ Smokeless
Alcohol Use	☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Beer/Wine ☐ Liquor Number of Drinks: _____
Recreational Drug Use	☐ Never ☐ Former ☐ Current (drug name): _____ (date last used): _____
IV/Street Drug Use	☐ Never ☐ Former ☐ Current (drug name): _____ (date last used): _____
Diet	☐ Regular ☐ Low Fat ☐ Low Carb ☐ Low Sugar ☐ Low Sodium ☐ Gluten Free ☐ Vegetarian ☐ Vegan
Caffeine /Energy Drinks	☐ Coffee ☐ Tea ☐ Soda ☐ Energy drinks How many drinks per day: _____
Exercise	Do you exercise 3 or more days a week for 20 mins or more? ☐ Yes ☐ No
Types of Exercise	☐ Walking ☐ Running ☐ Hiking ☐ Cycling/Spinning ☐ Yoga ☐ Aerobic/Cross Fit ☐ Weight Training ☐ Other: _____
Handedness	☐ Right ☐ Left ☐ Ambidextrous
Assisted Devices	☐ Glasses or Contracts ☐ Hearing aids ☐Dentures ☐ Cane ☐ Walker ☐ Wheelchair
Education	☐ High School ☐ College/Bachelors ☐ Grad School/Masters
Occupation- Current or Previous and/or Hobbies	: _____