Family First Physicians
2345 E Southern Ave Ste 101
Mesa, AZ 85204

Patient Demographics

Account #:_____

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable):
Date of Birth:	Sex : ☐ Male ☐ Female		Preferred Gender: ☐ Male ☐ Female ☐ Other:
Mailing Address:			Apt #
City/State/Zip:		Email:	
Home Phone:	Cell Phone:		Work Phone:
To receive communication via one of these numbers, please select:	Opt In: ☐		Opt Out: ☐
Preferred Method of Contact (Please Select Only One Option)	Voice ☐ Text ☐ Email ☐		If voice, please select preferred number Home ☐ Cell ☐ Work ☐
Guarantor/Financially Responsible Name:		Phone Number:	
Guarantor Address:			Guarantor D.O.B.:
Emergency Contact:	Phone Number:		Relationship:

Race:
☐ Caucasian ☐ American Indian/Native American ☐ African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other:

Ethnicity: ☐ Hispanic ☐ Non-Hispanic/White ☐ Other	Preferred Language: ☐ English ☐ Spanish ☐ Other:

Insurance Information

Primary Insurance - Complete with as much information as possible

Insurance Plan Name:	Member ID:	Group Number:	
Policy Holder Name:	Policy Holder D.O.B.:	Relationship:	
Policy Holder Address:	City/State/Zip:	Policy Holder Phone Number:	
Employer:	Occupation:	Policy Holder SSN:	

Secondary Insurance - Complete with as much information as possible

Insurance Plan Name:	Member ID:	Group Number:	
Policy Holder Name:	Policy Holder D.O.B.:	Relationship:	
Policy Holder Address:	City/State/Zip:	Policy Holder Phone Number:	
Employer:	Occupation:	Policy Holder SSN:	
Preferred Pharmacy:	Major Cross Streets:	Phone Number:	

Print Name _____ Signature _____ Date _____

Family First Physicians
2345 E Southern Ave Ste
101 Mesa, AZ 85204

Patient Demographics

Account #: _____

Medical Treatment Agreement

Medical Treatment: The patient consents to the treatment, services and procedures which may include but are not limited to: laboratory procedures, medical and surgical treatments or procedures, or anesthetics under the general or specific instructions of the responsible health care provider. As part of our mission to provide optimal health care for our patients, we allocate the use of the Arizona Prescription Monitoring program. The program is a tool used to promote the public health and welfare by detecting diversion, abuse and misuse of prescription medications classified as controlled

Teaching Program: Family First Physicians' participates in training programs for physician assistants and health care personnel. Some patient services may be provided by person's in training under the supervision and instruction of the physician or practice employee's. These person's in training may also observe care given to the patient by physician(s) and/or practice employee's.

Contraband: Drugs, alcohol, weapons and other articles specified as contraband by Family First Physicians is not allowed on office premises. Any illegal substance will be confiscated and turned over to the authorities.

Valuables: Neither Family First Physicians' nor the health care provider's will be responsible for loss or damage to items brought by the patient to the facility, including but not limited to: cell phones, tablets, laptops, glasses, contact lenses, dentures, hearing aids, jewelry, money or any other personal items.

Photography/Video Recording: I understand and agree that a photograph may be taken of me for identification purposes or for other treatment purposes. I will not take pictures or record videos of any Family First Physician's staff member without their permission.

Release of Information: According to Arizona State Law, A.R.S. Â§12-2294 and Â§12-2294.01 require physicians to disclose medical records without the patient's written authorization as required by law or when ordered by a court or tribunal of competent jurisdiction. This includes subpoenas. When required for diagnosis or treatment of the patient, a physician may disclose the medical records without written authorization from the patient to other health care providers. And the doctor may disclose them to other health care providers who have previously treated the patient without the patient's written approval. Doctors may also release them to ambulance attendants, to a private agency that accredits health care providers, to the Arizona Medical Board, to health care providers for peer review, to a person or entity that provides billing and administrative services, to an attorney for the purpose of obtaining legal advice, to the patient's third-party payor, or to the Industrial Commission of Arizona. Included information may be regarding alcohol or drug abuse as well as HIV related or other communicable disease.

HIE Participation: I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider. I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Telemedicine: Family First Physicians' is a telemedicine participating facility. Telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment and education using interactive audio or video communication. This service does incur a charge that will be billed to the financially responsible party.

Terms of Service: Effective 09/16/2024

By opting In to receive SMS messages from Family First Physicians, you agree to the following terms:

1. By providing your phone number, you consent to receive SIVIS messages, Including updates, promotions, and other relevant content.
2. Message and data rates may apply based on your mobile carrier's terms.
3. Your information will be handled in accordance with our Privacy Policy, which can be viewed in our Privacy Policy.
4. You can opt out by replying "STOP" to any SMS message. You may also contact us directly at 480-893-2345.
5. We are not responsible for any charges, errors, or delays in SMS delivery caused by your carrier or third-party service providers. By opting in, you confirm that you are the owner or authorized user of the phone number provided and that you are at least 18 years old.

By signing below, I confirm that I have read and understand Family First Physician's Medical Treatment Agreement.

Print Name	Signature	Date

2345 E. Southern Ave. Ste 101
Mesa, Az 85204
Tel: (480) 893-2345
Fax: (480) 926-0495

"Putting Your Family First"

Family First Physicians

Patient Release and Communication

Patient Name: _____Date of Birth: _____

There are occasions when Family First Physicians may have to contact you to discuss Confidential Protected Health Information. Please let us know how you would like to get this information to you:

___Okay to call my home/cell phone and leave a message on the answering machine regarding my Personal Health Information

___Okay to call my home but DO NOT leave a message

___Do not call my home number but call this number (___)_____

___Okay to email reminders to: _____

___Okay to email reminders if unable to reach by phone

Who may receive information regarding your Protected Health Information that you allow Family First Physicians to speak with?

___Spouse – Name: _____

___Children – Name(s): _____

___Parents – Name(s): _____

___Significant Other – Name: _____

___Friend – Name(s): _____

I have received a copy of Notice of Privacy Practices from Family First Physicians, PLLC, and authorize the above list of persons' who many receive information regarding my Protected Health Information. I may revoke this any time by giving written notification to **Family First Physicians, PLLC**.

_____ _____

Patient/Guardian Signature Date

Patient Name: _____ Account Number: _____

Family First Physicians Financial Policy

Family First Physicians is committed to providing quality medical services to our patients and clearly defining our financial policy. If you have any questions, please ask for a **billing staff member** for assistance.

Please initial all items and sign page two:

_____

1. **Insurance:** It is extremely important that you furnish us with accurate and updated information. If changes occur in your insurance policy or you may have additional information, such as **secondary** insurance, please make sure to provide our office with all the information and changes. This will ensure that your file has the most up-to-date information possible. Incorrect information could result in the denial of your claim. If this occurs, you assume responsibility for the entire amount of the claim.
    i. Please be aware that if you have an AHCCCS plan, it is **ALWAYS** the payer of last resort. Any other health insurance plan must be billed prior to AHCCCS. This means that if you do not provide our office with your primary insurance information, AHCCCS will not pay.
    ii. Please be aware that our will submit a claim for worker's compensation if authorization to treat you at Family First Physicians has been given. It is the patient's responsibility to provide our office with employer authorization/contact information regarding a worker's compensation claim. If the claim is denied by the worker's compensation insurance carrier, it then becomes the patient's responsibility.

_____

2. **Non-Covered Services:** All health plans are not the same and they do not always cover the same service. Please be aware that some of the services you receive may be determined "not covered" by your health plan. You must pay for these services in full within ninety (90) days. If you have questions as to what services are covered, contact member services (the number is listed on your insurance card.) **It is your responsibility to be aware of your benefits, we do not quote or verify benefits.**

    i. A "No Show" fee of $50 will be applied to any visit that is not cancelled or rescheduled 24 hours prior to the appointment time. We understand emergencies happen, but when they do, please contact our office as soon as possible to potentially avoid any fees.

_____

3. **Billing Dept Information:** A claim for services will be submitted to your insurance within 45 days of your visit. You should receive an explanation of benefits (EOB) from your insurance company explaining what they paid. As a courtesy, our office will send three (3) monthly statements to the responsible party for any balance remaining.
    i. Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency unless prior arrangements have been made.

Payment is due at the time of service. If you do not have your co-pay, your visit may be rescheduled. We recognize the need to set up payment plans for patients who require extensive treatment.

i. We accept cash, check, money order, VISA, and MasterCard. Any check returned to our office by the bank will be subject to an additional $25 service fee and our office will no longer accept payments via personal check.

ii. Our billing department will be happy to help you with these arrangements. Any payment arrangement made but not kept current will be voided with the balance being due in full and will result in the termination of this option in the future. Any payments made will be applied to oldest balance first.

_____ 4. **Motor Vehicle Accident and 3rd Party Billing:** We do not offer any third-party billing. Our relationship is with you and not with the third-party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them.

_____ 5. **Form Fees:** An administrative fee of $35-$75 per form will be charged for any forms that need to be reviewed and filled out by our physicians. This includes but is not limited to FMLA or disability forms, sports physicals, mission physicals, etc. If you like to request your records a medical records release form will need to be filled out prior to initiate the request and an administrative fee of $25 will be charged. This does not apply to laboratory or imaging reports.

_____ 6. **Responsible Party**: If the patient is a minor, the person signing these forms agrees to be listed as the Guarantor and accepts sole financial responsibility for services rendered by Family First Physicians.

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible. It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by insurance.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

I agree to pay all finance charges, late fees, collection costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding. I have read, understand and agree to the financial policy stated above and accept responsibility for all payment of all fees/charges incurred with Family First Physicians.

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Responsible Party Signature Print Patient Name

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Print Financial Responsible Name Date

Allen M. Germaine M.D.
2345 E Southern Ave. Ste 101
Mesa, AZ 85204
Ph: (480) 893-2345 Main Fax: (480) 926-0495
IF MORE THAN 30 PAGES PLEASE MAIL OR CALL FOR APPROVAL

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:		**Patient DOB:**
Patient Address:		
City, State, Zip:	**Phone Number:**	**Patient Social Security:**

Information Being Released: **To** **From**

Office/Physician Name:	
Address:	
City, State, Zip:	
Phone: **Fax:**	

Information Being Released: **To** **From**

Office/Physician Name:	
Address:	
City, State, Zip:	
Phone: **Fax:**	

Information to be released:

☐ All Health Information
☐ Information related to:_____
☐ Information covering the treatment period:
_____

Reason for Disclosure:

☐ Changing Physicians
☐ Continuation of Care
☐ Workers Compensation
☐ Legal
☐ Other: _____

I understand that this health information may include HIV-related information and/or information relating to the diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing information relating to:
Substance abuse (inc: alcohol/Drug abuse) Mental Health Psychotherapy Notes HIV related information (inc: aids related testing).
The confidentiality of this record is required under the ariz. rev. stat § 36-661, ariz. rev. stat § 36-664, ariz. rev. stat § 20-448.01©, ariz. rev. stat § 20-448-01€, ariz. rev. stat § 36-507 & ariz. rev. stat § 36-509. All of these statutes can be found on the Arizona Legislator government website. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes. By signing I understand I am authorizing the release of the above stated records, separate from my general healthcare information.

_____ _____
Patient Signature Date

_____ _____
Legally Authorized Representative/Guardian Relationship

By signing below, I understand that this authorization will expire one year from the date the release is signed. A photocopy of this form will be considered as valid as the original. I understand that I may revoke this authorization at any time in writing and this authorization will cease to be effective as of the date notified. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. However, state and federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS related information, and psychiatric/mental health information. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.

_____ _____
Patient Signature Date

_____ _____
Legally Authorized Representative/Guardian Relationship

Patient Name:	D.O.B.:

Who are your current medical providers?	
Provider Name	Specialty, or condition for which they treat you

Preventative Care					
	Date		Date		Date
Annual Physical		Dental exam		Pap Screen	
Bone Density		Diabetes screen		Mammogram	
Colonoscopy		Eye Exam		Prostate Screen	
Cholesterol test					

Immunizations					
	Date		Date		Date
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (Flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		Other (please write below)	
COVID-19					

Please list all medications, supplements, over the counter drugs, creams and inhalers.		
Name	Dose/Strength	Frequency taken

Allergies or intolerances to medications?	
Name	Reaction

Advance Directives		
Do you have a living will?	Yes	No
Do you have a medical power of attorney?	Yes	No
If you answered yes to either, please make sure our office has a copy		
If no, would you like information or a copy of advance directive forms?	Yes	No

Patient Name:				D.O.B.:	
Please check all current of past medical problems or conditions					
ADD/ADHD		Depression		HIV/AIDS	
Anemia		Diabetes Type 1		Hyperthyroidism	
Anxiety		Diabetes Type 2		Hypothyroidism	
Arthitis		Emphysema		Kidney Disease	
Asthma		Glaucoma		Migraines	
Bipolar Disorder		Heart Attack		Seizures	
Blood Clots		Heart Artery Disease		Seasonal Allergies	
Blood Transfusion		Heart Failure		Sexually Transmitted Infection	
Cancer		Heart Murmur		Stomach/Intestine Ulcers	
Cataracts		Heartburn		Stroke	
Chronic Lung Disease		High Blood Pressure		Substance Abuse	
Chronic Pain		High Cholesterol		Valley Fever	
Please check all major operations or surgeries					
None		Eye		Joint Replacement	
Appendectomy		Fracture Repair		Ovaries	
Breast Augmentation		Gallbladder		Spine	
Breast Surgery		Heart Bypass		Thyroid Surgery	
Cesarean Section		Heart Valve Surgery		Tonsillectomy	
Colon		Hernia Repair		Tubes Tied	
Coronary Artery Stent		Hysterectomy		Vasectomy	
Cosmetic Surgery					

Family Medical History- Please check the appropriate box if a condition is/was present.

					If unknown or if you were adopted, please check here:
	Father	Mother	Siblings	Children	Other
Year born					
Alive?					
If no, put year deceased					
Alzheimer's					
Arthritis					
Cancer					
COPD					
Depression					
Diabetes					
Alcohol/Drug Abuse					
Hearing Loss					
Heart Disease					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Mental Illness					
Miscarriages					
Stroke					
Vision Loss					
Other:_____					

Patient Name:	D.O.B.:

Social History

Tobacco Use- Please check your response.

☐ Smoke every day ☐ Smoke some days ☐ Former Smoker ☐ Heavy Smoker
☐ Light Smoker ☐ Never smoked ☐ Second-hand exposure

If current smoker: How soon after you wake up do you smoke your first cigarette?

☐ within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ after 60 minutes

If ever smoked, how many cigarettes/day average?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How many years smoked?

You ever chewed?

☐ Yes ☐ No

If you currently use any tobacco product, are you ready to quit?

☐ Yes ☐ No ☐ Thinking about quitting

Alcohol Use- Please check your response.

Did you have a drink containing alcohol in past year? ☐ Yes ☐ No

If Yes: How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

If yes: How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

If yes: How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Drug Use- Please check your response.

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No

Sexual History

Have you had sex (vaginal, oral, or anal) in the past 12 months? ☐ Yes ☐ No

Have you ever had a Sexually transmitted disease? ☐ Yes ☐ No

Miscellaneous

How often do you drink bevarages with caffeine?

☐ Never ☐ Occasionally ☐ 1-2 cups per day ☐ 2-3 cups per day
☐ 3-4 cups per day ☐ More than 4 cups per day

How often do you exercise? (At least 15 minutes or more of physical activity)

☐ Never ☐ Occasionally ☐ 1-2 times per week ☐ 2-3 times per week
☐ 3-4 times per week ☐ 5-6 times per week ☐ Daily

Do you wear your seatbelt?

☐ Yes ☐ No

In the last 6 months, have you travelled outside the United States?

☐ Yes; Where?_____ ☐ No