Family First Physicians
2345 E Southern Ave, Suite 101
Mesa, AZ 85204
P: 480-893-2345 l F: 480-926-0495

Patient Registration and Authorization Form

Please print neatly in black or blue ink

Patient Last Name:	**First:**	**M.I.:**
DOB (MM/DD/YYYY):	**Gender:** Male / Female **Phone Number:**	
Address:		
City:	**State:**	**Zip Code:**
Social Security Number:		
E-mail:	**Preferred Method of Contact:** ☐ Call ☐ Text ☐ E-mail	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Preferred Language: ☐ English ☐ Spanish ☐ Other:	**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic/White ☐ Other	
Race: ☐ Caucasian ☐ American Indian/Native American ☐ African American ☐ Asian ☐ Hawaiian/Other Pacific Islander ☐ Other:		
Emergency Contact: Name:	Phone Number:	Relationship:

POA Information (if applicable)

I am/have a Legal Medical Power of Attorney, caregiver or family member that must be informed of all medical decisions and visits: Yes / No (Select One) : ☐ Legal Medical POA ☐ Caregiver ☐ Family Member

POA Name:	Relationship to Patient:	
POA Address:		
City:	State:	Zip Code:
Phone:		

Group Home Information (if applicable)

Name of Group Home:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	

Name _____ Signature _____ Date _____

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Family First Physicians, or the insurance company to release any information required to process claims.

Patient's/POA Name:_____ **DOB**:_____

Patient's/POA Signature:_____**DATE:**_____

Insurance Information

Primary Insurance:	
Policy/ ID Number:	**Group Number:**
Subscriber Name:	**DOB:**
Relationship to Patient:	
Secondary Insurance (if applicable):	
Policy/ ID Number:	**Group Number:**

Preferred Pharmacy

Name:	Major Cross Streets:	Phone Number:
Address:		

_____ _____ _____
Name Signature Date

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A division of Family First Physicians, PLLC

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 substance(s) under the Arizona Uniform Controlled Substances Act

Release of Information: According to Arizona State Law, A.R.S. §12-2294 and §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.

HIPAA: The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. You will be provided with a copy of the office's HIPPA regulations which is your copy to keep.

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.

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

_____ _____ _____
Name Signature Date