New Patient Packet

Welcome to the Amistad Clinic!

Please complete all areas to the best of your ability.

Today's Date _____

1. Patient Information

First Name _____ Middle _____ Last Name _____

Date of Birth _____

Gender
☐ Female
☐ Male

Last 4 Digits of Social Security Number _____

Mailing Address _____

Apartment/Unit #/Lot# _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

Local Pharmacy _____ Pharmacy Address _____ City _____ State _____

Mail Order Pharmacy _____ Mail Order Pharmacy Address _____

Are you under the age of 18?
☐ Yes
☐ No

If you are under the age of 18, please list the name of your parent or legal guardian.

First Name _____ Last Name _____

Phone _____ Relationship _____

May we text message you for appointment confirmations and updates regarding your care plan?
☐ Yes
☐ No

(We only use text messaging for direct patient communication, never for advertising our services and you may always opt out by sending us a reply message of "STOP")

Do you reside in an assisted living community?
☐ Yes
☐ No

If you answered "yes" please include the name of the home below:

Name of Assisted Living _____ Room Number_____

2. Emergency Contact

First Name _____ Last Name _____ Cell Phone _____

Street Address _____ City _____ State _____ Zip _____

Relationship _____

3. Insurance

Primary Insurance Company _____ Member ID/Policy Number _____ Group Number _____

If you are the primary person insured on your plan please select “Self.” If you are insured by a spouse, parent, partner or other, please note the relationship below.

Patient’s relationship to insured
- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Other _____

Insured Name _____ Insured Date of Birth _____

Insured Phone Number _____

Secondary Insurance: Please list additional supplemental insurance. In many cases, Medicare patients will care a secondary insurance.

Secondary Insurance Company _____ Member ID/Policy Number _____ Group Number _____

Please provide our front desk with your photo ID and Insurance cards so we may make a copy for your patient record. Thank you.

4. Medical Background and History

Please share your reason for your visit

_____

_____

_____

Past Medical History

Condition / Disease	Check all that apply	Year Began / Concerns
Diabetes		
Hypertension		
High Cholesterol		
Hypthyroidism		
Depression		
Anxiety		
Heart Problems		
COPD		
GERD		
Chronic Heart Failure		
Chronic Renal Failure		
Asthma		
Dementia		
Other		

Are you currently taking any medications? (*Required)

- ☐ Yes
- ☐ No

Are you currently taking any vitamins? (*Required)

- ☐ Yes
- ☐ No

Are you currently taking any supplements? (Examples: calcium and iron, ; herbs such as echinacea and garlic, products like glucosamine, probiotics, fish oils, etc.) (*Required)

- ☐ Yes
- ☐ No

Medication List

If you answered “Yes” to taking any medications, vitamins or supplements, please list the name, dosage and frequency in this section. If you checked “Yes” and this is left blank, your intake form will be considered incomplete.

	Medication	Dose	Frequency	Check if Current
1				
2				
3				
4				
5				
6				
7				
8				

Please list any additional medications in the space below or attach a list to this form.

Are you allergic to any medications? (*Required)

- ☐ Yes
- ☐ No

If you answered “Yes” please list allergies below

	Medication	Reaction
1		
2		
3		
4		
5		

Please list any surgical procedures, hospitalizations and injuries

	Operation / Hospitalization / Injury	Month and Year
1		
2		
3		
5		

Family Health History: Please list the health history of our blood (genetic) first degree relatives

Relative	Living / Deceased	Age at time of death	Cause of Death	Health Problems
Mother				
Father				
Grandmother (maternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandfather (paternal)				
Brother				
Sister				

5. Life Style Choices

Please Check Yes or No	YES	NO	
Are you a current tobacco smoker?			
Are you a former tobacco smoker?			If yes, when did you quit?
Do you vape or use e-cigarettes?			
Are you currently using illicit drugs?			If yes: Type of drug _____ How often _____
Do you drink alcohol			If yes: Type of alcohol_____ Number of drinks per day _____
Do you drink coffee?			If yes, how many cups per day_____
Do you exercise?			If yes: Type of exercise_____ How often_____

6. Females Only Please share the following health history

Age onset periods _____ Age onset menopause _____

Are your periods regular?
- ☐ Yes
- ☐ No
- ☐ No longer applies

Number of pregnancies _____

7. Disease Prevention and Health Maintenance

Vaccinations and Procedures

Vaccination / Procedure	Month and Year
Flu Vaccine	
Pneumonia	
Hepatitis B	
Shingles	
Gardasil	
Mammogram	
Pap Smear	
Colonoscopy	
EKG	
Diabetes Eye Exam	
Bone Density Test	

8. Living Will and Power of Attorney for Healthcare

Do you have a living will?
☐ Yes
☐ No

Is this form being completed by a Power of Attorney for your healthcare?
☐ Yes
☐ No

If you answered yes, please state the name of your Power of Attorney and please submit a copy of your Power of Attorney (POA) with this form prior to your appointment.

Power of Attorney Name _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

9. Consent and Acknowledgment

Please read each of the following statements and sign in the space provided.

Consent for Treatment
I voluntarily give my permission to the healthcare provider/s of The Amistad Clinic, PLLC and such assistants and other healthcare providers as they deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me as long as I seek care from The Amistad Clinic, PLLC or until I withdraw my consent in writing.

Patient Signature or Power of Attorney for Healthcare Signature _____

Payment Acknowledgement
I understand that I am responsible for the full payment of my account, not my insurance company. I understand that the Amistad Clinic, PLLC can only make estimates regarding my insurance benefit based upon the information provided by me and my insurance company. In the event that my insurance company does not pay the amount expected, I will be billed for the balance. I understand that I am responsible for any deductibles, coinsurance and co-pays.

Patient Signature or Power of Attorney for Healthcare Signature _____

Cancellation/No-Show Policy
Patients are responsible for confirming their appointments. Unconfirmed appointments will be given to the next patient on our waiting list. We require a 24-hour notice to cancel or reschedule an appointment. Less than a 24-hour cancellation is subject to a $50 cancellation fee. Two consecutive last-minute cancellations, missed or rescheduled appointments will result in a discharge from clinic services. This also applies to telemedicine appointments. I understand that I may be charged $50 if I fail to give 24-hour notice to cancel an appointment or if I “no-show” a scheduled appointment.

Patient Signature or Power of Attorney for Healthcare Signature _____

Telemedicine Consent Form

In the event that you may require a telemedicine appointment in the future, we ask that you have a consent form on record.

PURPOSE: The purpose of "Telemedicine Consent Form" is to inform and receive consent for a telemedicine appointment with The Amistad Clinic, PLLC.

RECORDS: Telecommunications with patients are never recorded and stored.

TELEMEDICINE INFORMATION: The medical information related to history, records and tests of the patient will be discussed during the telemedicine appointment with video and/or audio.

ACCESS: The patient accepts that he/she needs access to a cell phone, mobile device or computer and a good internet connection in order to have an efficient telemedicine appointment.

PATIENT RIGHTS: The patient can withdraw his/her consent at any time and can ask the questions related to telemedicine appointments and technical requirements for telecommunication.

By signing this form,

I understand that all the laws that are protecting my privacy of medical history or information are also applied to telemedicine practices.

I understand that I can withdraw the consent at any time and that will not affect any of my future treatment procedures.

I accept and authorize the health care professionals at The Amistad Clinic PLLC to use telemedicine for my treatment and diagnosis.

Patient Signature or Power of Attorney for Healthcare Signature _____

Notice of Privacy Practice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Amistad Clinic, PLLC, believes individuals have a right to adequate notice of our policies, procedures and practices with respect to the uses and disclosures of protected health information. The Amistad Clinic, PLLC is required by law to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices. We are required to and will abide by the terms of the Notice of Privacy Practices in effect at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices even if we have already provided a copy to you previously.

The Amistad Clinic, PLLC will not use or disclose your individually identifiable or protected health information other than to carry out health care treatment, payment, and/or operations for you, or as required by law. An example of treatment is a visit to our office for the purpose of diagnosis or care of a health issue wherein doctors, nurses, technicians and/or others will share the information about you in the course of your treatment. Payment includes sharing protected health information with an insurer or third party that may be responsible for collecting payment from a health plan. Healthcare operations means sharing protected health information for the purpose of quality review.

The Amistad Clinic, PLLC will use and disclose protected health information to business associates in the course of providing treatment, securing payment for such treatment, and/or to facilitate health care operations of our practice, to facilitate the requirements of our business associates' contracts and to comply with requests from other covered entities to carry out treatment, payment or health care operations.

Except for the purposes described above, The Amistad Clinic, PLLC will only disclose protected health information with your express written authorization and you may revoke the authorization at any time in writing. The revocation will apply only to future uses and disclosures.

Any information The Amistad Clinic, PLLC provides to a third party other than to our business associates or other health care providers with a treatment relationship to you will be de-identified or stripped of any and all personal data which could be used to identify a specific individual.

The Amistad Clinic may contact you to provide appointment reminders or to provide you with information about alternative treatments or other health-care services we provide. When receiving communications from us, you may request that we communicate with you at an alternate location or by alternate means and we will make every effort to accommodate your request.

You may request that certain uses or disclosures of your protected health information are restricted. To do so, you must provide the request in writing. The Amistad Clinic will determine if the information constitutes required information to carry out treatment, payment or health care operations. If, in our sole opinion, your request does not involve information that is required by us to carry out treatment, payment, or health care operations, we will accept your request for restrictions and will notify you of your request and will be honored within 30 days or as required by law.

You may request a report containing your health information that has been collected by The Amistad Clinic for you to inspect or to obtain a copy. Such requests will be honored with 30 days or as required by law.

You may request that we amend or correct your health information that has been collected. Upon agreement by your health care provider, requests to amend health information with be honored with 30 days or as required by law and you will be notified that The Amistad Clinic has taken action.

You may request that we supply you with a listing of the disclosures of your protected health information which have been made by The Amistad Clinic except those made for treatment, payment or health care

operations, those required by the Final Privacy Rule or made pursuant to other law, and those made pursuant to your explicit authorization. Such requests will be honored within 30 days or as required by law, and you will

Notice of Privacy Practice Continued:

be notified in writing of the date on which the accounting will be available to you. At a minimum, the account of disclosures will include: Date of each disclosure, name and address of the organization of person who received the protected health information and a brief description of the information disclosed.

If you believe that your privacy rights have been violated, you may send questions or complaints about this notice or The Amistad Clinic's privacy practices to us and/ or to the Secretary of the Department of Health and Human Services (HHS) Such communication with The Amistad Clinic should be directed to Shaun McFarland, Clinic Manager 100 E. 24th Street, Suite 3-A, Yuma, AZ 85364. The address of the Secretary of Health and Human Services is 200 Independence Ave SW Washington, DC 20201.

The Amistad Clinic, PLLC reserves the right to revise this Notice of Privacy Practices at any time. You may request a copy of the revised notice and we will provide it to you. Effective November 4, 2018

Receipt of Acknowledgement of Privacy Notice

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Private Practices or to document our effort to obtain the acknowledgement.

I acknowledge this privacy notice and understand that I may request a copy of The Amistad Clinic, PLLC Notice of Privacy Practice at any time.

Patient Signature or Power of Attorney for Healthcare Signature _____

Please submit this New Patient Packet prior to scheduling your appointment and include your:

- ☐ Insurance Card(s)
- ☐ Photo ID
- ☐ Medication List
- ☐ Supporting documentation for Power of Attorney for healthcare (as applies)

Completed Forms with copies of insurance cards, photo ID and supporting documentation may be faxed directly to the clinic.

Fax: (928) 750-6433