VERDE COMMUNITY HEALTHCARE

657 E Cottonwood Street Ste 10
Cottonwood, AZ 86326-4407
P: 928-634-6369 F: 928-649-0228

PATIENT INFORMATION: Please answer each question. Mark N/A if not applicable.

Patient Name:______________________ __________ ______________________________
First Mid Initial Last

Date of Birth:__________________ SS# _____________________ Gender: Male or Female

Mailing Address:____________________ City:__________________ State:______ Zip:____________

Home Phone:______________________ Cell:____________________ Work:__________________

EMAIL:____

Marital Status:_________________ If married, Spouse's Name:______________________________

Emergency Contact:______________________ Phone #:________________ Relationship:__________

Preferred Pharmacy:____________________________ Pharmacy City:__________________

How did you hear about our providers?____

Race: White African American American Indian Asian Other:____________ Decline to specify
Ethnicity: Latino/Hispanic Not Latino/Hispanic Other:____________ Decline to specify

NSURANCE INFORMATION: In order for us to bill your insurance company accurately, please provide the following information along with your insurance card(s) and photo ID.

Primary Insurance:______________________
Policy Holder Name:______________________
ID Number: ______________________
Relationship to Policy Holder:______________
Policy Holder's Date of Birth:______________

Secondary Insurance:______________________
Policy Holder Name:______________________
ID Number:______________________
Relationship to Policy Holder:______________
Policy Holder's Date of Birth:______________

AUTHORIZATION to PAY BENEFITS TO PHYSICIAN: I hereby authorize payment to be made directly to Verde Community Healthcare. I will forward any payment that is paid to me by my insurance company, to Verde Community Healthcare. I am responsible for any non-covered services, copay's and or deductibles not paid by my insurance company.

______________________________ ______________________________
Patient Signature Today's Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Verde Community Healthcare to release any information that is acquired in the course of treatment and necessary to process my insurance claim(s)

______________________________ ______________________________
Patient Signature Today's Date

VERDE COMMUNITY HEALTHCARE
PAST MEDICAL HISTORY

NAME: ______________________ **AGE:** ________ **DOB:** ____________

Are you taking Blood Thinners? ________

ALLERGIES TO MEDICATIONS/REACTIONS:

______________ ______________ ______________
______________ ______________ ______________

ADVANCE DIRECTIVE/DNR:

[ ] I have an Advanced Directive
[ ] I have a DNR
[ ] I have provided a copy of my Advance directive
[ ] I do not have an Advanced Directive
[ ] I would like information about Advanced Directives

PAST SURGERIES AND DATES:

______________ ______ ______________ ______
______________ ______ ______________ ______
______________ ______ ______________ ______

FAMILY HISTORY:

Mother: Living/Passed Age: ______ Medical History ______________
Father: Living/Passed Age: ______ Medical History ______________
Siblings Living/Passed Age: ______ Medical History

PREVENTATIVE HISTORY: **Date of last exam (Mark N/A if not applicable)**

Annual Wellness/Physical Exam: ______
Breast Exam: ______
Mammogram: ______
Abnormal Mammogram? ______
Pap/Pelvic Exam: ______
Abnormal Pap Smear? ______
Last Menstrual Period ______
DEXA (Bone Density Scan): ______
Colorectal Screening: ______
Prostate Cancer Screening: ______
Last PSA ______
Lab Work-Up Which Lab? ______
Last EKG ______
Chest X-Ray ______

VACCINES/IMMUNIZATIONS YEAR:

Flu Vaccine: ______
Pneumonia Vacc: ______
Shingles Vaccine: ______
COVID 19 Vacc: ______
Measles Vacc: ______
Hepatitis shot A or B: ______
Tetanus: TD or TDAP ______

Do you plan to get the COVID 19 Vaccine ? ____________

SMOKING: Do you smoke? ______
If yes, # of Cig or packs a day? ______ # of Years? ______ Year Quit ______ Type of tobacco? ______

ALCOHOL: Do you consume alcohol? ______
If yes, how many drinks a day? ______ How long ? ______

CAFFEINE: Do you drink caffeine? ______ Type of caffeine? ____________
If yes, how often? ______

DIET: Are you on a special diet, or do you have diet restrictions? ____________

VERDE COMMUNITY HEALTHCARE

NAME: DOB:

MEDICATION LIST

MEDICATIONS/DOSAGES: Please bring a list of your current medications and supplements

Prescription Medication	Purpose or reason taken	Dose	How many times a day	Liquid, Capsule or Tablet	Special instructions

REVISED 1/2025

VERDE COMMUNITY HEALTHCARE
CURRENT MEDICAL CONDITIONS

NAME: ______________________________ **DOB:** ________________

CARDIOVASCULAR
- [ ] A-Fib **History of**
- [ ] Chronic Heart Failure
- [ ] Coronary Artery Disease
- [ ] Heart Attack **History of**
- [ ] Heart Murmur
- [ ] Heart Palpitations
- [ ] Heart Stent
- [ ] High Cholesterol
- [ ] Hypertension
- [ ] Mitral Valve Prolapse
- [ ] Pacemaker or Defibrillator
- [ ] Peripheral Vascular Disease
- [ ] Varicose veins
- [ ] Other:____________________

EYES
- [ ] Eye dryness
- [ ] Cataracts
- [ ] Glasses/Contacts
- [ ] Glaucoma
- [ ] Macular Degeneration
- [ ] Retinal disease
- [ ] Other: ____________________

ENDOCRINE
- [ ] Diabetes Type:
- [ ] Thyroid issues
- [ ] Other:____________________

HEMATOLOGY
- [ ] Anemia
- [ ] Blood Transfusion ________
- [ ] Other:____________________

INFECTIONS CHRONIC
- [ ] HIV/AIDS
- [ ] Other: ____________________

GASTRO-INTESTINAL
- [ ] Colitis
- [ ] Crohn's disease
- [ ] Gallbladder trouble
- [ ] Hemorrhoids
- [ ] Hepatitis B or C
- [ ] Hernia or History of
- [ ] IBS
- [ ] Liver disease
- [ ] Ulcers or history of
- [ ] Other:____________________

MENTAL STATUS
- [ ] Anxiety
- [ ] Bipolar
- [ ] Concentration Problems
- [ ] Depression
- [ ] Difficulty sleeping (Insomnia)
- [ ] Other:____________________

MUSCULAR/SKELETAL
- [ ] Arthritis
- [ ] Difficulty walking
- [ ] Gout
- [ ] Raynaud's
- [ ] Rheumatoid arthritis
- [ ] Lupus
- [ ] Other:____________________

NEURO
- [ ] Parkinson Disease
- [ ] Head Injury or **History of**
- [ ] Seizures
- [ ] Stroke **History of**
- [ ] Tremors
- [ ] Other:____________________

RESPIRATORY
- [ ] Allergies
- [ ] Asthma/Wheezing
- [ ] Chronic Cough
- [ ] COPD
- [ ] Pneumonia History of
- [ ] Sleep apnea C-PAP / Bi-PAP
- [ ] TB **History of**
- [ ] Other: ____________________

SKIN
- [ ] Easy bruising/bleeding
- [ ] Eczema
- [ ] Psoriasis
- [ ] Other: ____________________

URINARY/KIDNEY
- [ ] Dribbling
- [ ] Incontinence
- [ ] Recurrent Bladder Infections
- [ ] Urinary frequency
- [ ] Kidney Stones, **History of**
- [ ] Other:

FEMALE HISTORY
- [ ] Birth Control ______________
- [ ] Bladder Prolapse
- [ ] Breast Implants
- [ ] Fibroid or Endometriosis
- [ ] Menstrual Flow: Reg____ Irreg_____
- [ ] Menopausal or symptoms
- [ ] Pregnancies: _________
- [ ] # of living children
- [ ] Other:

MALE HISTORY
- [ ] Enlarged Prostate
- [ ] Sexual dysfunction
- [ ] Other:

Cancer(s) ____________________
____
____

OTHER ____________________ ____________________
____________________ ____________________
____________________ ____________________

VERDE COMMUNITY HEALTHCARE
REVIEW OF SYSTEMS

NAME:______________________________ **DOB:** _______________

Please check the Symptoms that apply to you

CONSTITUTION
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Night Sweats

EYES
- ☐ Vision Changes
- ☐ Eye Pain
- ☐ Eye Discharge

EARS, NOSE THROAT
- ☐ Change in Hearing
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Throat Pain
- ☐ Congestion

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Dizziness
- ☐ Fainting
- ☐ Shortness of Breath
- ☐ Leg Swelling

PULMONARY
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Blood in Sputum

GASTRO-INTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Incontinent of Stool

GENITOURINARY
- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Urinary Urgency
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incontinence
- ☐ Pain with Intercourse
- ☐ Discharge

ENDOCRINE
- ☐ Fatigue
- ☐ Dry Skin
- ☐ Tremors
- ☐ Sweating
- ☐ Cold or Heat Intolerance
- ☐ Change in Hair

HEMATOLOGY
- ☐ Bruising Easily
- ☐ Unusual Bleeding
- ☐ Bleeding from Nose

MUSCULAR/SKELETAL
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain

NEURO
- ☐ Headache
- ☐ Extremity Weakness
- ☐ Numbness
- ☐ Loss of Balance

PSYCH
- ☐ Depression
- ☐ Anxiety
- ☐ Memory Loss
- ☐ Thoughts of Suicide

SKIN
- ☐ Rash
- ☐ Lesions

BREASTS
- ☐ Masses
- ☐ Lumps
- ☐ Lesions
- ☐ discharge

VERDE COMMUNITY HEALTHCARE
657 E Cottonwood Street Ste 10, Cottonwood, AZ 86326
P: 928-634-6369 / F: 928-649-0228

HIPAA Authorization to Release Protected Health Information

Name of Patient: ________________________________ Date of Birth: __________________

I hereby authorize medical providers and personnel of Verde Community Healthcare to discuss my protected health information with:

(Printed Name) (Phone #) (Relationship)

(Printed Name) (Phone #) (Relationship)

(Printed Name) (Phone #) (Relationship)

I understand certain protected health information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information (check all that apply)
________ Information regarding a diagnosis and treatment for HIV/AIDS
________ Information specific to mental health or illness
________ Information specific to drugs and/or alcohol abuse
________ Information specific to a sexually transmitted disease and/or reproductive care

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

This authorization shall remain in effect for all past, present, and future periods unless revoked, preferably in writing, at any time by notifying your doctor or his/her staff.

- **I understand I have the right to revoke this authorization, in writing, at any time.**
- **I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.**
- **I understand I have the right to refuse to sign this authorization.**

Signature of Patient/Personal Representative **Printed Name of Patient/Personal Representative** **Today's Date**

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices and Rights and Responsibilities

I understand that under the Health Insurance Portability & Accountability Act 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- **To conduct, plan and direct my treatment and follow-up among the healthcare providers who are involved in my medical treatment, directly and indirectly.**
- **To obtain payment from my Insurance Company and any third-party payers.**
- **To conduct normal healthcare operations such as quality assessments and physician certifications.**

By signing below, I understand that I can request a copy of the HIPAA Notice of Privacy Practices. These forms are also available on our website @ verdecommunityhealthcare.com. The HIPAA Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office healthcare operations. The HIPAA Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Verde Community Healthcare reserves the right to revise the privacy practices that are described in the HIPAA Notice of Privacy Practices. If this notice changes, I will be offered a copy of the revised HIPAA Notice of Privacy Practices at the time of my first visit the revisions become effective. I may also obtain a revised copy by requesting that one be mailed to me.

Signature of Patient/Personal Representative **Printed Name of Patient/Personal Representative** **Today's Date**

VERDE COMMUNITY HEALTHCARE
657 E COTTONWOOD ST, STE 10, COTTONWOOD, AZ 86326
928-634-6369

FINANCIAL POLICY/CONSENT FOR TREATMENT

1. The patient is responsible for all charges incurred at Verde Community Healthcare (VCH). The charges on the bill cover the office visit, injections, minor procedures, EKGs, and any other services that were provided at the time of service.
2. If you have insurance, VCH will file a claim on your behalf as a courtesy. Your insurance company may not cover the entire amount of the fees. Any fee not paid by your insurance company will be the responsibility of the patient. The fees that may not be covered in full may be due to any of the following reasons:
   a. Your insurance may deny coverage for this particular service.
   b. Your insurance may be out of network for the provider.
   c. You may have a deductible, co-insurance, and/or a co-pay that you must first meet.
3. VCH may or may not be contracted with your insurance company. We suggest that you contact your insurance company to verify your in-network and out- of- network benefits. VCH will call your insurance company to verify if authorization is required, but this is not a guarantee of payment by your insurance.
4. If your insurance is an HMO plan, you will need to contact your insurance company and verify that you have selected our provider(s) as your PCP.
5. If you do not have insurance, payment will be collected at time of service. You may request a price quote of the charges for service prior to being seen. The quote of charges will be an estimate amount of what the minimal charge could be and the maximum charge.

NO SHOW POLICY: If you are unable to make your appointment, we ask that you cancel your appointment at least 24 hours prior to your appointment time. Failure to cancel in a timely manner may result in a NO-SHOW fee of $25.00. Continuous No-show encounters may result in you being discharged from our practice.

If you arrive 10 minutes after your appointment time, you will be asked to reschedule your appointment.

FINANCIAL AGREEMENT By signing below, I agree that payments for all charges incurred are my responsibility. I certify that I have read, understood, and agree to the above financial information, and that I can receive a copy of this information upon my request.

CONSENT FOR TREATMENT

1. By signing below, I consent to any and all health care treatment provided by VCH and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at VCH.
2. I consent to the use and disclosure of my/the patient's protected health information for the purposes of obtaining payment for service rendered to me/the patient, treatment and health care operations consistent with the VCH Notice of Privacy Practices.
3. I authorize payment of medical benefits to VCH for services rendered.
4. I give permission to obtain all of my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

DISCLOSURE

I have been advised that VCH is a For Profit Center and that Farshid Paydar, M.D. has a financial interest in VCH.

Patient/Responsible Party Signature:______________________ Date:______________Time:_________

Relationship to patient: ___________________________ Witness:________________________________

Verde Community Healthcare

Commonwell
HEALTH ALLIANCE

Dear Patient,

We believe that patients and your caregivers should have easy access to your medial information, no matter where you receive care. That's why we're participating in CommonWell, a service that allows a network of healthcare providers to identify you, securely send and receive your medical information, and ensure that you receive optimal care.

What is CommonWell?
A free, secure service offered by your doctor so your health information can be available to you and your doctors regardless of where you've received care.

You simply need to enroll in the service with a driver's license (if applicable) and then confirm the other CommonWell network doctors you see. Don't worry if you don't have a government-issued picture ID, you can still register.

How do we use the health information we share through CommonWell?

- **Better coordinate your care across different doctors –** We'll provide and request to receive your information where and when it's needed for your healthcare provider to deliver the care you need as you move from doctor to doctor.
  Only healthcare staff directly involved in your care will access your medical information shared through CommonWell.
- **Support better care decision-making** – With timely access to information from other healthcare providers you've seen, your doctors may be able to make better decisions about your health.
  This information will only be used to help improve your care; and won't be shared without your permission or unless it's required by law.
- **Deliver care more promptly and efficiently** – With less time wasted on tracking down your test result and other health information, your healthcare providers can treat you more efficiently, and spend less time on paperwork and more time on your care.
  We do need your help in confirming the other doctors or hospitals you've visited when you enroll in CommonWell.
- **Securely and confidentially –** Your Protected Health Information (PHI) will always be confidential and used to inform the CommonWell participating healthcare providers. We Won't use your PHI for discriminatory purposes of any kind or to deny medical treatment.
  You can opt-out of this service anytime by calling or visiting this doctor's office and asking them to unenroll you from CommonWell.

How do I sign up?
It's quick and easy. Show the staff at the front desk or during patient discharge your government-issued ID (If applicable) and tell them what other doctors, hospitals and healthcare providers you've seen.

Patient Signature: ______________________________ Date: ______________

REVISED 1/2025

VERDE COMMUNITY HEALTHCARE

657 E COTTOWOOD ST STE 10
COTTONWOOD, AZ 86326
Ph: 928-634-6369 / Fax: 928-649-0228

RELEASE OF MEDICAL INFORMATION

*** * * Please note that we cannot receive records in the form of CD, Thumb Drive or Email due to security policies * * ***

PATIENT INFORMATION:

Full Name: ____

Last 4 #'s of Social Security #: ____________ Date of Birth: ____________ Telephone: _(____)________________

Address: ______________________________ City: _________________ State: __________ Zip Code: ___________

Date (s) of Medical Care: __________________

Health Care Provider We Are REQUESTING Records From:

I authorize ______________________________to release all information contained in my medical record.
(Name of provider)

Date (s) of Medical Care: ____

Including:

Confidential HIV-Related information (As defined in A.R.S. Section 36-661)
Confidential communicable disease related information (As defined in A.R.S. Section 36-661)
Confidential alcohol or drug abuse-related information (As defined in 42 CRF Section 2.1 ET SEQ)
Confidential mental health diagnosis/ treatment information
Confidential genetic testing information (As defined in A.R.S. Section 12-280)

Please mail or fax to:
Verde Community Healthcare @ 657 E Cottonwood Street Ste 10 Cottonwood, AZ 86326 Fax: 928-649-0228

I release Verde Community Healthcare, LLC, and its staff from all legal responsibility or liability that may arise from the release of this information. This consent may be revoked by me at any time, except when action has been taken. This release expires 90 days from the below date.

Patient's Signature: ____ Date: __________________________