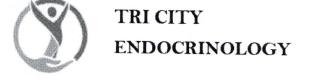


## Tri City Endocrinology New Patient form

	_	
Last Name:	First:	M. I:D.O.B:Sex:
		State: Zip Code:
		Advance <i>Directive:</i> Yes or No
SSN:	Home number:	Cell number:
		Employer number:
		Phone#:
		Phone#:
	INSURANCE INFORMATION	
Primary Insurance:	ID#:	Group#:
		Phone#:
		Occupation:
Secondary Insurance:	ID#:	Group#:
		Phone#
		Occupation:
Address (if different):		SSN:
	EMERGENCY CONTACT	
	Relationship to patient:	Phone#:

\_Date:\_

Signature of patient/guardian:\_\_\_\_\_



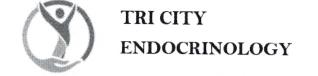
As a patient or guardian for a patient receiving services from Dr. Manal Alhakim, MD, I understand that I am responsible to cancel appointments within appropriate time frames. I do hereby agree to the following:

- 1.) I will cancel a scheduled appointment at least 24 hours before the appointment.
- 2.) I agree to pay a **\$50 No Show Fee** for a scheduled appointment and confirmed appointment.
- 3.) Allowances will be made for failing to keep my appointments due to unavoidable or reasonably.
- 4.) My provider may terminate my services if I do not cancel or fail to attend three scheduled appointments
- 5.) Should my provider terminate my services, they will send me a letter. This letter will explain a 30-day grace period that will be given to enable me to secure alternative services and will also allow prescription refills when medically appropriate for 30 days from the date of the termination of service letter.

Patient Signature:	Date:		
	PRESCRIPTION REFILL POLICY		

Prescription refill request must be made **7-10 days before running out of medication**, also please allow up to 72 hours for the refill to be processed. Refills will only be approved if your follow- up visits have been kept per your physician's recommendation. Prescriptions will only be handled during business hours.

Patient Signature:	Date:	

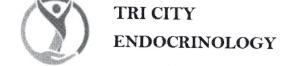


Patient Name:

## **Notice of Privacy Practices**

Patient Name:	DOB:
I have the option to receive or decline <u>(cir</u>	rcle one) this practices Notice of Privacy Practices written in plain
	the uses and disclosures of my protected health information that
	ial rights and the practices' legal duties with respect to my protected
	the right to change the term of its Notice of Privacy Practices and to
	ected health information that is that it maintains. I understand that I
can obtain this practice's Notice of Privacy	y Practices on request.
I participate in an organized health care arr	rangement consisting of greater Phoenix metropolitan area hospitals
as well as physicians who have medical sta	aff privileges at one or more of these hospitals.
Participants in this arrangement work toget	ther to improve the quality and efficiently of the delivery of healthcare to
their patients. As a participant in this arran	gement, we may share you PHI with other members of this arrangement
for purpose of treatment, payment or the he	ealth care operations of this organized health care arrangement.
Signature	Date:

I am a patient of Tri City Endocrinol	logy.		
I would like to request that this in	ndividual:		
	Phone Number:		
		ndividual:	
and any medical changes.		ons, allowing the staff or physician	
Patient Signature:		Date:	
Please note: All medical records ar mail without written/verbal consen	re kept confidential; no info	rmation will be transmitted by phor	ne, fax, or



## Authorization of Medical records

Patient Name:	DOB:	
The above authorizes:		
Medical provider:		
Phone:	Fax:	
Purpose of release:		
Appointment/ Continuation of care	other:	
Medical records:		
Specific records:	Date:	
Radiology Reports:		
Other:		
Patient Signature		

\*\*\*PLEASE NO CD'S. THANK YOU!!!\*\*\*

To Release medical records information concerning the above mention patient to **Manal Alhakim**, **MD**This consent will expire in 90 days after the signed date below. I have given my consent freely, voluntarily and without coercion, I may revoke this authorization at any time providing I notify them in writing to that effect. I understand that any release which wasn't made prior to revocation in compliance with this authorization shall not constitute a breach of my rights to confidentially. I understand subject to re- disclosure by the recipient and no longer protected by the privacy act.



## **Medication List**

ient Name:		DOB:		
'Pharmacy /MailOrder**	Pharmacy Phone #		Cross Streets	
Name of Medication	Dosage (mg)	Times	Гакеп <b>(АМ-РМ)</b>	Pill/Injection
Name of Insulin	# 06	T: 5		
Ivalite of Hisuffi	# of units per day	Times	Taken (AM-PM)	Pen or Vials
Name of BS Meter	Name of Test Strips	Nam	ne of Lancets	# of times you test daily
Name of Insulin Pump				
· · · · · · · · · · · · · · · · · · ·				