

MediTouch Upload & Update

Entered By: _____

Date: _____

YEAR

Patient Information

Patient Name: _____ Date of Birth: ____/____/____ Gender: M / F

Address: _____ Apt,Suite,Unit#: _____

City: _____ State: _____ ZIP: _____

Home#:(____)____ - _____ Work#:(____)____ - _____ Cell#:(____)____ - _____

Occupation: _____ Referred By: _____

Email: _____ Marital Status: Single / Married / Divorced / Widowed

Emergency Contact List

Name: _____ Date of Birth: ____/____/____ Phone#: _____

Relationship: _____

*Are you currently covered by health insurance? **Yes / No***

Insurance Company: _____

Subscriber/Policy ID#: _____ Group#: _____

*Are you the Primary Insured, Policy Holder? **Yes / No***

(If you answered No; please fill out the Policy Holder's information)

Policyholder's Name: _____ Policy Holder's Date of Birth: ____/____/____

******PLEASE ALLOW OUR STAFF TO MAKE A COPY OF YOUR DRIVERS LICENSE & INSURANCE CARD******

Release of Medical Information

I _____, give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members listed below.

<u>Name of Authorized Individuals</u>	<u>Relationship to Patient</u>	<u>Date of Birth</u>
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

Printed Name

Signature

____/____/____
Date



HIPAA – Notice of Privacy Practices

This notice, effective immediately, describes how medical information about you may be used and disclosed as well as how you can get access to this information. Please review carefully. Our office is required by law to maintain the privacy and confidentiality of your protected health information in addition to providing our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for payment or health care operations. We have your permission to disclose your health care information to your insurance company for appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers’ Compensation laws, Public Health Authorities, Emergency situations, Judicial an Administrative proceedings, Law Enforcement and Medical Examiners. Your health care information may also be disclosed to Research that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information as well as provide you with notice of its legal duties and privacy practices with respect to your health information.

I understand and have been provided with a Notice of Privacy Practices, which offers a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Printed Name

____/____/_____
Date

Signature

Vitality Internal Medicine
18205 N. 51st Ave Ste 129
Glendale, AZ 85308

Scottsdale Internal Medicine
13840 N. Northsight Blvd Ste 121
Scottsdale, AZ 85260

Vitality Internal Medicine
4653 S. Lakeshore Drive Ste 2
Tempe, AZ 85282

McKellips Internal Medicine
3049 E. McKellips Road Ste 5
Mesa, AZ 85213

Vitality Internal Medicine
4643 N. 12th Street Ste 101
Phoenix, AZ 85014

Vitality Internal Medicine
10320 W. McDowell Road Ste 5015
Avondale, AZ 85392



Patient Responsibility & Assignment of Benefits

Our practice is committed to providing you with the best possible health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions or concerns about our fees, or any content written in our Financial Policy below.

As a courtesy, we will submit claims for all services rendered to your insurance company. Please note your individual health insurance policy is a contract between you and your insurance company, and we cannot guarantee benefit coverage and/or payment. Coverage is based on medical necessity, plan limitations, and guidelines. Please keep in mind that some of our services may not be covered by your insurance policy. By providing for care, you agree that you are responsible for all services and charges, regardless of your insurance.

While providing care for your medical need's certain tests and/or services are necessary for diagnosis, treatment, and maintenance of good health. All lab work performed in our office will be sent to Labcorp, Sonora Quest, or a third-party laboratory, and billed to your insurance. If these tests and/or services are not covered by your health insurance; you may receive a separate bill from Labcorp, Sonora Quest, or third-party laboratory for those services rendered.

It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment, co-insurance, or deductible balances at the time of service, you may also be responsible for services not covered by your insurance carrier. Insurance companies may set certain guidelines and/or limitations, understand it is your responsibility to abide by the guidelines set by your individual insurance policy. If your insurance carrier denies the medical claim, the patient is responsible for timely payment of the account.

Cancellation & Late Fees

A 24-hour notice is required if you are unable to keep your appointment. Missed appointments and appointments not cancelled within a 24-hour notice will be subject to a fee of \$50.00 and must be paid before you are able to be rescheduled. _____ (Initial)

If you are more than 15 minutes late for your scheduled appointment (other than weekly TRT visits) and fail to call informing the practice in advance you will be subject to a late fee of \$25.00. _____ (Initial)

I have read the financial policy for the practice and understand that I am responsible for all charges on my account. It is my financial responsibility to supply payment for any charges not covered by my insurance plan including, but not limited to co-insurance, co-payments, and deductibles. I understand that co-payments for the office are due at the time of service.

Printed Name

_____/_____/_____
Date

Signature

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Lab Test Results Communication

The foundation of good healthcare is built on timely and thorough communication. We want to give solutions for those who may not be available to accept phone calls during traditional office hours. Additionally, we take our responsibility to protect your privacy seriously. Regardless of which option you choose, if at any time you have questions regarding test results we are happy to discuss them with you further. Carefully read the options below and choose the option that best fits your needs by initialing it. Thank you!

_____ **Phone/Voicemail**

Please call me to review my test results. If you do not reach me, you may leave a detailed message on my voicemail with my results.

_____ **Phone only**

Please call me to review my review my test results. If you do not reach me, please leave a message for a return call. I only want to receive test results by speaking to a staff member, and DO NOT want detailed messages left on my voicemail.

_____ **Email only**

Please send my test results at _____.

If I have any questions I will call the office and speak with a staff member.

_____ **No call**

Please do not call, I will go over my test results at my next office visit.

Patient Name: _____ Phone Number: _____

Patient Signature: _____ Date: _____

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Electronic Prescription Pharmacy Preference

Name _____

Date _____

Please choose your preferred retail and/or mail order pharmacy for approved prescriptions to be sent electronically.

Local Pharmacy:

Pharmacy Name: _____ Phone Number: _____

Address / Cross Streets:

Mail Order Pharmacy:

Pharmacy Name: _____ Phone Number: _____

Address / Cross Streets:

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ALERT TO ALL PATIENTS
NO CALL - NO SHOWING APPOINTMENTS

Hello All Patients,

A new protocol is in effect 01/01/2019 regarding the importance of calling 24 hours in advance to cancel a scheduled appointment and calling prior to your appointment time to notify the office that you will be late to your scheduled appointment. If the appointment is not canceled 24 hours in advance or you no show an appointment there will be a fee of \$50. Also, if you are more than 15 minutes late to your appointment there is a late fee of \$25 and it is up to the providers discretion if you can still be seen that day or need to be rescheduled to another day. These fees must be paid for prior to scheduling your next appointment. This is to ensure each patient has the availability to schedule an appointment if needed in that time slot. We appreciate your cooperation in advance.

Sincerely,
MVC/Vitality Internal Medicine Staff

Please sign/print your name below stating you understand the new protocol and that you are aware of this new update effective 01/01/2019.

Signature

Print

Date: _____

Employee Initial: _____

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Health History Form

Your answers to this form will help your healthcare providers better understand your medical concerns and conditions.

Name _____ Date of Birth _____ Age _____ Today's Date _____

PAST MEDICAL HISTORY

Medical Problems/Hospitalizations (i.e. diabetes, cancer, high blood pressure, high cholesterol, depressions, ect.)	Surgical History (i.e. tonsillectomy, appendectomy, hernia, hysterectomy, colonoscopy, ect.) Include month/year

FAMILY MEDICAL HISTORY

Father Living, Any Medical Conditions: _____
 Deceased, Cause of Death: _____

Mother Living, Any Medical Conditions: _____
 Deceased, Cause of Death: _____

Brothers ____ # Living, Any Medical Conditions: _____
 Deceased, Cause of Death: _____

Sisters ____ # Living, Any Medical Conditions: _____
 Deceased, Cause of Death: _____

Specific Illness in Family History: (i.e. colon cancer, breast cancer, prostate cancer, heart disease, stroke, etc.) None
If so, please state disease and who: _____

SOCIAL HISTORY

Tobacco Use: Never Former Current ____ #packs/day ____ # years Date stopped smoking: _____

Alcohol: None Rarely Social 1-2 Drinks/Day Greater than 2 drinks/day Greater than 6 drinks/day

Is your alcohol use a concern for you or others? No Yes

Illicit Drug Use: Never Former Current: _____ Stopped Use Date: _____

Caffeine Use: None Coffee Tea Soda ____ # cups/day

Education: High School Some College Degree(s) _____

Occupation: _____

Marital Status: Single Married ____ years Divorced Widowed Spouse's Name: _____

Number of Children/Ages: _____

Special Interest/Hobbies: _____

Do you have Advanced Directives? Yes No **Power of Attorney for Medical Care?** _____

Health History Form

Allergies (If any, please list name of agent and reaction such as rash/hives, swelling) No Known Drug Allergies

Current Prescription Medication NONE

Name	Dose	How Often	Reason For Use

Non-Prescription/Herbals/OTC/Vitamins NONE

Name	Dose	How Often	Reason For Us

PREVENTATIVE SCREENING/IMMUNIZATIONS

Exam/Test <i>(indicate last date performed)</i>	Immunizations <i>(indicate last date administered)</i>
<input type="checkbox"/> Cholesterol (Lipid Panel) _____	<input type="checkbox"/> Pneumovax (Pneumonia) _____
<input type="checkbox"/> Glucose (Diabetes) _____	<input type="checkbox"/> Influenza (Flu) _____
<input type="checkbox"/> Cardiovascular Disease (EKG) _____	<input type="checkbox"/> Zostavax (Shingles) _____
<input type="checkbox"/> Osteoporosis (Bone Density) _____	<input type="checkbox"/> Tdap (Tetanus/Diphtheria/Pertussis) _____
<input type="checkbox"/> Prostate Cancer (PSA/DRE) _____	<input type="checkbox"/> Td (Tetanus/diphtheria) _____
<input type="checkbox"/> Breast Cancer (Mammogram) _____	<input type="checkbox"/> Hepatitis B _____
<input type="checkbox"/> Cervical Cancer (Pap Smear) _____	<input type="checkbox"/> Hepatitis A _____
<input type="checkbox"/> Colon Cancer (Colonoscopy) _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Lung Cancer (Chest Xray) _____	
<input type="checkbox"/> Abdominal Aorta (AAA) _____	
<input type="checkbox"/> Carotid Disease (Ultrasound) _____	
<input type="checkbox"/> Echocardiogram _____	
<input type="checkbox"/> Last Menses (Period) _____	

Health History Form

REVIEW OF SYSTEMS Please check any recent or recurring problems:

<p>Constitutional</p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight Gain _____ lbs <input type="checkbox"/> Weight Loss _____ lbs <input type="checkbox"/> Exercise Intolerance	<p>Respiratory</p> <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Pain with Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Snoring <input type="checkbox"/> Sleep Apnea	<p>Genitourinary</p> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Pain with Urination <input type="checkbox"/> Incomplete Emptying <input type="checkbox"/> Urinary Loss of Control <input type="checkbox"/> Urinary Frequency <input type="checkbox"/> Urinary Hesitancy <input type="checkbox"/> Post-Void Dribbling <input type="checkbox"/> Erectile Dysfunction	<p>Psychiatric</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Stress <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Depression <input type="checkbox"/> Mania <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Alcohol Overuse <input type="checkbox"/> History of Addiction <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Do Not Feel Safe
<p>Eyes</p> <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Irritation <input type="checkbox"/> Vision Changes <input type="checkbox"/> Cataract History	<p>Cardiovascular</p> <input type="checkbox"/> Arm Pain with Exertion <input type="checkbox"/> Chest Pain with Exertion <input type="checkbox"/> Chest Heaviness <input type="checkbox"/> Irregular Heart Beats <input type="checkbox"/> Known Heart Murmur <input type="checkbox"/> Lightheaded on Standing <input type="checkbox"/> Shortness of Breath w/ Exertion <input type="checkbox"/> Swelling (Edema)	<p>Musculoskeletal</p> <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Fractures <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Use of Assist Device	<p>Integumentary (Skin)</p> <input type="checkbox"/> Change in Mole <input type="checkbox"/> Dry Skin <input type="checkbox"/> Eczema <input type="checkbox"/> Rash <input type="checkbox"/> Growth/Lesion <input type="checkbox"/> Itching <input type="checkbox"/> Jaundice (yellow skin/eye) <p>Allergic/Immunological</p> <input type="checkbox"/> Sneezing <input type="checkbox"/> Hives/Rash <input type="checkbox"/> Itching <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sinus Pressure
<p>Ears/Nose/Mouth/Throat</p> <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Ear Pain <input type="checkbox"/> Nose/Sinus Issues <input type="checkbox"/> Snoring <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Frequent Nosebleeds <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> Hoarseness <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Mouth Breathing <input type="checkbox"/> Mouth Ulcers	<p>Hematologic/Lymphatic</p> <input type="checkbox"/> Easy Bruising/Bleeding <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Anemia	<p>Neurologic</p> <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Poor Balance <input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Memory Loss <input type="checkbox"/> Numbness <input type="checkbox"/> Restless Legs <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness	
<p>Gastrointestinal</p> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Black/Tarry Stool <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Change in Appetite <input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn <input type="checkbox"/> Frequent Belching <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood			

<p>Men Only</p> <input type="checkbox"/> Pain or Lump in Testicle <input type="checkbox"/> Penis Burning/Itching/Discharge <input type="checkbox"/> Prostate Disease/Problems <input type="checkbox"/> Night-Time Urination <input type="checkbox"/> Sexual Problems/Concerns <input type="checkbox"/> Low Sex Drive	<p>Women Only</p> <input type="checkbox"/> Vaginal Itching/Burning/Discharge <input type="checkbox"/> Night-Time Urination <input type="checkbox"/> Breast Tenderness/Discharge <input type="checkbox"/> Breast Lump <input type="checkbox"/> Ovarian Cysts	<p>Total Pregnancies _____</p> <p>Births _____</p> <p>Miscarriages _____</p> <p>Abortions _____</p> <p style="text-align: right;">Age Menses/Period Started _____</p>
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