Patient Registration/Release Authorization

Thank you for choosing our office for your healthcare needs. In order to serve you properly, we ask that you complete this form. All information will be strictly confidential.

Today's Date: ______________________

Patient Information

Last Name: ________________________ Middle Name: _____________________First Name: _________________________

Date of Birth: _________________________ Gender: (please circle one) Female Male

Marital Status: (please circle one) Single Married Divorced Separated Widowed Partner

Mailing Address: ____ APT #: _______________________

City: _____________________________________ State: ______________________ Zip: ______________________

Social Security Number: ___________________________ Email Address: ____

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: ______________________

Primary phone number for follow up purposes? (please circle one) Home Cell Work

Preferred method of communication for appointment reminders? (please circle one) Phone Text Email

Spouse Full Name: ______________________________________ Date of Birth: __________________________

If patient is a minor, please complete:

Person Responsible or Guardian: __________________________ Date of Birth: ________________ Phone: ___________

I'm interested in signing up to use the Patient Portal? (please circle one) Yes No

How did you learn about OneLife Medical Center? (please circle one) Online Print Advertisement Friend/Family Other

Insurance Information

Primary Insurance: _______________________________Policy #: __________________________ Group #: ____________

Primary Insurance Address: ____

City: ___________________________________ State: __________________________ Zip: ___________________________

Effective Date: ________________________ Co-Pay: ____________________ Deductible: ___________________

Policy Holder (if different than patient): ___________________________________ **Date of Birth:** ____________________

Secondary Insurance: _____________________________ Policy #: __________________________ Group #: ___________

Secondary Insurance Address: ____

City: ____________________________________ State: _________________________ Zip: ___________________

Effective Date: _________________________ Co-Pay: ____________________ Deductible: ___________________

Patient's relationship to subscriber? (please circle one) Self Spouse Child Other

Patient Registration/Release Authorization

Patient Name: ____ Date: _________________________

Demographic Information

Race (please circle one): White African American American Indian Asian Declined to Specify

Ethnicity (please circle one): Hispanic/Latino Not Hispanic/Latino Declined to Specify

Pharmacy Information

Preferred Pharmacy: ____ Phone Number: ______________________

Address: ________________________________ City: ___________________ State: __________ Zip: _________

Emergency Contacts

Emergency Contact Name: _________________________________ Phone: ___________________________

Relation to Patient: _________________________________

Emergency Contact Name: _________________________________ Phone: ___________________________

Relation to Patient: _________________________________

HIPAA

To protect your privacy as outlined by HIPAA (Health Information Portability Accountability Act), please indicate below who we may release medical information to. Please include their name and relationship to patient.

Name: ______________________________________ Relationship to Patient: _____________________________

Name: ______________________________________ Relationship to Patient: _____________________________

Please indicate below anyone we may **NOT** release medical information to.

Name: ______________________________________ Relationship to Patient: _____________________________

Name: ______________________________________ Relationship to Patient: _____________________________

Please initial the following statement:

______________ The above information is true to the best of my knowledge.

______________ Yes, I give permission to OneLife Medical Center to leave a message regarding my test results, appointments, etc.., at the following phone numbers.

______________ No, I do not give OneLife Medical Center to leave any messages regarding my test results, appointments, etc..

Patient or Guardian Signature: ____ Date: ___________________

Patient or Guardian Name (print): ____ Date: ___________________

**Failure to sign the above acknowledgements may results in having to reschedule your appointment until a signature is obtained.*

New Patient Health Information

Patient Name: ___________________________________ Date of Birth: __________________ today's Date: __________

Prescriptions, Over the Counter Medications, and Supplements

Include name, strength, number of pills and how often taken. Example: Ibuprofen, 200mg, 2 tablets, 2 times a day.

1.	**2.**
3.	**4.**
5.	**6.**
7.	**8.**
9.	**10.**
11.	**12.**
13.	**14.**
15.	**16.**

Medical History (previous health problems)

1.	**2.**
3.	**4.**
5.	**6.**
7.	**8.**
9.	**10.**

Drug Allergies or Intolerances: Yes/No

1.	**2.**
3.	**4.**
5.	**6.**

Surgical History

Please also list any implants you may have had, such as pins, plates, stents, pacemakers, augmentations.

1.	**2.**
3.	**4.**
5.	**6.**
7.	**8.**

Recent Hospitalizations

Please include the name of the hospital, reason and duration of stay.

1.	**2.**
3.	**4.**
5.	**6.**
7.	**8.**

Family History

☐ **Father**	☐ **Living-Age:**	**Deceased, Age at Death:**	**Cause:**
☐ **Mother**	☐ **Living-Age:**	**Deceased, Age at Death:**	**Cause:**

List other illnesses in your family (example-diabetes, heart disease, colon cancer, breast cancer, etc.)

Family Member: ____________________ Illness: _____________________ Family Member: __________________

Family Member: ____________________ Illness: _____________________ Family Member: __________________

☐ **Smoke?**	**If yes, how much? ____**	**# of packs/day: ____**	**# of years: ____**	**When did you stop? ______**

☐ **Alcohol?**	**If yes, how much?**

Have you ever used recreational drugs? (i.e. marijuana, cocaine) If yes, what/when: ________________________________

Victim of Domestic Violence? ☐ Yes ☐ No

Exercise regularly? ☐ Yes ☐ No If yes, what/when: ____

Patient Consent for Use and Disclosure of Health Information

Patient Name: ____

Address: ____ APT #: ____________________________

City: ____ State: ____________________________ Zip: _____________________

Telephone: ____ E-mail: ____

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purpose of carrying out treatment, obtaining payments, and carting on healthcare operations for your care.

By signing this consent form, you will have acknowledged that you have read our Notice of Privacy Practices.

You have the right to revoke this consent by submitting your revocation to us in writing. Any action we took prior to your revocation will not be affected. We may choose to discontinue your treatment you revoke your consent for us to use and disclose your health information for the reason stated above.

I, ____, (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____ Date: _____________________________________

Personal Representative's Name: ____________________ Relationship to Patient: _____________________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IN.

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that any action you took prior to my revocation will not be affected. As a result of my revocation, you may elect to discontinue treating me.

Signature: ____ Date: ___________________________________

Print Name: ____

**Failure to sign the above acknowledgements may results in having to reschedule your appointment until a signature is obtained.*

21321 E Ocotillo Rd Ste. 133 Queen Creek, AZ 85142
Ph: 480-987-5525 – Fax: 480-987-5115

Authorization for Release of Medical Records

Patient Information (please print)

Name: ____ Date of Birth: _____________________________
Address: ____
City: _____________________________________ State: ___________________________ Zip: _______________________
Phone: ___________________________________

Release Information

Name/Business: ____
Address: ____
City: ____ State: ________________________ Zip: ____________________
Telephone: ____ Fax: ____

Specific Description of Information to be Used and Disclosed

Please indicate the time period you are requesting records for Dates of Service Form: _____________to_____________

- ☐ Entire Medical Records, **including** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS
- ☐ Entire Medical Records, **excluding** information related to treatment of substance abuse or dependency, psychiatric or mental health treatment, information related to the testing or treatment of sexually transmitted diseases and HIV/AIDS
- ☐ Past _____________ years
- ☐ Lab Results
- ☐ Imaging Results
- ☐ Other (please be as specific as possible, including any information you DO NOT want released):
  ____
  ____
  ____

Reason for Release

- ☐ Personal Copy
- ☐ Legal
- ☐ Continuation of Care (specialist)
- ☐ Changing Primary Care Physician

By voluntarily signing this form I affirm that I am the above patient, parent or legal guardian and have read and fully understand all statements made in this document. I understand that this authorization is valid for 1 year unless otherwise specified and I have the right to revoke this authorization at any time by providing a written statement to OneLife Medical Center where the authorization was originally submitted, expect to the extent that OneLife Medical Center has already completed action on it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

Patient or Guardian Signature: ____ Date: ______________________
Print Name: ____ Relationship to Patient: __________________________

Office Policies

Please carefully read and sign below to indicate understanding of the OneLife Medical Center Office Policies.

- **Documentation to be Completed:** To ensure accuracy in the completion of any insurance forms (including disability, FMLA or other documents), we require an office visit. **No exceptions**.

- **Medical records request:** Medical records will be sent to another provider at no charge. There will be up to a $25 charge for patients requesting a copy of their personal medical records.

- **Minor age patients:** OneLife Medical Center requires that a parent or legal guardian accompany all minor patients. The parent or legal guardian that accompanies the minor for medical services will be responsible for payment.

- **Release of information:** I authorize OneLife Medical Center to release any information acquired in the course of my treatment as required for processing insurance claims. I also authorize the release of my medical information to any requesting source presenting a signed authorization by me.

- **Authorization to treat**: I hereby authorize the staff of OneLife Medical Center to provide me with medical treatment. I agree to inform them if I have any concern about my medical treatment at the time the services are being rendered.

- **Callbacks:** When you are leaving a message for the providers, please disclose the reason for your call. This will expedite your call through our office. Also keep in mind callbacks will be done after all patients in the office have been seen. Non-urgent messages will be returned within 24-48 hours. The quickest way to communicate with your provider or medical assistant is through your portal.

- **Referrals/Prior Authorization:** It is your responsibility to make sure the specialist's is in your network. Notify our office one week prior to your specialist appointment with the specialist's information to complete the referral. For prior authorization for medications, your insurance company may take 72 hours or more.

Patient or Guardian Signature: ____ Date: ____________________

Patient or Guardian Name (Print): ____

Financial Policies

Thank you for choosing OneLife Medical Center as your health care provider. We are committed to provide the best quality medical care. In order to reduce potential confusion, we have adopted the following Financial Policy Guidelines. Please carefully read and sign below prior to the commencement of any treatment. It is important that we work together to assure that payment for services is as simple and straightforward as possible.

Insurance

- I understand that if I do not have my insurance card and/or copayments the day of the appointment, that my appointment may be rescheduled until such time that I can provide documents or payments.
- I understand OneLife Medical Center cannot bill my insurance company unless I give current and valid insurance information. All health plans are not the same and they do not always cover the same services. In the event your health plan determines a service is "not covered", I will be responsible for the complete charge.
- I understand that OneLife Medical Center will collect deductibles and coinsurance up to an amount equal to payment in full for the planned office visit, prior to any office visit and procedure takes place. Payment in full and expected coinsurance payment responsibility are determined by the anticipated medical billing codes (s), details of your insurance policy, and agreement between your insurance company and OneLife Medical Center.
- I understand that if my account is not paid in full within 90 days, a collection processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.
- I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payments of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds.
- OneLife Medical Center will allow 60 days from the date of filing for my insurance company to process or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for service. It is also my responsibility to notify OneLife Medical Center if there is any change in my insurance coverage, residence or phone number. Ultimately, it is up to me to know my insurance benefits.
- I understand OneLife Medical Center is not responsible for disputing my insurance company's decision regarding coverage.
- I have read and understand the above Financial Policy and I agree to abide to its terms.

Patient or Guardian Signature: ____ Date: ______________________

Patient or Guardian Name (print): ____