PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES				
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**CELL PHONE**	
PATIENT DATE OF BIRTH	**PATIENT SSN**	**SEX** ❑ **Male** ❑ **Female**	**MARITAL STATUS** ❑ **Single** ❑ **Married** ❑ **Other**_____	
PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)**		**EMPLOYER PHONE**	

INSURED/RESPONSIBLE PARTY INFORMATION		RELATION TO PATIENT: ❑spouse ❑parent ❑guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)		**ADDRESS (if different from patient)**		
HOME PHONE	**WORK PHONE**	**SSN**	**BIRTH DATE**	**EMPLOYER**

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**
SECONDARY INSURANCE NAME	**ADDRESS (STREET - CITY - STATE - ZIP)**		**PHONE**
GROUP NUMBER	**ID NUMBER**	**EMPLOYER**	**EMPLOYER PHONE**

PRIMARY DOCTOR/FAMILY DOCTOR	**REFFERING DOCTOR**	
IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE NUMBER**

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or if minor signature of parent or guardian)	**DATE**

Authorization to release health information to:			
Name(s)		**ADDRESS**	
CITY, STATE	**ZIP**	**HOME/CELL PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**		**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**	

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**	**EMAIL**

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies

- ❑ NONE/No Known Allergies
- ❑ Adhesive Tape
- ❑ Anesthesia
- ❑ Aspirin
- ❑ Codeine
- ❑ Dairy Products
- ❑ Iodine/Shellfish/Contrast Dye
- ❑ Latex
- ❑ Morphine
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Wheat

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures, or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ allergies
- ❑ anemia
- ❑ arthritis conditions
- ❑ asthma
- ❑ atrial fibrillation
- ❑ bleeding problems
- ❑ BPH
- ❑ CAD coronary artery disease
- ❑ cancer
- ❑ cardiac arrest
- ❑ celiac disease
- ❑ chest pain
- ❑ CHF congestive heart failure
- ❑ chronic fatigue syndrome
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ erectile dysfunction
- ❑ fibromyalgia
- ❑ gerd
- ❑ heart disease
- ❑ high cholesterol
- ❑ hyperinsulinemia
- ❑ hyperlipidemia
- ❑ hypertension
- ❑ hypogonadism male
- ❑ hypothyroidism
- ❑ infection problems
- ❑ insomnia
- ❑ irritable bowel syndrome
- ❑ kidney problems
- ❑ menopause
- ❑ migraines/headaches
- ❑ neuropathy
- ❑ nail fungus
- ❑ organ injury
- ❑ osteoporosis
- ❑ pulmonary embolism/blood clot in legs
- ❑ seizure disorders
- ❑ shortness of breath
- ❑ sinus conditions
- ❑ stroke
- ❑ syndrome X
- ❑ tremors
- ❑ wheat allergy

Medications: List any medications you are currently taking (to include over the counter medications):

PLEASE PRINT LEGIBLY

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

AUTHORIZATION FOR TREATMENT

CONSENT FOR MEDICAL TREATMENT / PROCEDURE

____ I give my consent for my physician at Agape Clinic to carry out any treatments, anesthetics, or operations that he or she determines are appropriate or required for my diagnosis and care. I am aware that practicing medicine and having surgery is not a precise science, and I acknowledge that the doctor has not given any assurances or warranties. I give permission and consent to having a sample of my blood tested for certain infectious diseases, such as hepatitis and the AIDS virus, in the event that a healthcare worker comes into contact with my blood or bodily fluids by mistake. I am aware that if certain tests are carried out as a result of exposure to a healthcare professional, I won't be charged for them. I understand the significance of such testing for both my own benefit and for healthcare personnel.

AUTHORIZATION FOR RELEASE OF INFORMATION

____ The physician is permitted to provide requested information or excerpts from the patient's medical record to the primary care or referring physician, if applicable, as well as to any insurance company or third-party payor in order to get paid for the patient's care. To any healthcare facility or provider for continuum of care, the doctor is permitted to distribute information from my medical file.

ASSIGNMENT OF INSURANCE BENEFITS

____ If the patient is eligible for medical benefits through an insurance policy protecting them or another person responsible for them, those benefits are hereby allocated to the doctor for inclusion on the patient's bill. The doctor may accept any such payment, and to the extent of that payment, the said insurance shall be released from all responsibilities under the policy. Charges not covered by this assignment are my responsibility.

FINANCIAL RESPONSIBILITY

____ I accept (as the patient or the responsible party) the obligation to pay all fees incurred by the doctor in connection with the patient`s treatment or expenses associated therewith in exchange for the services to be provided to the patient. The undersigned shall be responsible for paying the actual charges billed. Any prices that were anticipated at the time of treatment are liable to change.

CONSENT FOR PHOTOGRAPH TO BE TAKEN

____ I give my Agape Clinic consent to release my medical records to my primary care doctor, my referring doctor, my insurance company for the purpose of processing a claim, and any other entity I may authorize in the future, including my picture, if the doctor determines that it is appropriate to do so.

_____

Signature of Patient **Date**

Financial Responsibility

Verification of eligibility and benefits are conducted every time you have an office visit. However, per your insurance, this is not a guarantee of payment.

A copayment may apply if an illness is evaluated, or procedure is performed during a Well Exam.

Please, be advised that you may be subject to a deductible, co-insurance amount or copayment which we may not be aware of until the claim for the office visit has been processed by your insurance carrier. Should there be a remaining balance due after your insurance carrier has processed the claim; a statement will be sent to you for payment. Also, please be advised that failure to provide correct, new, or additional insurance information in a timely manner may result in additional financial charges. This includes any private insurance coverage as well as AHCCCS.

In the event that I have failed to pay for the services provided by this office, and the account is placed for collection, I understand and agree that an additional amount will be added to the current balance owed.

I have read the above statement and understand my financial responsibility.

_____ _____

Patient Signature Today's Date

Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)			
Patient Name	Date of Birth	Social Security Number	
Address	City	Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]
PREVIOUS PRIMARY CARE PROVIDER OR SPECIALIST

I authorize release of my medical record from

Physician/Facility			
Address	City	Zip	Phone

Please send my medical record to:

Physician/Facility **Agape Clinic**			
Address **2140 W 24th Street, Suite B**	City/State **Yuma Arizona**	Zip **85364**	Phone **928-459-3400** **928-459-2077 Fax**

RELEASE INFORMATION

Reason: [ ] Change of insurance [ ] Transfer of care [ ] Personal file
[ ] Moving out of area [ ] Specialist consultation [ ] Legal

Please release the following (check all that apply)

RECENT H&P		LAST THREE VISITS	
LAB REPORTS		X-RAY REPORTS	
HOSPITAL REPORTS		OTHER:	

ALL RECORDS: ***ALL RECORDS FOR LAST 12 MONTHS ONLY***

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.

		YES	NO	Initials
*****	I authorize the release of HIV/HTLV/AIDS test results.			
*****	I understand that I may be charged for copies provided.			

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
By signing below, I revoke this document as of the date signed. _____	Effective Date: _____

Note: It may be revoked by the signer at any time.

Insurance Benefits and Information Release

Patient Name: _____ Date of Birth:_____

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

_____

Patient's Signature **Date**

Patient Bill of Rights

You have the right to be treated with courtesy and respect, with appreciation of your individual dignity and with protection of your need for privacy. The clinic, your doctor, and others caring for you will protect your privacy as much as possible.

You have the right to access treatment regardless of race, color, creed, sex, sexual orientation, gender identity, national origin, mental or physical disability, diagnosis, religion, age, or socio-economic status.

You have the right to not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse or assault, restraint, or seclusion (subject to R9-10-1012(B)), retaliation for submitting a complaint to the Department of Health Services, or another entity, or misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student.

You have the right to and are encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.

Except in emergencies when the patient lacks decision-making capacity and the need for treatment is urgent, the patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, the possible length of recuperation, and the medically reasonable alternatives and their accompanying risks and benefits.

You have the right to know the identity of physicians, nurses, and others involved in your care, as well as when those involved are students, residents, or other trainees.

You have the right to know the immediate and long-term financial implications of treatment choices, as far as they are known.

You have the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and medical facility policy and to be informed of the medical consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the medical facility provides or transfer to another medical facility. The medical facility should notify patients of any policy that might affect patient choices within the institution.

You have the right to have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision-maker with the expectation that the medical facility will honor the intent of that directive to the extent permitted by law and medical facility policy. Health care institutions must advise patients of their rights under state law and medical facility policy to make informed medical choices, ask if the patient has an advance directive, and include that information in patient records. The patient has the right to timely information about medical facility policy that may limit its ability to implement fully a legally valid advance directive.

You have the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.

You have the right to expect that all communications and records pertaining to your care will be treated as confidential by the medical facility, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the medical facility will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records.

You have the right to review the records pertaining to your medical care and to have the information explained or interpreted as necessary, except when restricted by law.

You have the right to expect that, within its capacity and policies, a medical facility will make reasonable response to the request of a patient for appropriate and medically indicated care and services. The medical facility must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a patient has so requested, a patient may be transferred to another facility. The institution to which the patient is to be transferred must first have accepted the patient for transfer. The patient must also have the benefit of complete information and explanation concerning the need for, risks, benefits, and alternatives to such a transfer.

You have the right to ask and be informed of the existence of business relationships among the medical facility, educational institutions, other health care providers, or payers that may influence the patient's treatment and care.

You have the right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct patient involvement and to have those studies fully explained prior to consent. A patient who declines to participate in research or experimentation is entitled to the most effective care that the medical facility can otherwise provide.

You have the right to expect reasonable continuity of care when appropriate and to be informed by physicians and other caregivers of available and realistic patient care options when medical facility care is no longer appropriate.

You have the right to be informed of medical facility policies and practices that relate to patient care, treatment, and responsibilities. You have the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution. You have the right to be informed of the medical facility's charges for services and available payment methods.

You have the right to voice out any issues or concerns about your care, please contact Administration at **(928)459-3400.** All concerns are taken seriously and will be resolved immediately. Formal concerns will be documented and given to the Practice Manager, Executive Director, and Medical Director. Upon completion of the investigation, you will be given a verbal or written response. If the concerns are not resolved through the Clinic management team, the individual is encouraged to contact the Arizona Department of Health Services at **(602) 364-3030 150 North 18th Avenue Phoenix, Arizona 85007.**

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Signature of Patient **Date**