CHOLLA MEDICAL GROUP- PRIMARY CARE

10631 S. 51st Street • Suite 8 • Phoenix AZ 85044 Phone:
(480) 418-7246 • Fax: (480) 304-3534
www.chollamedicalpc.com

PATIENT REGISTRATION FORM

Today's Date: _____

Name (First, Middle, Last: _____ Date of Birth: _____ Sex: ____

SS#: _____ Marital Status: _____ Spouse's Name: _____

Home Phone #: _____ Cell Phone #: _____

Home Address: _____ City/State/Zip: _____

Email Address: _____

Employer Name: _____ Employer Address: _____

Work Phone #: _____ City/State/ Zip: _____

Do you have Advance Directives / Living Will: Are you and Organ Donor:

Emergency Contact: _____ Phone #:_____

Responsible Party Information (Complete only if different from patient)

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: _____ SS#: _____ Phone#: _____

Address: _____ City/State/ Zip: _____

Email Address: _____

Primary Insurance Information

Name of Insurance Company: _____ I.D. #: _____

Group#: _____ Policy#: _____ Employer: _____

Billing Address: _____ City/State/Zip: _____

Customer Service Phone #: _____ Copay $: _____

Secondary Insurance Information

Name of Insurance Company: _____ I.D. #: _____

Group#: _____ Policy#: _____ Employer: _____

Billing Address: _____ City/State/Zip: _____

Customer Service Phone #: _____ Copay $: _____

By signing this form, the patient or legal representative verifies that all the information provided is true and correct. The patient or legal representative has full knowledge that the patient is responsible for all services rendered and that he/she is contractually bound to pay for said services. This includes all costs of collections and a reasonable attorney's fee, if collections become necessary. Patient waives his/her confidentiality rights should collection become necessary. Patient or authorized representative authorizes and requests payments under insurance plans be made directly to Cholla Medical Group Primary Care for all services provided. Patient or authorized representative also authorizes the release of any information requested by the patient's insurance carrier necessary to process claims.

Signature: _____ Date: _____

Credit Card for Balance Billing: visa/mc/amex/disc number:_____

Exp: _____ CVV: _____ Signature:_____

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Today's Date: _____

PATIENT HEALTH HISTORY - page 1

Patient Name: _____ Date of Birth: _____

Symptoms: Check if you have any of the following:

GENERAL CONSTITUTION
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Sleeping Difficulties
- ☐ Swollen Glands
- ☐ Weight Gain
- ☐ Weight Loss

EYES/HEAD/NECK
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Changes
- ☐ Headache
- ☐ Neck lumps/swelling
- ☐ Other_____

Date of Last Eye Exam
_____

EARS/NOSE/THROAT
- ☐ Earache
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Mouth Sores
- ☐ Sinus Problems
- ☐ Teeth or Gum Problems
- ☐ Hoarseness
- ☐ Hay fever
- ☐ Other_____

Date of Last Dental Exam
_____

CARDIOVASCULAR
- ☐ Chest Pains
- ☐ Irregular/Rapid Heartbeat
- ☐ Poor Circulation
- ☐ Swelling of Ankles/Feet
- ☐ Varicose Veins
- ☐ Artificial Heart Valves
- ☐ Other_____

Date of Last EKG
_____

RESPIRATORY
- ☐ Coughing up Blood
- ☐ Frequent Cough
- ☐ Wheezing
- ☐ Chronic Lung Problems
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Other_____

Date of Last Chest XRay
_____

GASTROINTESTINAL
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Colitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Excess Belching
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ Indigestion
- ☐ Nausea
- ☐ Nervousness
- ☐ Pancreatitis
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Stools Black/Tarry
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Other_____

Date of Last Colonoscopy
_____

GENITOURINARY
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination
- ☐ Difficulty Urinating
- ☐ Kidney/Bladder Problems
- ☐ Other_____

MUSCULOSKELETAL

Pain, Stiffness, Swelling in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

List Any Artificial Joints
_____

Pain Level 1-10 _____
(1 least, 10 highest)

SKIN
- ☐ Bleed or Bruise Easily
- ☐ Change in Mole
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Skin Changes
- ☐ Other_____

NEUROLOGIC/PSYCHIATRIC
- ☐ Depression or Anxiety
- ☐ Forgetfulness
- ☐ Numbness
- ☐ Weakness or Tremors
- ☐ Other_____

ENDOCRINE
- ☐ Thyroid Problem
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Other_____

ALLERGIES/HEMATOLOGIC/ LYMPHATIC
- ☐ Allergic Disorders
- ☐ Bleeding Disorders
- ☐ Cancer (Type?)
- ☐ Swollen Glands
- ☐ Other_____

MEN Only
- ☐ Breast Lump
- ☐ Erectile Difficulties
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Prostate Problems
- ☐ Sores/Warts on Penis

Date of Last Prostate Exam
_____

WOMEN Only
- ☐ Abnormal Pap smear
- ☐ Abnormal Menstrual Periods
- ☐ Bleeding Between Periods
- ☐ Breast Lumps
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Painful Intercourse
- ☐ Vaginal Discharge/Itching
- ☐ Other_____

Date of Last Period
_____

Date of Last Pap smear
_____

Date of Last Mammogram
_____

Are You Pregnant?
Do you use birth control?

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PATIENT HEALTH HISTORY page 2

Patient Name: _____ Date of Birth: _____

CONDITIONS: Check if you currently have or have had in the past:

☐ AIDS	☐ Bronchitis	☐ Herpes	☐ Miscarriage(s)	☐ Scarlet Fever	
☐ Alcoholism	☐ Bulimia	☐ Crohn's Disease	☐ High Blood Pressure	☐ Mononucleosis	☐ Stomach Ulcers
☐ Anemia	☐ Cancer	☐ Goiter(s)	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Stroke
☐ Anorexia	☐ Chemical Dependency	☐ Gonorrhea	☐ HIV Positive	☐ Mumps	☐ Suicide Attempt
☐ Appendicitis	☐ Chicken Pox	☐ Gout	☐ Kidney Disease	☐ Pacemaker	☐ Thyroid Problems
☐ Arthritis	☐ Diabetes	☐ Heart Attack	☐ Liver Disease	☐ Pneumonia	☐ Tonsillitis
☐ Asthma	☐ Emphysema	☐ Heart Disease	☐ Measles	☐ Polio	☐ Tuberculosis
☐ Bleeding Disorder	☐ Epilepsy	☐ Heart Problems	☐ Migraines	☐ Prostate Problems	☐ Vaginal Disease
☐ Breast Lump	☐ Glaucoma	☐ Hepatitis	☐ Rheumatic Fever	☐ Psychiatric Care	☐ Prescription Drug Abuse
		☐ Hernia			

MEDICATIONS YOU ARE CURRENTLY TAKING: include over-the-counter supplements i.e.: vitamins, calcium, or herbal remedies), frequency of usage, and dosage of medication:

_____

_____

ALLERGIES: List name of drug & reaction:

_____

SURGERIES: List type of surgery & date:

IMMUNIZATIONS:

Date of last: Tetanus_____ Pneumonia_____ Flu_____ TB test_____ Hepatitis B_____ Other_____

FAMILY HISTORY: Indicate which family members have the following (F) father (M) mother (B) brother (S) sister:

Heart Failure	☐	Diabetes	☐	Osteoporosis	☐
High Blood Pressure	☐	Emphysema	☐	Migraines	☐
Heart Attack/ Angina	☐	Asthma	☐	Depression	☐
Stroke	☐	Thyroid Disease	☐	Cancer	☐
High Cholesterol	☐	Glaucoma	☐	Alcoholism	☐

PHARMACY NAME:_____

SOCIAL HISTORY:

Marital Status: Single / Married / Divorced / Widowed / Separated **Address:**_____**Phone:**_____

Exercise: _____ x a week

Tobacco: _____ packs per day / week Quit: date: _____

Alcohol: _____ drinks per day / week / month Quit: date: _____

Street Drugs: What? _____ Quit: date: _____

Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

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FINANCIAL POLICIES AND ARRANGEMENTS

We recognize the need for understanding in the areas of payment arrangements and insurance filings. We have put together this sheet to address some of these issues and to advise you of our financial policies.

Insurance - Filing/Benefits/Payments

There are numerous insurance plans with which we have contracted to receive payment directly from the insurance company. With these plans, the patient is generally required to make a co-payment and/or meet a deductible and/or co-insurance. If you are covered by insurance, please show us your ID card. Be prepared to make your co-payment, or pay for your services if your deductible has not been met at the time of service. We accept: cash, checks, money orders and all major credit/debit cards. If you are covered by an insurance plan that is not contracted by our office, you will be asked to pay for all services at the time of service.

If you would like us to bill your insurance for you, it is extremely important that you provide us with accurate and updated information at each visit, so your claim can be properly filed. It is your responsibility as a consumer to know what benefits are covered by your insurance plan. Most insurance carriers have numerous plans that cover many types of services. Some injections, visits & services may not be covered by your particular plan. If you have a question, you should contact member services at your insurance company for specific benefit information prior to you visit. Their phone number should be located on your insurance card. This office can not become involved in prolonged insurance negotiations. If your claim is unpaid after 45 days, you will receive a bill requesting payment in full and you will be responsible for further contact with your insurance company. You will continue to be billed until the balance is paid.

Payment Arrangements

Payment is expected at the time of service. Any balance due on your account must be paid prior to your visit and will be collected in addition to your co-pay. If you do not have your co-pay or payment for your outstanding balance at the time of service, your visit may be rescheduled. Should you ask us to bill your copay, a $10.00 service fee will be added. Payments on balances can be made online.

Delinquent Accounts

Bills that are delinquent for more than ninety (90) days will be transferred to an outside collection agency for processing unless prior arrangements have been made with our business office. If you have questions or reason to believe there is an error, please discuss them with us prior to the 90 days.

Returned Checks

There is a $25.00 service fee for checks returned for insufficient funds. We will not re-deposit checks and will no longer be able to accept checks for payment. The balance due + service fee must be paid with cash or credit card immediately upon notice of the returned check.

Cancellation of Appointments/No Show Appointments

If you need to cancel your appointment, we require 24 hour notice; if you do not cancel an appointment and no show, you will be charged a $50.00 service fee. Three no show appointments are grounds for dismissal from the office.

Advance Beneficiary Agreement

Medicare and other insurance plans will only pay for services that they determine to be reasonable and necessary under section 1862 (a) (1) of Medicare Law. If they deny payment for services or tests, (i.e. routine exam, testing, labs, vaccinations, injections, procedures, etc) then the patient agrees to be personally and fully responsible for payment.

In addition, I understand and acknowledge that for hormone replacement therapy or similar programs, Dr. Talluri has a small in house dispensing program where individualized custom medications can be dispensed directly to patients. I understand there is an extra cost associated for the service and convenience of these programs.

Additional Help

Please feel free to discuss any concerns you may have with our office staff. Our staff is dedicated to making your visits with us as pleasant as possible.
It is your responsibility to know what is covered by your insurance plan as well as being financially responsible for any services denied or not covered by your insurance.

I have read and agree to the above policy of Cholla Medical Group Primary Care. I understand the contents and by signing below accept the financial responsibilities listed above.

Patient/Legal Representative: _____ **Date:** _____

ACKNOWLEDGEMENT OF RIGHT TO REVIEW CHOLLA MEDICAL GROUP PRIMARY CARE'S NOTICE OF PRIVACY PRACTICES

I understand I have a right to review Cholla Medical Group Primary Care's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices is available at the reception desk. Cholla Medical Group Primary Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I understand that I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, or by requesting a revised copy at the time of my next appointment.

_____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (i.e. Legal guardian, parent, attorney, etc.)

(over)

If you wish to request RESTRICTIONS or limitations on the use of your Protected Health Information, or to request confidential communications please let our receptionist know, so that the proper forms may be completed. Please indicate below if you **do not** want us to leave account information on your cell phone, answering system or your home answering machine.

☐ _____

Please list the names and relations of anyone you authorize to be involved in your care and payment and with whom we may share your medical information:

_____

_____

For Office Use Only:

Acknowledgement of receipt of Notice Of Privacy Practices was unable to be attained because:

_____

_____

Signature of Staff Member:_____

Date:_____

Cholla Medical Group, Inc.
Controlled Substance Agreement

I, _____ understand that in order to receive prescribed medications at **Cholla Medical Group, Inc.** (hereafter referred as **CMG)**, I agree to comply with the following:

A. **USE OF MEDICATIONS**: I will take all medications as prescribed. I will speak with my provider at **CMG** before making any change in either the dose or frequency of taking my medications. There will be no early refills of controlled substances due to self escalation of medications. Narcotic pain medications must all be obtained from the same pharmacy (any exceptions must be approved by **CMG**).

B. **SEEKING PRESCRIPTIONS**: I will neither seek nor fill controlled prescriptions for any medications including pain relief from any other health care provider unless discussed/ authorized by **CMG**.

C. **MEDICAL RECORDS RELEASE:** I will inform all of my health care providers that I receive controlled prescriptions including pain management medication(s) through **CMG** and will maintain an unrestricted and current medical records release on file with **CMG**. I authorize **CMG** to provide a copy of this Controlled Substance Contract to release medical information to necessary pharmacies.

D. **DRUG SCREENING: I will participate in drug screening as a part of my plan of care. I understand that drug screening will be conducted ongoing and may be required more frequently at the discretion of CMG. Presumptive and Definitive Screening may include urinalysis, blood testing and/or pill counts. I further understand that if I fail two drug screens or the absence of the prescribed medication detected in my system during the course of my treatment, it will result in discharge or from the medical practice.**
***Failure means: the presence of Illegal drugs, or unprescribed/undetected medications**

E. **ALCOHOL USE:** Any use of alcohol with prescriptions is against **CMG** policy. Testing for alcohol use may be added to random and routine urine drug screens at the discretion of the physician. Any use of alcohol deemed inappropriate by the physician will be grounds for discharge from **CMG**.

F. **ILLEGAL AND NON-PRESCRIBED DRUG USE**: I understand that the use of any controlled medication, not prescribed by **CMG**, may result in termination of care. I authorize **CMG** to cooperate fully with any city, state, or federal law enforcement agency. I agree to waive any applicable privileged, right of privacy, or confidentiality with respect to these authorities.

G. **LOST OR STOLEN MEDICATION**: I agree to safeguard all medication prescribed by **CMG** and understand that **lost, stolen, or damaged medications will not be replaced.**
***Does not apply to Facilities/Group Homes with Medication Management Control**

H. **PRESCRIPTIONS WHILE TRAVELING: CMG** may choose to provide prescriptions for up to 60 days when I am traveling out of state. I will only be eligible for early medication when proof of travel can be obtained. Identification includes paper tickets and electronic confirmation sheet that shows how much I paid for travel tickets. I will have to arrange for shipment of controlled substances by my pharmacy at my own expense. If I will be out of state longer than 60 days, I need to arrange for my healthcare at my travel destination. On my return to Arizona, I need to advice **CMG** of the name and address of my medical provider out of state. I also authorize **CMG** to contact my provide to obtain any detailed information deemed necessary of my medical care.

I. **DRIVING AND OPERATING EQUIPMENT**: Many controlled substances, including pain medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy.

J. **MISSED APPOINTMENTS**: I will contact the clinic if I will be 5 to 10 minutes late. If I arrive more than 15 minutes late, I will be rescheduled. Three missed appointments per year are grounds for discharge from **CMG**. ***Does not apply to House-call Patients**

K. **CANCELLATIONS:** As of **January 1, 2023**; we require a 24 hour notice to cancel or reschedule your appointment. Appointments missed, rescheduled due to tardiness, or rescheduled without a 24 hour notice will result in a **$50.00** fee to the patient.
***Does not apply to House-call Patients**

L. **CHARGES:** All fees from patients are due at the time of visit. Non-payment of fees may result in the account being sent to collections and patient termination from **CMG.**
***Does not apply to House-call Patients**

M. **TERMINATION**: I will no longer be eligible for care at **CMG** if I am in possession of illicit drugs or substances, trafficking of controlled or illegal substances, intoxicated or convicted for DUI. If I forge or alter the prescriptions in any way, sell or share medications, or fail to comply with this contract, I will no longer be eligible for care at **CMG**.

N. **TREATMENT OF STAFF**: **Our office has a zero tolerance policy for verbal/physical abuse towards our staff. swearing, yelling at, or threatening our staff will result in termination of our medical service.**

O. **EMERGENCY ROOM VISITS:** I am allowed to receive controlled substances, including pain medication in the emergency room, but it is a violation of the **CMG** contract to receive narcotic medication to take home and it must be discussed with my doctor prior to receiving medication. A violation includes any prescription and/or samples. ***Does not apply to House-call Patients**

I HAVE THOROUGHLY READ THIS AGREEMENT BEFORE RECEIVING TREATMENT AT CMG. I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM. ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED. I KNOW THAT FAILURE TO COMLPY WITH ANY OF THESE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATIONS OF SERVICE.

Patient's Signature: _____Date: _____

POA/Witness Signature: _____Date: _____

CHOLLA
MEDICAL GROUP, INC.

Authorization for Release of Protected Health Information

I hereby authorize _____
to disclose Protected Health Information (PHI) as deemed below.

Patient:
Name_____
Soc. Sec. #_____
DOB_____

Requestor (if other than patient):
Name_____
Relationship_____
Source of Legal Authority_____
_____

Name & Address of who to receive health records/information:
Cholla Medical Group, Inc.
10631 S. 51st Street, Suite 8
Phoenix, Arizona 85044-5225
Phone # 480-298-9951
Fax # 1-866-246-5494

☐ I wish to have the following records copied and I will pick the up at your facility
☐ **I request the facility copy the following records and fax/send them to the above address**

I request the release of **all** medical records created between Date: _____ and _____

Legal Authority Request:
☐ I am the Patient noted above
☐ I am the Patient's legal representative
☐ I am the Patient's Power of Attorney
☐ I am the Patient's legal Guardian
Requestor's Initials_____

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for use in medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

If signing as a POA, please include a copy of documentation, as some providers will not release records without additional documentation.

Signature_____ Date_____
Relationship to Patient_____
Name of Person Completing this Form_____