Tucson Family and Geriatric Medicine

6867 North Oracle Rd, Ste 157, Tucson, AZ 85704
Ph: 520-395-2220 Fax: 520-395-2746

Patient Intake Form

Name:____
First Middle Last
Todays Date:_______________ Sex _________ (M/F)
DOB _____________________ SSN ______________________________
*Cell Phone ____________________Home Phone ____________________
Work phone______________________
*Email ____________________________
Home Address:____
City:____ State:________
Zip:__________
Do you agree to receive email reminders and messages? Y/N
Do you agree to receive voicemail reminders and messages? Y/N

VIP/Concierge Options
Are you interested in participating in concierge or VIP medical services which include guaranteed same/next business day appts, longer visits, direct communication with the provider? Y / N / Maybe

Are you concerned about: (circle any) losing weight? Hair loss? Stress incontinence? Joint pain? Skin texture/tone/wrinkles/dark spots

Insurance Information
Name of Insurance Company: ________________________
Address:____
City: ______________________ State: ____________ Zip:
____
Insured's Name:
____ Group
Number: ___________ Policy ID Number________________
[Secondary Insurance]
Name of Insurance Company: _____________________________
Address____
City: ______________________ State: ____________

Zip: ____________ Insured's Name: ______________________ Group Number: __________ Policy ID Number: _________________

Employer ____
Employer's Address________________________________
City:_____________________ State:_____ Zip:_________
Occupation:_________ Work Phone (   )______________

Complete this section ONLY if someone other than the patient is financially responsible:
Financially Responsible Party:__________________________
Relationship to Patient:__________________
Home Address:____
City:____ State:________
Zip:__________________ Home Phone(   )___________________
Cell Phone (   )__________Email ______________________________
Birth date:_____________________ Age:________
SSN:_____________________________________

**How did you learn about our practice?
____

Preferred Pharmacy (Name & Location)
____

Care Team (List of Specialists)
Name _____________________ Specialty______________________
Name _____________________ Specialty______________________
Name _____________________ Specialty______________________
Name _____________________ Specialty______________________
Name _____________________ Specialty______________________

Emergency/Next of Kin_________________________________
Relationship_____________________________
Phone___________________________________
Address____

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Are you ALLERGIC to any medications? Yes No
Drug Name: ____________________ Reaction: ________________
Drug Name: ____________________ Reaction: ________________
Drug Name: ____________________ Reaction: ________________
Drug Name: ____________________ Reaction: ________________

Allergies to food/environment ____________________________________
____

Current Medications:(include over the counter medications)
Drug/Dose ___________________________Freq(example 1x/d)________
Drug/Dose ___________________________Frequency________________
Drug/Dose ___________________________Frequency________________
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Drug/Dose ___________________________Frequency________________
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Health Habits:
1. Do you smoke currently? Yes No If so, specify quantity /frequency
____________________ (ex, 1 pack per dy x 20 yrs)
Are you a former smoker? Yes No What year did you quit? ________
2. Do you drink Alcohol? Yes No What kind? Beer Wine Liquor
Other:__________ If so, how often________________
3. Have you ever used street drugs? Yes No Which ones?
____

Social History: Marital Status (circle one): Single Married Separated Divorced Widowed

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Highest Level of Education: <6th grade Jr. High High School College Graduate school Professional Occupation: ____________________
If you have any children, please list their names and ages. If pt desires, include contact info of adult children (after verbal consent to do so):

____

____

Past Medical History: (circle) or list

High blood pressure Cholesterol Abnormal Pap Smear Eczema

Osteopenia Acne Emphysema Osteoporosis ADD/ADHD COPD

Frequent UTI's Alcohol Abuse Sinus Infections Prostate Problems

Anemia Gallstones Psoriasis Anxiety Dementia/Memory

Glaucoma Reflux (heartburn) Asthma Gout Heart Attack

Rheumatoid Arthritis Bipolar Disorder Rosacea Blood Clot

Heart Condition (specify) ___________________________________

Seasonal Allergies Seizures Osteoarthritis

Cancer (What kind)____

Crohn's Disease or IBS Kidney Disease Stomach Ulcers

TIA/Stroke Depression Kidney Stones Lupus Thyroid

Diverticulitis Ulcerative Colitis Recurrent Falls Migraines

Other medical problem not on list:_____________________________

____

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Please check or list all of the SURGERIES you have had: Year Type of surgery:
Year Type of surgery:
Year Type of surgery:
Appendectomy Hysterectomy Arthroscopy (joint) Knee or Hip Replacement Back or Neck Surgery Mastectomy or Lumpectomy Cataract Surgery Mastectomy/ Lumpectomy Cesarean Section Polyp Removal (colon) Gallbladder Removal Tonsillectomy/Adenoidectomy Heart Surgery (specify)_______________ Tubal Ligation or Vasectomy Hemorrhoids Hernia Other (specify) ____________________

For Women:
Last menstrual period / / Age of first period
Last pap smear n/a / /
Last mammogram n/a / / Length of period (days)__________
# of pregnancies _______________# of live births _____________
# of miscarriages __________ # abortions _______________
Last bone density / / result? _______________
Are you menopausal Y N
Age at onset of menopause # of living children.
Last colonoscopy date__________

For Men:
Last colonoscopy date__________ Last PSA_________

Immunizations:
Td or Tdap-adult________________________ Date _____________
Prevnar 13-adult________________________ Date _____________
Pneumococcal 23 - adult _________________Date _____________
Shingles-adult __________________________Date _____________
Influenza______________________________ Date _____________
(Children: bring or include copy of current vaccine record)

Family History (list medical condition and relationship to pt)
Condition_____________________ Relationship______________________
Condition_____________________ Relationship______________________
Condition_____________________ Relationship______________________
Condition_____________________ Relationship______________________

Release of information

I authorize the release of any medical information necessary to process my claim.
Initial: _____________ I authorize payment of medical and surgical benefits to Tucson Family and Geriatric Medicine, LLC.
Initial: _______
Signature of Patient/Legal Guardian: ________________________________
Date: ___________

Assignment of Benefits

I hereby assign to any insurance or other third-party benefits available for health care services provided to me. I understand that Dr. Lee has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Dr. Lee, I agree to forward Karen Lee, MD all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: ______________________________ Date: ________________

Consent to Treat I (or my legal guardian or parent) authorize Karen Lee, MD, to provide medical care reasonable by today’s standards.

Patient Name: __________________ Date of Birth: ____________ Signature of Patient/Legal Guardian:________________________ Date: _______________________

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as: a basis for planning my care and treatment a means of communication among the many health professionals who contribute to my care a source of information for applying my diagnosis and surgical information to my bill a means by which a third-party payer can verify that services billed were actually provided and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals I understand and will be provided by request a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and

practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information: ____ Accepted ___ Denied
Name of Patient____________________________________
Signature X _________________________ Date: ________
(Signature of Patient or Legal Representative)

Financial Policy

Insurance: Tucson Family and Geriatric Medicine participates in some insurance plans, including Medicare. If you are not insured by a plan, payment in full is expected at each visit. If you are covered by a participating plan, but you are either missing an updated insurance card or you cannot provide policy and group number, you will be responsible. You will be required to pay for your visit in full until our office is able to confirm your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Proof of Insurance: All patients must confirm and/or complete a patient information form before being seen. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Non-Covered Services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurers. You will be billed for these services.

Change in Insurance Plans: You are expected to notify our office if your insurance coverage changes. We will ask you to update your record at each visit to our office. It is also your responsibility to notify the office immediately of these changes. Balances left over 90 days will become the responsibility of the patient. Insurance carriers give us a 90-day period to submit claims to them for payment. After that time, it will be denied as past timely filing. If we are unable to process your claim due to incorrect information given, we will bill you directly for our services.

Claims Submission: We will submit your claims and assist you in any way reasonable to help get your claim paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their

request. If payment is denied due to a lack of response from you, the balance will immediately become due and payable by you. Your insurance benefit is a contract between you and your insurance company. We are not party to the contract.

Payment is Required at the Time of Service: Patients who are not covered by health insurance, on a plan that we do not participate with, or if we are not able to verify your coverage must pay at the time of service. Patients who have plans that we do participate with are asked to pay their co-payment, coinsurance, deductibles, or non-covered services at the time of their visit.

Self-Pay: Any self-pay patients (such as I -693 immigration, specialized lab tests, aesthetic products or services, PRP, amniotic, C-section derived placental/umbilical cord stem cell injections) will be charged according to an established fee schedule. These fees are non-refundable.

Nonpayment: Should your account become 90 days delinquent, you will receive a letter stating that you have 10 days to pay your account in full. Patient payments will not be accepted unless otherwise negotiated with a member of our business office. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency. The patient or guarantor will be responsible for all costs of collection including attorney fees, collection fees and contingent fees to collection agencies of not less than 35 percent. The contingency fees will be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Third Party Billing: We do not do any third party billing, follow-up or related activity. If a third party may be involved, it will be the patient’s responsibility to seek reimbursement. Patients involved with a third party payer will be expected to provide health insurance or if uninsured, will fall under the self-pay guidelines. Minors: For all services rendered to minor patients, the patient or guardian who brings the patient to the appointment is responsible for payment. Our practices are committed to provide the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions. I have read and understand the financial policy and agree to abide by its guidelines.

____ _____________
Signature of Patient or Responsible Party if a Minor Date

____ _____________
Printed name of patient Date