DR. JEFF CARLS, FAMILY MEDICINE & AESTHETICS
1720 MESQUITE AVE., SUITE 100
LAKE HAVASU CITY, AZ 86403-5602
PHONE: 928-855-1550 FAX: 928-855-4008

PATIENT INFORMATION FORMS

Name_____ Nickname_____

Social Security # _____ Date of Birth _____

Age_____ Sex: M F Marital Status_____ Preferred Language_____

Primary #_____ Cell #_____ Work #_____

Mailing Address_____

City_____ State_____ Zip_____

Email _____ Pharmacy Name_____

Occupation_____ Employer_____ Driver's License_____

Emergency Contact: _____ Phone #_____

Race: (Check all that apply)

[] Native Hawaiian [] Hispanic [] Alaskan Native
[] American Indian [] Asian [] Pacific Islander
[] African American [] White [] Other

Ethnicity: (Check One)

[] Hispanic
[] Non-Hispanic
[] Refuse to Report

RESPONSIBLE PARTY ON INSURANCE (IF APPLICABLE)

Subscriber on Insurance (Name) _____ Date of Birth___/___/____

Subscriber's Social Security #_____-_____-_____ Relationship to Patient_____

INSURANCE INFORMATION

Medicare #_____ Medicaid/AHCCCS #_____

Name of Medicaid Plan (Circle One): Healthchoice APIPA Phoenix Health Plan

PRIVATE INSURANCE INFORMATION

Company Name_____ ID #_____ Group #_____

I understand that payment for services rendered is due at the time of service, unless previous arrangements have been made. I authorize the provider to release any information needed for the payment. I further permit copies of this authorization to be used in place of its original. I give consent for the communication of care and /or medications with my pharmacy. **IT IS THE PATIENT'S RESPONSIBILITY TO KNOW THE PROVISIONS OF THEIR INSURANCE POLICY.**

Patient Signature_____ **Date**_____

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Acknowledgement of Notice of Privacy Practices

I acknowledge that there is always a readily available copy of the office privacy policy at the front desk supplied by Dr. Jeff Carls, Family Medicine & Aesthetics.

Name of Patient (Please Print)

Signature of Patient/or Guardian Date

Release of Information

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE FOLLOWING PERSONS:

1. _____ **Relationship:** _____
2. _____ **Relationship:** _____
3. _____ **Relationship:** _____

Name of Patient (Please Print)

Signature of Patient/or Guardian Date

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PATIENT RESPONSIBILITES

We frequently experience delays in completing necessary testing ordered by the physician due to the complexity of the administrative process of your insurance policy. We will assist yo in the process of obtaining authorization for the tests ordered, but ultimately it is your responsibility to communicate with your insurance company.

It is your responsibility to:

- Follow through with all tests ordered
- Follow-up with your doctor as recommended
- Allow 72 hours for all prescription refill requests
- Inform us immediately if your symptoms worsen, change, or if you are experiencing difficulties with your treatment plan.
- Pay your co-payments and deductibles at time of service.

You are fully aware that your doctor cannot be responsible or held liable if you do not follow through with the tests ordered or fail to follow-up on the test results that are necessary to diagnose and treat your disease process.

You, the patient, must actively participate in your care. Open communication is vital to any doctor-patient relationship. Please sign below to acknowledge that you have read and understand your responsibility as a patient.

Name of Patient (Please Print)

Signature of Patient/or Guardian Date

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New Patient and Annual Wellness Visits

PLEASE KEEP THIS COPY FOR YOUR RECORDS

Please be aware that Dr. Jeff Carls does not generally perform an annual wellness on the first initial visit. This is meant to be a "get acquainted" visit between you, the new patient, and the provider. We will obtain your medical history and try to answer any questions or concerns you may have. Tests cannot be ordered for you without knowing your medical history and/or concerns.

It is common for a provider to address new or chronic health issues at the same time that they are performing a wellness exam. If a problem is discovered and treated during a wellness exam or if a chronic issue is discussed at this time, a separate office visit will be charged. You may choose to schedule a separate visit to address these issues if you'd like. Your insurance may have separate benefits for preventative/wellness visits vs a regular office visit.

The purpose of a preventative/wellness visit is to review the patients' health history, perform a physical examination, review risk factors, instruct the patient on how to reduce their risk factors and to order labs or other tests for screening reasons. Most insurance policies that cover annual wellness visits will pay for ONE wellness exam per year and then ONE office visit at which time the provider performs the examination and gives the test results. Most insurance companies WILL NOT pay for the first visit (the ordering of tests) as an annual wellness and also the second visit (the exam and test results) as an annual wellness. Generally, we bill the first visit as an office visit using whatever diagnoses you have discussed with your provider at the time of your new patient visit.

We know how confusing insurance can be and it is our intention to help clarify any concerns or issues prior to you receiving treatment. If you have any questions regarding this policy, please don't hesitate to contact the billing department.

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IMPORTANT OFFICE POLICIES

Please read the following important office policies. You are responsible for understanding these policies. If you are a minor, your parent or legal guardian must agree to these terms and sign.

Insurance and/or payment protection forms: You may be charged a fee of $25.00 per form, for filling out additional forms from various companies that are above and beyond the usual and customary disability form.

Financial Responsibility: I understand and agree that I am financially responsible for all services rendered by this office and its employees. If my account is not paid in full within 90 days, my account may be sent to collections.

Insurance Coverage: This office works with several different insurance companies that carry several different types of coverage-which change constantly for a variety of reasons. As a result, I understand and agree that I am solely responsible for knowing which types of services are covered under my policy or not covered on my policy.

Proof of Insurance: All patients must complete our patient information **prior to being seen**. We must obtain current and valid proof of insurance. If you fail to provide these you may be responsible for the balance of a claim.

Coverage Changes: If your insurance changes, please notify us prior to your next visit.

Insurance Billing: We will bill all primary and secondary insurance companies as a courtesy. We **do not** bill third party insurances. Your insurance plan is a contract between you and your insurance. Ultimately, the patient is responsible for any account balances past 90-days.

Co-payments/Deductibles: I understand that I am responsible for knowing if my insurance plan has a co-payment or deductible, and if applicable, how much it is. The co-payment/deductible is **due at the time services are rendered**. If for some reason the co-payment/deductible is not paid at the time of service, I am still responsible for the co-payment/deductible and will be billed for it in addition to any other charges that may be due.

Cash Pay Patients: Full payment is due at the time of treatment. We accept cash, checks, Mastercard, Visa, and Discover.

Non-Sufficient Funds: In the event that I pay for services by check and that check is returned because of non-sufficient funds, I understand that I will be billed for the charges again. In addition, a **twenty-five-dollar non-sufficient funds fee** will be applied to compensate the office for expenses it incurs as a result.

Appointment Order & Rescheduling of Late Arrivals: I understand that it is possible that someone who arrives after me may be seen first because of my late arrival. If I arrive late for my appointment, I also accept that my appointment may have to be rescheduled at Dr. Jeff Carls' discretion.
By my signature below, I hereby agree to the preceding important office policies.

Name of Patient (Please Print)

Signature of Patient/or Guardian Date

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CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice, we are unable to offer that slot to other people.

Office appointments which are canceled with less than 24 hours notification may be subject to $25.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as NO SHOW. Patients who No-Show three (3) or more times in a 12-month period, may be dismissed from the practice and thus they will be denied any future appointments. Patient may also be subject to a $25.00 fee for office appointment NO SHOW fee.

This Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

We believe that a good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department (928-855-1550 ext: 1020).

Please sign that you have read, understand and agree to this Cancellation and No-Show policy.

Name of Patient (Please Print)

Signature of Patient/or Guardian Date

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PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: ____/____/_____ Age: _____

Emergency Contact: _____ Relationship: _____ Phone # _____

Reason for your visit today _____

MEDICAL HISTORY (Circle all that apply):

Diabetes	High Blood Pressure	High Cholesterol	Thyroid Disease
COPD (Emphysema)	Asthma	Heart Disease	Atrial Fibrillation
Strokes	Peripheral Arterial Disease	Headaches	Rheumatoid Arthritis
Enlarged Prostate (BPH)	Kidney Cancer	Kidney Stones	Bladder Cancer
Breast Cancer	Colon Cancer	Diverticulitis	Pancreatitis
Intestinal Obstruction	Acid Reflux	Glaucoma	Hepatitis
HIV (AIDS)	Melanoma	Blood Clots	

Other _____

PRIOR SURGERIES

□ Please check box if you have had no previous surgeries

Previous Surgical Procedures:	When:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you had a COLONOSCOPY in the past? (CIRCLE) YES or NO

If Yes – Date of last colonoscopy: _____

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LIST ALL CURRENT MEDICATIONS (Including aspirin and over the counter medications)

MEDICATION	DOSAGE (How much, how often?)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: Are you allergic to any **MEDICATIONS**? (CIRCLE) YES or NO

NAME OF MEDICATION:	TYPE OF REACTION:
_____	_____
_____	_____
_____	_____
_____	_____

ARE YOU ALLERGIC TO ANYTHING ELSE? (CIRCLE) YES or NO

EXPLAIN: _____

IS THERE ANYTHING ELSE YOU FEEL THAT YOUR PHYSICIAN/SURGEON SHOULD KNOW?

_____

Name of Patient: _____

Patient Signature/or Guardian: _____ Date: _____

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ARE YOU CURRENTLY EXPERIENCING OR HAVE HAD ANY OF THE FOLLOWING?

		Details:
Have you had recent weight loss (> 10 lbs.)?	[] Yes [] No	_____
Have you had recent fevers?	[] Yes [] No	_____
Are you fatigued/extremely tired?	[] Yes [] No	_____
Do you have night sweats?	[] Yes [] No	_____
Have you had recent weight gain (> 10 lbs.)?	[] Yes [] No	_____
Do you have any memory loss?	[] Yes [] No	_____
Do you have sleep apnea?	[] Yes [] No	_____
Do you have hay fever/seasonal allergy?	[] Yes [] No	_____
Has there been any changes in your voice?	[] Yes [] No	_____
Do you have a history of heart murmur?	[] Yes [] No	_____
Any unusual chest pain w/ exertion?	[] Yes [] No	_____
Do you have any leg or foot swelling?	[] Yes [] No	_____
Do you have a history of heart disease/heart attack?	[] Yes [] No	_____
Do you suffer from pain in legs when you walk?	[] Yes [] No	_____
Do you have palpitations or abnormal heart rhythm?	[] Yes [] No	_____
Do you have a pacemaker?	[] Yes [] No	_____
Do you have artificial heart valves?	[] Yes [] No	_____
Do you have a persistent cough?	[] Yes [] No	_____
Do you have any shortness of breath?	[] Yes [] No	_____
Do you have asthma?	[] Yes [] No	_____
Do you have a history of tuberculosis?	[] Yes [] No	_____
Have you recently coughed up blood?	[] Yes [] No	_____
Do you have a history of valley fever?	[] Yes [] No	_____
Do you have any blood disease or bleeding disorders?	[] Yes [] No	_____
Do you have unusual bleeding (bruise easily)?	[] Yes [] No	_____
Do/Did you have blood clots (legs or lungs)?	[] Yes [] No	_____
Could you have HIV or AIDS?	[] Yes [] No	_____
Do you take a blood thinner (Coumadin/Plavix)?	[] Yes [] No	_____
Do you have blood in stool?	[] Yes [] No	_____
Any recent diarrhea?	[] Yes [] No	_____
Any recent constipation?	[] Yes [] No	_____
Any nausea or vomiting?	[] Yes [] No	_____
Do you have difficulty swallowing?	[] Yes [] No	_____
Do you have severe frequent heartburn?	[] Yes [] No	_____
Have you had recent loss of appetite?	[] Yes [] No	_____
History of liver disease (cirrhosis or hepatitis)	[] Yes [] No	_____
History of diverticulitis?	[] Yes [] No	_____
History of jaundice?	[] Yes [] No	_____
Do you have unusual headaches?	[] Yes [] No	_____
Do you have seizures?	[] Yes [] No	_____

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History of stroke or stroke symptoms (TIA)? [] Yes [] No _____
Do you suffer from fainting spells? [] Yes [] No _____

ARE YOU CURRENTLY EXPERIENCING OR HAVE HAD ANY OF THE FOLLOWING?

		Details:
Do you have a history of stomach ulcers?	[] Yes [] No	_____
Any stool incontinence (stool leaking)?	[] Yes [] No	_____
Have you ever had an upper endoscopy (stomach)?	[] Yes [] No	_____
Have you ever had a colonoscopy?	[] Yes [] No	_____
Do you have joint problems?	[] Yes [] No	_____
Do you have a history of gout?	[] Yes [] No	_____
Do you have a history of back problems/sciatica?	[] Yes [] No	_____
Do you suffer from depression?	[] Yes [] No	_____
Any history of eating disorders?	[] Yes [] No	_____
Do you suffer from anxiety?	[] Yes [] No	_____
Psychiatric problems?	[] Yes [] No	_____
Any history of kidney stones?	[] Yes [] No	_____
Any history of kidney disease?	[] Yes [] No	_____
Do you suffer from frequent kidney infections?	[] Yes [] No	_____
Have you had any recent blood in urine?	[] Yes [] No	_____
Do you have any urine incontinence (leaking)?	[] Yes [] No	_____
Do you have painful urination (peeing)?	[] Yes [] No	_____

For <u>Females</u> Only

Do you have any nipple discharge	[] Yes [] No	_____
Have you gone through menopause? (date of last period)	[] Yes [] No	_____
Are you pregnant?	[] Yes [] No	_____
Date of last bone density?		_____
Date of last pap smear?		_____
Date of last mammogram?		_____

For <u>Males</u> Only

Do you have difficulty urinating (peeing)?	[] Yes [] No	_____
Do you suffer from impotence?	[] Yes [] No	_____
Do you awake at night to urinate (pee) more than twice?	[] Yes [] No	_____
Have you had a PSA screening within the last year?	[] Yes [] No	_____

<u>Date of Last:</u>

Tetanus shot _____
Whooping Cough/Pertussis shot _____
Shingles shot _____
Pneumonia shot 13_____ 23 _____
Flu shot _____

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FAMILY HISTORY: (Check all that apply)

Mother:
[] Diabetes
[] Heart Disease
[] High Blood Pressure
[] Blood Disease
[] Kidney Disease
[] Thyroid Disease
[] Cancer (Type of Cancer): _____
Cause of Death: _____
Age of Death: _____

Father:
[] Diabetes
[] Heart Disease
[] High Blood Pressure
[] Blood Disease
[] Kidney Disease
[] Thyroid Disease
[] Cancer (Type of Cancer): _____
Cause of Death: _____
Age of Death: _____

Brother:
[] Diabetes
[] Heart Disease
[] High Blood Pressure
[] Blood Disease
[] Kidney Disease
[] Thyroid Disease
[] Cancer (Type of Cancer): _____
Cause of Death: _____
Age of Death: _____

Maternal Grandfather:
[] Diabetes
[] Heart Disease
[] High Blood Pressure
[] Blood Disease
[] Kidney Disease
[] Thyroid Disease
[] Cancer (Type of Cancer): _____
Cause of Death: _____
Age of Death: _____

Maternal Grandmother:
[] Diabetes
[] Heart Disease
[] High Blood Pressure
[] Blood Disease
[] Kidney Disease
[] Thyroid Disease
[] Cancer (Type of Cancer): _____
Cause of Death: _____
Age of Death: _____

Sister:
[] Diabetes
[] Heart Disease
[] High Blood Pressure
[] Blood Disease
[] Kidney Disease
[] Thyroid Disease
[] Cancer (Type of Cancer): _____
Cause of Death: _____
Age of Death: _____

SOCIAL HISTORY:

Occupation: [] Employed [] Retired [] Unemployed []Disabled [] Student
Marital Status: [] Single [] Married [] Divorced [] Widow [] Life Partner
Do you smoke: [] Yes [] No [] Quit (when: _____ OR how much: _____)
How often do you drink alcohol: [] Never [] Daily [] Occasionally (what kind: _____)
Do you use recreational drugs: [] No [] Frequently [] Occasionally (what kind: _____)

MEDICAL RECORDS RELEASE FORM

I hereby authorize (mark one):

___ _____

___ FPS Medical Center at 297 Lake Havasu Avenue, Suite 204 Lake Havasu City, AZ 86404

to disclose the following information from the health records of:

Patient name: _____ Date of Birth: _____

Phone Number:_____ SSN:_____

To be disclosed to: Dr. Jeffrey Carls, M.D. 1720 Mesquite Avenue, Suite 100 Lake Havasu City, AZ 86403 928-855-1550

Records to be disclosed to the above entity (please mark):

____` All medical records, images, documents, etc. from the date first seen at FPS Medical Center. Records to be sent in an electronic, CCDA format compatible with Nextgen Share.

____ Other: (specify)_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released, all EXCEPT:

_____Drug/Alcohol abuse/ treatment & diagnosis _____Sexually transmitted diseases

_____HIV/AIDS treatment and testing _____Mental Illness or psychiatric diagnosis/treatment

For the purpose of : _____continuing treatment _____transferring care ____Other (specify):_____

FOR YOUR INFORMATION:

- This authorization for Dr. Jeff Carls shall be in force for **90 days**, unless otherwise specified by the patient, at which time this authorization to use or disclose this protected health information expires.
- I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Dr. Jeff Carls at 1720 Mesquite Avenue Suite #100 Lake Havasu City, AZ 86403. I understand that a revocation is not effective to the extent of FPS Medical Center has relied on the use or disclosure of the protected health information.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- Dr. Jeff Carls will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure.

_____ _____

Signature of Patient **Date**