NORTH PHOENIX INTERNAL MEDICINE, P.C.

W. KENT BRUBAKER, M.D. • PHUC H. PHAM, M.D. • KIM VU, P.A.-C

Welcome to our Practice

Enclosed you will find a packet of information that needs to be completed before you have your visit with us.

The information packet has been divided into what you need to bring with your visit.

Please make sure that you bring:

1. Change your Primary Care Physician to who you are seeing for your visit if applicable.
2. Make sure to bring ALL current Insurance Card(s) including Medicare and AHCCCS to your visit. Failure to give us your correct Insurance information will result of receiving a bill for non-payment of Claims.
3. Always bring your Copay for your Office Visit if applicable. It will be collected at the time of service are rendered.
4. Cash Patients: PAYMENTS MUST BE MADE AT THE TIME OF SERVICE ARE RENDERED.
5. New Patients: Please arrive at least 15 minutes early prior to your appointment so we may help you with the Paperwork, copy your Insurance Card(s) and Picture ID, and any questions that you may have for us.
6. If you have Medicare, please be advised that not ALL services are covered under Medicare Guidelines. Please contact your Insurance prior to your Appointment if you are unsure of what services are covered by their Guidelines.
7. If you are covered by more than One (1) Insurance, we will gladly bill for the two (2). If you have a Third (3) Insurance, you will be responsible for submitting the Claim to that Insurance.

This is a small checklist that will make your Check-in and Check-out as smooth as possible. We know how important your time is and this will make your visit to our office a pleasant one.

Sincerely,

Management at North Phoenix Internal Medicine

This Information will be review by the Office Manager with you after visit is completed.

_____

Patient Signature

1747 E. MORTEN, SUITE 303 • PHOENIX, ARIZONA 85020 • 602-589-0370 • FAX 602-589-0650

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INTEROFFICE MEMORANDUM

TO: OUR PATIENTS

FROM: NORTH PHOENIX INTERNAL MEDICIN E.

SUBJECT: INCORRECT INSURANE INFORMATION

DATE: EFFECTIVE IMMEDIATELY

CC:

ALL CURRENT INSURANCE INFORMATION MUST BE GIVEN TO US AT THE TIME OF YOUR VISIT.

IF THE INSURANCE INFORMATION GIVEN IS NOT CORRECT AND THE INFORMATION CAUSES A CLAIM TO BE RETURNED- YOU WILL BE RESPONSIBLE FOR ALL UNPAID AMOUNTS UP TO AND INCLUDING - COPAY'S-COINSURANCE AND DEDUCTBLES.

IF YOU ARE UNSURE ABOUT YOUR INSURANCE PLEASE CALL YOUR HUMAN RESOURCE DEPARTMENT AND GET CLARIFICATION ABOUT YOUR PLAN.

THE MANAGEMENT

NORTH PHOENIX INTERNAL MEDICINE, P.C.

W. KENT BRUBAKER, M.D. • PHUC H. PHAM, M.D. • KIM VU, P.A.-C

Patient Information:

Last Name:_____ First Name:_____ M._____

Date of Birth: _____/_____/_____ Sex: ____Male ____Female Marital Status: _____

Social Security#:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Home#:_____ Work#:_____ Cell#:_____

If Minor Parent/Guardian Name: _____

Contact Phone Number:_____ Relationship to Patient:_____

Patient's Employer: _____

Employer's Address:_____

Employer's Phone: _____ Occupation:_____

Emergency Contact:

Name:_____

Address:_____

Relationship to Patient:_____ Phone:_____

Insurance Information:

PRIMARY Insurance Name:_____ Policy No: _____

Group#:_____ Relation to Insured: _____Self _____Spouse _____Child _____Other:_____

Name of Insured:_____ Insured Date of Birth: _____

Insured SS#: _____

SECONDARY Insurance Name:_____ Policy No: _____

Group#:_____ Relation to Insured: _____Self _____Spouse _____Child _____Other_____

Name of Insured:_____ Insured Date of Birth: _____

Insured SS#: _____

I request that payment of authorized Medicare, AHCCCS, and any other Insurance Benefits be made to me or on my behalf to North Phoenix Internal Medicine, P.C...I authorize any holder of Medical Information about Me to release to Health Care Financing Administration, it's Agents, or any other Insurance Company and Information needed to determine these benefits payable for related services.

Patient Name (Print): _____ **Today's Date:**_____/_____/_____

Patient Signature: _____

1747 E. MORTEN, SUITE 303 • PHOENIX, ARIZONA 85020 • 602-589-0370 • FAX 602-589-0650

NORTH PHOENIX INTERNAL MEDICINE

Dr. W. Kent Brubaker, M.D., Dr. Phuc Pham, M.D., Kim Vu, PA-C

1747 E. Morten Avenue, Suite 303 Phoenix, Arizona 85020

Phone: (602) 589-0370 Fax: (602) 589-0650

I authorize _____ Phone: _____ Fax: _____

to disclose Protected Health Information (PHI) from the health records of:

Patient's Name: _____

Date of Birth: _____

Address: _____

Social Security Number: _____

SEND RECORDS TO:

North Phoenix Internal Medicine

1747 E. Morten Ave., Suite 303 Phoenix, Arizona 85020 or Fax to (602) 589-0650

Information to be Disclosed: (Please Mark)

- ❑ All Records (Progress Notes, Labs, X-rays, Hospitalization, etc...)
- ❑ Other (Specify Information): _____

Purpose of the Disclosure: (Please Mark)

- ❑ Continuation of Care
- ❑ Primary Care Physician or Insurance Changed
- ❑ Disclosure at Patient's Request
- ❑ Other (Specify): _____

I authorize the Provider to use or disclosure of information related to my Health and I consent to release of my information.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand that the Clinic/Hospital or Doctor's office will not condition treatment on my signing this Authorization. The Clinic/Hospital or Doctor's office will not deny me treatment if I do not wish to sign this form. I may refuse to sign this Authorization Form. I understand that I may revoke this Authorization at any time. I must submit a written request for Medical Records unless I revoke this Authorization earlier; It will be expired one (1) year from the Date of Signature. I understand that if this Information is disclosed to a Third party, the Information may no longer be protected by the Federal Privacy Regulation and maybe disclosed by the Person/Organization of the received information. I understand that the matters discussed on this form. I release the Providers, it's Employees, Officers, and Directors, Medical Staff Members, and Business Associates from any Legal responsibility or Liability for the Disclosure of the above Information to extent indicated and the Authorization here in.

Patient's Name (Print): _____ **Witness:** _____

Patient's Signature: _____ **Date:** _____

NAME _____ DOB _____ DATE _____

Please circle yes or no to all of the following:

PAST ILLNESS

Regular Measles - 10 day ..... Y N
German Measles - 3 day ..... Y N
Mumps ..... Y N
Chicken Pox ..... Y N
Diphtheria ..... Y N
Whooping Cough ..... Y N
Scarlet Fever ..... Y N
Venereal disease ..... Y N
Pneumonia ..... Y N
Rheumatic Fever ..... Y N
Arthritis or Rheumatism ..... Y N
Any bone or joint disease ..... Y N
Bursitis ..... Y N
Polio ..... Y N
Meningitis ..... Y N
Anemia ..... Y N
Jaundice ..... Y N
Epilepsy ..... Y N
Valley Fever ..... Y N
Hepatitis ..... Y N
TB ..... Y N

CURRENT ILLNESSES:

_____

_____

FAMILY HISTORY:

Name those having any of the following:

Cancer _____

Tuberculosis _____

Diabetes _____

High Blood Pressure _____

Heart Disease _____

Epilepsy _____

SYSTEMS REVIEW:

E.E.N.T.

Migraine headaches ..... Y N
Frequent headaches ..... Y N
Dizziness ..... Y N
Double vision ..... Y N
Glasses ..... Y N
Ear infections ..... Y N
Hearing Loss ..... Y N
Nose bleeds ..... Y N
Gums bleed easily ..... Y N
Nasal Discharge ..... Y N
Hard to Swallow ..... Y N

CARDIOVASCULAR

Pain over heart ..... Y N
Climb stairs easily ..... Y N
Swelling of ankles ..... Y N
Heart Attack ..... Y N
Stroke ..... Y N
Pain in legs ..... Y N
High Blood Pressure ..... Y N
Nervous Breakdown ..... Y N
Hay Fever ..... Y N
Asthma ..... Y N
Hives or Eczema ..... Y N

ALLERGIES:

List medications you are allergic to:

_____

_____

_____

_____

OTHER ALLERGIES:

_____

_____

PREGNANCIES:

How many live pregnancies _____

How many live children _____

Any complications _____

Age of children _____

_____

MENSTRUAL:

Periods regular ..... Y N

Usual interval from first day of cycle to first day of next cycle.

Flow ..... heavy mod. light

Pain ..... severe mod. light

Date of last Pap _____

VAGINA:

Excessive discharge ..... Y N
Vaginal itching ..... Y N
Contact Bleeding ..... Y N
Bleeding between menses ..... Y N

LUNGS:

Chronic cough ..... Y N
Cough with blood ..... Y N
Pain on breathing ..... Y N

GASTROINTESTINAL:

Nausea ..... Y N
Sour stomach ..... Y N
Bloating ..... Y N
Rectal Bleeding ..... Y N
Color of Stool _____

HABITS:

Alcohol: ..... never occ. freq. daily
Cigarettes: ..... never occ. freq. daily
_____ packs per day

DRUG USE:

Chemical Abuse never occ. freq. daily

TRANSFUSIONS: Have you had,

Blood or Plasma ..... Y N
Any Reactions ..... Y N

DRUGS:

Sedative ..... never occ. freq. daily
Tranquilizers ..... never occ. freq. daily
Sleeping Pills ..... never occ. freq. daily
Aspirin ..... never occ. freq. daily
Insulin ..... never occ. freq. daily
Hormones ..... never occ. freq. daily
Cortisone ..... never occ. freq. daily
Thyroid ..... never occ. freq. daily

IMMUNIZATION: Have you had,

Small pox ..... Y N When _____
Tetanus Toxoid ... Y N When _____
Polio ..... Y N When _____
MMR ..... Y N When _____
DPT ..... Y N When _____
Pneumonia ..... Y N When _____
Influenza ..... Y N When _____

KIDNEY AND BLADDER:

Attacks of kidney paid ..... Y N
Burning on urination ..... Y N
Frequency of urination ..... Y N
Poor control of urine ..... Y N
Kidney / bladder infection ..... Y N

OTHER:

Phlebitis ..... Y N
Varicose veins ..... Y N
Leg/foot cramps ..... Y N
Muscle weakness ..... Y N
Paralysis ..... Y N

BLOOD AND GLANDS:

Any anemia ..... Y N
Are you a bleeder ..... Y N
Any enlarged glands
in neck or groin ..... Y N
Any enlarged glands under arms .. Y N
Any HIV history ..... Y N

Weight _____ One year ago _____

SURGERIES / OPERATIONS / HOSPITALIZATIONS:

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Live alone? ..... Y N
Pets? ..... Y N
Family living close by? ..... Y N

NORTH PHOENIX INTERNAL MEDICINE

Patient Name: _____ Date of Birth: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

____ I give permission to call my place of business/work.

____ I give permission to leave ONLY normal results on my Answering Machine. Cell/Home

____ I give permission to leave ALL test results on my Answering Machine. Cell/Home

____ I give permission to speak to _____ regarding my test results.

____ I give permission to have my results mailed to me at (**$1.00 per page for copies**):

_____

_____

Patient Signature: _____ Date: _____

Witness: _____

This will be effective immediately unless revoked by Patient

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North Phoenix Internal Medicine P.C.
(Effective December 1, 2002)

Thank you for choosing North Phoenix Internal Medicine P.C. as your Primary Physician. We welcome you! We are committed to providing the finest in personalized and professional health care possible for our patients. Please carefully read and sign the following statement policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient of their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present you insurance card at each visit. You will be responsible for all co-pay, coinsurance, and deductibles on the day of service. Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request.

IT IS YOUR RESPONSIBILTY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If we do not receive payment within 60 days, the patient will be billed. If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective if you do not have insurance, payment in full will be expected the day you are seen. For your convience, we accept VISA, MasterCard, cash, or checks.

Delinquent accounts over 90 days will be subject to the following action. Your outstanding balance will be turned over to J.R. Brothers Financial Inc. for further processing.

There will be a $25 service fee for all returned checks. NSF checks must be redeemed with certificed funds. (Cashier's check, money order, certified check or cash)

If you need to cancel a scheduled appointment, please contact our office at least **24 hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A $50 FEE WILL BE ASSESED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCE NOTICE.**

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the above Financial Policy and I agree to abide by its terms.

PRINTED NAME OF PATIENT _____ SIGNATURE OF PATIENT/RESPONSIBLE PERSON _____

DATE: _____

ACKNOWLEDGEMENT OF RECIEPT OR NORTH PHOENIX INTERNAL MEDICINE P.C NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the opportunity to review a current copy of North Phoenix Internal Medicine "Notice of Privacy Practices". My signature means that I agree to the terms of this notice. Please return this acknowledgement of receipt of notice to North Phoenix Internal Medicine P.C. I understand that I may refuse to sign this acknowledgement.

I knowledge receipt and have read and understand the Notice of Health Information Practices regarding my Provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

_____ Date: _____
Print Patient Name or Authorized Representative

_____ Date: _____
Signature of the Patient or Authorized Representative

_____
Relationship to the Patient if signed by anyone other than the Patient

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FOR OFFICE USE ONLY

North Phoenix Internal Medicine P.C. could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited it
- ☐ An emergency situation prevented us
- ☐ Other (please specify) _____
  _____
  _____

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NORTH PHOENIX INTERNAL MEDICINE

W. Kent Brubaker,M.D.-Phuc H.Pham,M.D.-Kim Vu,P.A.-C.

ADVANCE DIRECTIVES

To comply with Medicare, managed health care plans, and hospital admission requirements, we are required to provide to you information about Federal and State laws that allow you to accept or refuse treatment to formulate Advance Directives. Advance Directives are documents that enable you to give directions about your future medical care. This form is not intended to provide you legal advice but merely to provide information only.

Before making any decision about Advance Directives, please talk with your family, physicians, and/or attorney, if you need assistance. If you already have an Advance Directive or have decided to develop one, please give copies to your family, close friends, and your physician, so that they will be aware of your wishes.

We would like to assure you that this is not required and that you may elect to not have Advance Directives. In the event of a medical emergency, all measures, including life support will be given to those who do not sign Advance Directives.

Please review the enclosed information and sign at the bottom. Your signature does not signify any decision but merely shows that you have been given the information, and offered the opportunity for Advance Directives. Thank you.

Patient Signature

Date