Vita Medica Institute

Tucson, Arizona, USA

Name: _____ Date: _____ Social Security: _____

Age: _____ DOB: _____ Height: _____ Weight: _____

Gender: _____ Address: _____

Phone Number: Home: _____ Cell: _____

Email Address: _____

Place of Employment: _____ Employer Phone: _____

Ethnicity (Please check most appropriate): ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

Race: ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Black/ African American ☐ Native Hawaiian

☐ Other Pacific Islander ☐ White ☐ I decline to provide this information

Female Patients: Pregnant? ☐ Yes ☐ No

Name of the physician who sent you to us: _____

Name of Primary Care Physician: _____

Work Status: ☐ Occupation: _____

☐ Disabled (reason): _____

What is the main reason for your consultation today? _____

Please describe the symptoms you are experiencing: _____

_____

_____

Approximate date of onset of symptoms: _____

What helps your symptoms? _____

What worsens your symptoms? _____

If this is a spinal problem, please fill out the following:
Have you tried? Physical therapy ☐ Yes ☐ No Steroid Injections ☐ Yes ☐ No
Severity of pain: ☐ Constant ☐ Occasional ☐ Wakes you up ☐ Difficulty walking

Do you have any of the following diagnoses?

Diabetes	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Asthma or Emphysema	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Bleeding disorder	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

Type of Cancer: _____ Year of diagnosis: _____

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

How many children do you have? _____

Do you smoke? ☐ Yes ☐ No Packs per day _____ Did you previously smoke? ☐ Yes ☐ No

If yes, what year did you quit smoking? _____

Do you drink alcohol? ☐ Yes ☐ No Amount: _____

Do you do street drugs? ☐ Yes ☐ No Type and Amount: _____

Do you exercise? ☐ Yes ☐ No Type and Amount: _____

Please list all medications you currently take:

Medications	Dosage	Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Preferred pharmacy and address: _____ Phone#: _____
Insurance name on pharmacy card: _____
Pharmacy card ID/Group Number: _____
Policy Holder Name: _____
Relationship to patient: _____

	Resting	Sitting	Standing	Exercise
Makes pain better				
Makes pain worse				

Please list all allergies (**Medications and other**):

Allergy to: Reaction

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe any **major injuries and/or illnesses** you have had:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list all **surgeries/hospitalizations** you have had:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Have you ever had a reaction to anesthesia? If so, describe: _____

Please list all serious illnesses you blood relatives have had:

Father: _____ Deceased at age: _____
Mother: _____ Deceased at age: _____
Brother(s): _____
Sister(s): _____
Children: _____

Do you have an Advance Directive? ☐ Yes ☐ No

If yes, which do you have? ☐ Do Not Resuscitate ☐ Living Will ☐ No Decision Maker Provided ☐ Non-Surrogate Decision Maker ☐ Surrogate Decision Maker

The above patient information is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ DATE: _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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Tucson, Arizona, USA

Authorization to Request Medical Records

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

I authorize:

_____

_____

_____

To release copies of my medical records to:
Vita Medica Institute
2850 E. Skyline Dr., Suite 130 Tucson, AZ, 85718
Phone: 520-638-5757
Please Fax ASAP to: 520-447-5701

Records Authorized To Be Released:

- Admission History and Physical
- Discharge Summary
- Complete Hospital Chart
- Office Notes
- Outpatient Records
- Psychiatric and Other Mental Health Records
- Records Relating to Drug and Alcohol Abuse
- Lab Reports
- Radiological Imaging
- Consultation Notes or Reports
- Complaint or Grievances Filed with Responses or Dispositions
- Medication Administration Logs, Dietary Logs, Staff Contact or Service Logs, and Other records that may not be part of the Individual Medical Records
- Other

I understand that I can revoke this authorization at any time by writing to the health care provider, but revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected.
- I am entitled to receive a copy of this authorization.

Patient Signature: _____ Date: _____

Vita Medica Institute

Tucson, Arizona, USA

Confidentiality Agreement

Release of Information Form

Patient Name: _____ DOB: _____ Date: _____

The confidentiality of our patients' medical information is very important to us. We understand that there may be circumstances in which a family member or close friend needs access to your health information, or to the health information of someone under your care.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records, or to your dependents medical records. This information is not limited to but includes appointments, billing information, and test results.

Please list a minimum of 3 emergency contacts.

Significant Other: _____ Contact Number: _____

Child's Name: _____ Contact Number: _____

_____ Contact Number: _____

Parents' Name: _____ Contact Number: _____

Contact Number:

_____ _____

Other's Name: _____ Contact Number: _____

_____ Contact Number: _____

Do Not Release information to the following people:

Please check if applicable:

_____ I give permission for my child (of >15 years old) to be seen without the presence of an adult.

_____ I give permission for my child (of > 15 years old) to have minor procedures immunizations without the presence of an adult

_____ I give permission for my child to be taken to medical appointments by:

Patient/Parent/Guardian Contact Numbers:

Home: _____ Work: _____ Cell: _____

Signature of patient or Parent/Legal Guardian

_____ Date: _____

Financial & Office Policies

Patient Name: _____ DOB: _____

Payment Policy:
Payment is required at time of service. Your copay is due at time of visit. For your convenience, we accept cash, checks, Visa or MasterCard as a form of payment. Please also note that any patient account credits cannot be refunded back to the patient for a term of 2-6 months depending on when the insurance claims are processed.

_____
(Initials)

Insurance Policy:
As one of your insurance companies' network providers we **require your copayment in advance** of your appointment. We also will require a digital scan of your insurance card. We will bill your insurance company. Any deductible, coinsurance or non-covered services will be your responsibility.
The original insurance card as well a photo ID have to be presented at each visit. Should the insurance be terminated for whatever reason the office needs to notified immediately. No claims will be processed retrospectively if the insurance has been terminated.
For those plans we are non-contracted with, as a courtesy, we will submit claims to your carrier; any deductible, coinsurance or non-covered services will be your responsibility.
Monthly statements will be sent to collect those balances. **Please inform our staff immediately of any insurance changes**.

_____
(Initials)

Non-covered Service Policy:
For any tests performed at Vita Medica Institute, we will contact your insurance to obtain and authorization and an estimate of out-of-pocket costs. This estimated cost will be disclosed to you before we perform the test. We **highly recommend** that you check this information with your insurance company as well. Certain services performed by our office are NOT COVERED by insurance plans. Some of these services include acupuncture, Durable Medical Equipment (DME), Urine Drug Screens (UDS) and certain injections. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice (ABN) for non-covered services.

_____
(Initials)

Delinquent Accounts Policy:
Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency, **patient will be responsible for all collection and/or legal costs**. If a balance is over 61 days late, a 3.5% monthly interest fee will be added to the outstanding balance. Please inform our billing staff if you know your payment will be late in arriving or if payment arrangements are needed.

_____
(Initials)

Late Arrivals:
For our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 15 minutes late, our office will reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.
We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late. Please be patient in these circumstances.

_____
(Initials)

Medical Records:
Should you request a copy of your medical records, please allow our office 7 Business days for completion. The fee for this service is $35.

_____ (Initials)

Forms Policy:
Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., There will be a charge of $50.00 per form. This fee is subject to change.

_____
(Initials)

Appointment Cancellations/No Shows/Reschedules:
There is a $35.00 charge for established patients and New Patients, EMG's and procedures who cancel, reschedule or no show for an appointment without giving 24-hour notice, these appointment times could have been given to another patient who needs medical care. A no show for an Ambulatory appointment will result in a $100.00 fee. We understand unusual circumstances may arises, please contact our office as soon as possible. This fee is subject to change.

_____
(Initials)

Prescriptions:
Appointments are required for most medication refills. Please contact our office a minimum of 10 days prior to your scheduled refill date. Phone call refills are not allowed.

_____
(Initials)

Returned Checks:
Our office charges a $50.00 fee for all account closed, stop payment or non-sufficient funds refunds returned checks. This fee is subject to change.

_____
(Initials)

Referrals & Authorizations:
If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. *We suggest you contact your insurance carrier to verify your coverage, benefits and preauthorization requirements prior to having any procedures performed*. Please be aware authorizations and referrals are not a guarantee of payment.

_____
(Initials)

Patient Scheduling:
Please be advised that all patients scheduled at VitaMedica Institute will be seen by either the Doctor a Certified Nurse Practitioner, or both. All patients are scheduled according to availability.

_____
(Initials)

By signing this form, I am consenting to recommended procedures and treatment plans.

_____ Date _____
(Patient/Guarantor Printed Name)

_____ Date_____
(Patient/Guarantor Signature)

Vita Medica Institute

Tucson, Arizona, USA

Notification of Rights and Privacy Practices

It is our goal at Vita Medica Institute to provide you with the highest quality of care while addressing your individual needs.

Patient Rights
It is your right as a patient:

1. To be treated with respect for personal dignity and need for privacy regardless of race, color, religion, sex, age, physical or mental limitations or national origin.
2. To participate in decisions involving treatment or the plan of care.
3. To express an inquiry /complaint and receive an answer to this inquiry/ complaint within a reasonable period of time.
4. To reasonably access information regarding financial charges for which you will be responsible.

Privacy Practices
Vita Medica Institute is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy practices that are outlined in this notice.

1. Health information may be disclosed to other health care professionals for the purpose ofproviding proper treatment.
2. Health information may be used to seek payment from your insurance health plan provider or other sources of coverage.
3. Health information may be disclosed to law enforcement agencies to support government audits and inspections in order to comply with government mandated reporting.
4. Health information may be disclosed to public health agencies as required by law.
5. Health information may not be used without written authorization for any purpose other than those listed above.

Please be aware that your decision to deny authorization will not undo or affect any use or disclosure of information that occurred before you notified Vita Medica Institute of your decision to revoke authorization.

By signing this document, you are hereby notified that you have read the above information and are aware of your personal rights and Vita Medica Institute privacy practices in their entirety.

_____ _____
Patient's Name (Printed) Date of Birth

_____ _____
Patient's Signature Date