

# 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 drink caffeine?  Yes  No Amount: \_\_\_\_\_

Do you use recreational drugs, including marijuana?  Yes  No

If yes, what 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. _____		

Preferred pharmacy and address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Insurance name on pharmacy card: \_\_\_\_\_

Pharmacy card ID/Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Have you had any recent falls?  Yes  No

If so, when was your most recent fall? \_\_\_\_\_

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. \_\_\_\_\_

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 fidgety 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, TOTAL:   
please refer to accompanying scoring card).

<p><b>10.</b> If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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# Vita Medica Institute

*Tucson, Arizona, USA*

## Authorization to Request Medical Records

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize:

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To release copies of my medical records to:

**Vita Medica Institute**

**3530 E Campo Abierto, Ste 200 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: \_\_\_\_\_

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## 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:

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### 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 expected 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 6 to 8 weeks.

\_\_\_\_\_  
(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.

For those plans we are non-contracted with our office, as a courtesy, 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 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 1.5% 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:**

In order 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 25 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 schedules 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 7-10 Business days for completion. The fee for this service is \$35.00.

\_\_\_\_\_  
(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 arise, please contact our office as soon as possible. This fee is subject to change.

\_\_\_\_\_  
(Initials)

**Prescriptions:**

Appointments are required for 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 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 Vita Medica 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)

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*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 of providing 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