SUMMIT HEALTHCARE MEDICAL ASSOCIATES

Last Name_____ First Name _____

Preferred Name_____ Middle Name, Suffix_____

Former Last Name_____ Sex_____ DOB_____

Social Security Number _____

Mailing Address _____

Physical Address _____

City, State, Zip Code _____

Home Phone_____ Mobile Phone_____

Employer_____ Work Phone_____

Preferred Language_____ Email _____

Race: White African-American Asian Decline to answer Other_____

Ethnicity: Central American Cuban Dominican Hispanic/Latino Mexican Not Hispanic/Latino Puerto Rican South American Spaniard Decline to answer Other_____

Marital Status: Married Single Divorced Separated Widowed Partner Decline to answer

Homebound? Yes No

Preferred Pharmacy_____ Location_____ Preferred Laboratory_____

Parent/Guardian/Representative Information

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Social Security Number_____

Mailing Address_____

City, State, Zip Code_____ _____

Home Phone_____ Mobile Phone_____

Employer_____ Work Phone_____

Insurance Information

Primary_____ Member ID #_____

Secondary_____ Member ID #_____

Is patient's condition related to employment? Yes No

Is patient's condition related to an auto accident? Yes No

SUMMIT HEALTHCARE MEDICAL ASSOCIATES

Last Name_____ First Name _____

Emergency Contact

Name_____ Relationship_____

Home Phone_____ Mobile Phone_____

Name_____ Relationship_____

Home Phone_____ Mobile Phone_____

Protected Health Information – Preferences

Who may we talk to about your medical condition and protected/private information?

Name_____ Relationship_____ Phone number_____

Name_____ Relationship_____ Phone number_____

Summit Healthcare staff and/or representatives may contact you using common business technologies. Select all methods you prefer:

☐ Letter: ☐ use home/billing address ☐ Use alternative address_____

☐ Email_____

☐ Phone_____ ☐ Do not leave a message

☐ Leave message with call back number only

☐ Leave detailed message

☐ Text message me with call-back information

How would you like to receive your patient care summary? ☐ Portal ☐ Paper

Patient/Representative Signature_____ Date_____ Time_____

Witness Signature_____

SUMMIT HEALTHCARE MEDICAL ASSOCIATES

Last Name_____ First Name _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

What other concerns do you have: _____

ALLERGIES

List anything you are allergic to (medication, food, bee stings, etc…) and how each affects you

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

PHARMACY

Name:_____ City: _____State:_____

MEDICATIONS

Please list all medications you are taking. Include prescribed drugs, over-the-counter, vitamins, minerals and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN

IMMUNIZATION HISTORY

Chickenpox	Yes/No Date:_____	Hepatitis A	Yes/No Date:_____
Flu Shot	Yes/No Date:_____	Hepatitis B	Yes/No Date:_____
Gardasil/HPV	Yes/No Date:_____	MMR	Yes/No Date:_____
Pneumonia	Yes/No Date:_____	TDaP	Yes/No Date:_____
Tetanus	Yes/No Date:_____	Zostavax	Yes/No Date:_____

SUMMIT HEALTHCARE MEDICAL ASSOCIATES

Last Name_____ First Name _____

WOMEN ONLY (Obstetric & Gynecological History)

PAP Smear Last Date: _____ Abnormal? Yes / No

Vaginal Itching, burning or discharge? Yes / No Waking at night to urinate? Yes / No

Mammography Last Date: _____ Hot Flashes Yes / No
Age of first Period: _____ Date of last period: _____

Bleeding between periods? Yes / No Heavy periods? Yes / No

Extreme menstrual pain? Yes / No

Breast lump or nipple discharge? Yes / No Painful intercourse? Yes / No

# of Pregnancies: _____ # of Births: _____ # of Miscarriages: _____ # of Abortions: _____

Cesarean sections Yes / No How many? _____

Sexually active? Yes / No Current sexual partner Male / Female

Types of birth control: _____ Interested in being screened for STDs Yes / No

PAST MEDICAL HISTORY

Please leave blank if unsure

CONDITION	Y	N	CONDITION	Y	N
Anxiety / Depression			High Cholesterol		
Arthritis			Hiatal Hernia or Reflux		
Asthma			High Blood Pressure		
Bleeding Disorder			Kidney Disease		
Blood Clots / DVT			Kidney Stones		
Cancer			Leg/Foot Ulcers		
Diabetes / Insulin – Non-Insulin			Liver Disease		
Coronary Artery Disease			Osteoprosis		
Claustrophobic			Stroke		
Dialysis			Thyroid Condition Overactive/Under		
Diverticulitis			Other:		
Fibromyalgia					
Gout					
Heart Attack					
Heart Murmur					
HIV or AIDS					

SUMMIT HEALTHCARE MEDICAL ASSOCIATES

Last Name_____ First Name _____

PAST SURGICAL HISTORY

TYPE OF SURGERY	REASON	YEAR	HOSPITAL

FAMILY HISTORY

DISEASE	RELATION	DIAGNOSED AGE	LIVING / PASSED AGE
Alcoholism			
Arthritis			
Depression			
Cancer Type:			
Diabetes			
Genetic Disease			
Heart Disease			
Hypertension			
Osteoporosis			
Stroke			
Other:			

SOCIAL HISTORY

Occupation: _____ Highest Grade Completed: _____ College? _____

Marital Status: _____ Who do you live with? _____

Exercise Level: None Occasional Moderate Heavy

Tobacco: Do you use tobacco? Yes / No Cigarettes: Packs per day _____ Chew: X per day: _____

Cigars: # per day _____ Vape: X per Day: _____ Marijuana: X Per Day: _____

Former Smoker? Yes / No When did you quit? _____

Alcohol: Do you drink alcohol? Yes / No Type of Alcohol: Beer / Wine / Liquor How many drinks per day? _____ Per Week? _____ Per Month? _____

SUMMIT HEALTHCARE MEDICAL ASSOCIATES

Last Name_____ First Name _____

REVIEW OF SYSTEMS

Please circle all that apply

Constitutions: Fever Night Sweats Weight Gain (_____ lbs) Weight Loss (_____ lbs) Exercise Intolerance

Eyes: Dry Irritation Vision Changes When was your last eye exam? _____

Ears: Difficulty Hearing Ear Pain Ringing

Nose: Frequent Nosebleeds Nose/Sinus Problems

Mouth: Sore Throat Bleeding Gums Snoring Dry Mouth Oral Abnormalities Mouth Ulcer Teeth Abnormalities Breathing through your mouth

Cardiovascular: Chest Pain on exertion Arm Pain on Exertion Shortness of Breath when Walking Shortness of Breath when Lying Down Palpitations Know Heart Murmur Light-Headed when Standing

Respiratory: Cough Wheezing Shortness of Breath Coughing up Blood Sleep Apnea

Gastrointestinal: Abdominal Pain Vomiting Change in Appetite Black or Tarry Stools Frequent Diarrhea Vomiting Blood Difficult or Labored Breathing GERD/Reflux/Heart Burn Unable to Restrain Bowel Movements

Genitourinary: Urinary Loss of Control Difficulty Urinating Blood in Urine Increase Frequency Incomplete Emptying How many times during the night to you wake to urinate: _____

Musculoskeletal: Muscle Aches Muscle Weakness Arthralgia/Joint Pain Back Pain Swelling in Hands or Feet

Skin: Abnormal Mole Jaundice/Yellowing of Skin Rash Itching Dry Skin Growths/Lesions

Neurological: Loss of Consciousness Weakness Numbness Seizures Dizziness Frequent or Severe Headaches Migraines Restless Legs Memory Lapses or Loss

Psychiatric: Depression Anxiety Sleep Disturbances Restless Sleep Feeling Unsafe in Relationship Alcohol Abuse

Endocrine: Fatigue Increased Thirst Hair Loss Increase Hair Growth Cold Intolerance

Hematologic/Lymphatic: Swollen Glands Easy Bruising Excessive Bleeding

Allergy / Immunologic: Runny Nose Sinus Pressure Itching Hives Frequent Sneezing

_____ Date: _____

PATIENT / PARENT / GUARDIAN / CAREGIVER SIGNATURE

CONDITIONS OF TREATMENT, NOTIFICATIONS, AUTHORIZATIONS & TERMS OF SERVICE

Thank you for choosing Summit Healthcare Medical Associates (SHMA) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of this document is important to our professional relationship. Please read it carefully and ask questions if you do not understand our fees, our policies, or your responsibilities. If you would like an interpreter, we will provide one at no charge. By signing this document, you are agreeing and consenting to the information within. Note: Complete annually.

NOTIFICATIONS (check all that apply)

Patient Bill of Rights and Responsibilities

☐ I received or was offered a copy (1st visit & annually) ☐ I had an opportunity to review the information.

Notice of Privacy Practices (HIPAA)

☐ I received or was offered a copy. (1st visit) ☐ I had an opportunity to review the information.

Health Information Exchange (HIE): SHMA participates in the Arizona HIE. The *Notice of Health Information Practices* explains my health information may be securely shared through the HIE, unless I complete an Opt Out Form.

☐ I received or was offered a copy. (1st visit) ☐ I have completed an Opt Out Form.

AUTHORIZATIONS

Consent to treat: I agree to receive medical care which may include routine diagnostic procedures and such medical treatment as my attending physician(s) or other SHMA medical staff considers necessary. I may be offered medical services via telemedicine systems that involve the delivery of health care by electronic communication with a provider who is at a different physical location, and I consent to such services. I understand my medical care and treatment may be provided by physicians, fellows and residents, medical and allied health students, nurse practitioners, physician assistants, nurses and other health care providers. I have read and understand this authorization for treatment and understand no guarantee or assurance has been made as, to the result or outcome of treatment.

Consent to release of information: I authorize SHMA and my insurer(s) to share my past, current and future information regarding my health, treatment and account records. This includes services I've received from SHMA and other care providers as needed to manage or coordinate my care and to improve the quality of that care.

Authorization and Assignment of Benefits, Designation of Authorized Representative and Agent:

- I hereby assign to SHMA all of my benefits and interests in recovery of any type whatsoever receivable by me or on my behalf arising out of any policy or plan of insurance, trust, fund, healthcare sharing ministry, or any entity otherwise providing benefits, coverage, or monies of any type to me (or any third-party responsible for me) for all charges for the services provided to me by SHMA, related entities, and it's employed or affiliated physicians; this assignment is further inclusive of coverage through a state or federal program, liability-based coverage including but not limited to personal injury, general liability, automobile liability inclusive of uninsured motorist coverage or med-pay, workers compensation, or any other or plan or policy for medical benefits stemming from my employment of the employment of my spouse, parent, or guardian, inclusive of

self-funded employer group plans. MEWA collective, union, or any other employment related entity or association (herein after collectively “Insurance” or “Coverage Source”). I authorize directed payment of any benefits or monies be made directly to SHMA on my behalf for any services furnished to me as a patient inclusive of payment for physician services, from any coverage source or third- party, inclusive of those related to a settlement, judgement, or lien.

- I authorize SHMA to bill my Payer(s). I also authorize Summit, its affiliates, assignees, and third-party entities subject to a Business Associate Agreement with SHMA (my “Third Party Designees”) to act as my authorized representative and/or designated agent as it relates billing, appeals, and/or administrative or legal dispute(s) or remedy relating to my medical claim(s). Pursuant to such authority, I hereby ascribe all rights and privileges available as by and between me and my coverage source as well as all rights, remedies, and privileges afforded to me under state and/or federal law; including but not limited to ability to pursue and dispute any form of adverse determination or denial related to or arising from the medical care provided to me by SHMA at any stage during my medical care, be it before my care is rendered (“pre-service”), during any admission (“concurrent”), or after any or all medical care has been provided to me (“post-service”). to the fullest extent permissible by law, this shall include but is not limited to submission of claims, filing of liens, all rights to the filing or submission of a reconsideration, grievance, appeal, external appeal, or review by any relevant source including but not limited to an independent review organization, board of trustees, or other review board or entity as established by my plan or policy, or as authorized or directed under state or federal law; review by a state or federal agency and/or committee or panel formed through a state or federal agency, administrative law judge, attorney adjudicator; and any and all legal claims related to my medical care as against any coverage source or third party for monetary, equitable, and/or declaratory remedies including but not limited to mediation, arbitration, or the filing and pursuit of litigation against a coverage source in state, federal, workers compensation, or admiralty court, including those where a coverage source or employing agency or entity may be named as a party and where I may be named as a Plaintiff.
- As my authorized representative and designated agent, I convey to my Third Party Designees the right to directly contact and communicate with my coverage source(s) via any reasonable medium or instrumentality. If my coverage source is funded or provided through my employer, or the employer of my spouse, parent or guardian, I expressly consent to my Third Party Designees directly contacting the employer, union, or association who sponsors the plan as well as any union representative, board of trustees, committee or other entity responsible for oversight or administration of benefits or handling of disputes. I further authorize my Third Party Designees to directly contact any third-party administrator, designated decision maker, pricer, claims processor, or adjudicator affiliated with the plan, policy, fund, trust, employer, union, attorney or any other affiliated entity of my coverage source(s) or liable third party.
- I agree to cooperate fully with SHMA in billing my insurance and any other third-party payor, including promptly responding to requests for information from Summit, or any insurer or other third-party payor. I also understand that in order to receive any financial assistance in paying my bill, I must promptly and truthfully complete all required applications, provide requested supporting documentation and fulfill all other requirements of the assistance program. I agree that my failure to cooperate in these matters may result in the denial of benefits or assistance. If any insurer or other third-party payor denies payment of Summit’s claim, where required by my Insurance. I will promptly pursue and/or assist in the pursuit of all appeals processes and Summit’s claim, where required by my Insurance. I will promptly pursue and/or assist in the pursuit of all appeals processes and remedies available to me.

- I understand that it is the healthcare provider's obligation to verify the medical necessity and authorization for all services prior to the services being provided. If my Payer(s) will not allow direct payment to SHMA or if SHMA chooses not to accept assignment of medical benefits, I agree to pay SHMA all health care payments I receive directly for services provided.

Coordination of Benefits:

- I hereby certify and attest that the information given regarding my Insurance, the ordering of responsibility provided below, and all the other information provided regarding the coordination of my benefits, if I hold coverage under more than one policy, is accurate and current to the best of my knowledge. I wish for all plans or policies of Insurance under which I may be a beneficiary to accept this attestation from my Third-Party Designees in place of independent completion of any coordination of benefit form issued by any Coverage Source or responsible third-party payor, entity, or individual.
- In the event it is determined that I, the patient, provided incomplete or inaccurate information leading to a claim denial, I agree to accept full financial responsibility.

Patient Payment Credit Balance Transfers

- I expressly authorize and direct that SHMA apply any monies paid by me, or by an individual on my behalf, which may have resulted in a credit balance toward any unpaid balance owing and due by me on any accounts held by SHMA or by any of our affiliated entities, inclusive of both facilities and clinicians. I understand that my current or future care is not dependent upon this authorization, and that if in the future I wish to dispute my obligation on any account and do not want that account to be subject to transfer of funds that I must provide written notice of such election to SHMA and/or affiliate and such notice shall be deemed effective on the third business day after receipt.

TERMS OF SERVICE

Use of Phone To Contact: I agree SHMA, its affiliates and agents may use common business technologies to contact me. This includes the use of an automated telephone dialing system, pre-recorded voice messages and texting to contact the wireless number(s) and/or residential lines I provide to SHMA for medical care, appointment and payment purposes.

Financial: I accept full financial responsibility of all charges for services rendered by SHMA, including any amount not paid by my healthcare plan(s), other than billing terms and restrictions under a government program. I understand payment of deductibles and co-pay amounts are expected at time of service, as well as any balance due owed to other SHMA entities. If I do not have my co-pay and my insurance card, I understand that I may be rescheduled. I agree that SHMA may obtain financial information, including consumer credit reports to determine eligibility for financial assistance and/or payment options.

Self-pay Accounts: Self-pay accounts involve patients without insurance coverage, patients without an insurance card on file with us, and patients in the grace period with their insurance premiums. Self-pay discounts are available with a signed affirmation of income. Self-pay patients must pay a minimum of $60 at time of service. In the event of a financial hardship, please discuss payment options with the office manager.

Minors: The parent(s) or guardians(s) accompanying a minor child receiving medical services is responsible for payment for the minor child's services received. If another party is also financially responsible, we will accept payment from the other party; however, that does not relinquish the accompanying parent(s) or guardians (s) responsibility to pay any unpaid balance. Newborns must be added to the parent's insurance policy within 5 days of delivery.

Outstanding Balance Policy: It is our policy that all past due accounts be sent three statements. If no resolution can be made, the account will be sent to the collection agency or attorney, and could result in possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs. Additionally, once a patient is in collections, they may no longer be seen by any of the SHMA providers until the account is placed back in good standing.

Well Visits (Adults & Children): If during an annual well exam or OB visit, an acute illness/issue is addressed and/or treated, it may be considered a separate visit/encounter. This may result in an additional office visit copay, dependent upon your individual health plan benefits.

No Shows: A "no show" is defined as no notification given by the patient to cancel or reschedule an appointment prior to the appointment time. We ask that you give at least a 24 hour notice of cancellation prior to your scheduled appointment time. No shows greatly jeopardize the provider/patient relationship. We know that emergencies or unforeseen circumstances may cause you to no show for an appointment. Please let us know should this be the case. After 3 consecutive no shows, a patient may be terminated from the practice as per SHMA policy.

Additional Fees: Additional fees may be charged for the following:

No Show Fee - $25 Returned Check Fee - $25

By signing, I agree that I understand and accept the terms on this document. I understand I have the right to revoke the authorizations on this form at any time by notifying SHMA in writing, except to the extent that SHMA has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

➤If the patient is 18 years of age or older, the patient must sign/date the form. If he/she is incapable of signing, a legally authorized substitute may sign/date the form. Please indicate your legal authority and include documentation of your relationship: ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

☐ Other Legal Representative Relationship: _____

➤If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign/date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature_____ Date_____ Time_____

Printed Name (If Patient Not Signing)_____

Witness Signature_____ Date_____ Time_____