INTERNAL MEDICINE OF ARIZONA
3333 E CAMELBACK ROAD
SUITE 122
PHOENIX, ARIZONA 85018
PH: 602.522.1900 | FAX: 602.381.3281

LAST NAME: _____ FIRST NAME: _____ DOB: _____

SS# _____ SEX:

PRIMARY PHONE: _____ ALTERNATE PHONE: _____

MARITAL STATUS: SPOUSE: _____

STREET ADDRESS: _____

MAILING ADDRESS IF DIFFERENT: _____

ALTERNATE ADDRESS IF ANY: _____

EMAIL: _____

PRIMARY INSURANCE: _____

ID: _____ GROUP: _____

SECONDARY INSURANCE: _____

ID: _____ GROUP: _____

PRESCRIPTION INFO: RX BIN: _____

PREFERRED PHARMACY: _____ PHONE: _____

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

AUTHORIZATION TO LEAVE MEDICAL REPORTS ON VOICE MAIL: YES NO

EMERGENCY CONTACT: _____ PHONE _____

SIGNATURE: _____ DATE: _____

STATEMENT OF FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

I acknowledge that I am responsible for all charges for Internal Medicine of Arizona services provided to me, including any amount not paid by my insurance plan, Medicare or other health service plans.

If my health insurance will not allow direct payment to IMA or if IMA chooses not to accept assignment of medical benefits, I agree to make payment to IMA all health insurance payments I receive for care at IMA immediately upon receipt of such payments. I understand that IMA has the right to refuse or accept assignment of medical benefits.

I also authorize IMA to release all medical information including, but not limited to, information relating to the diagnosis and treatment of psychiatric conditions, sickle cell anemia, alcohol and drug abuse and HIV or communicable diseases, if any such information exists, necessary for processing insurance claims to my insurers, the Health care financing administration (Medicare) or any other third-party payer or their agents.

I authorize IMA to contact my insurance company, health plan administrator or other third-party payer and obtain all pertinent financial information concerning coverage and payments made under my policy. I direct the insurance company, health plan administrator or third party payer and obtain all pertinent financial information concerning coverage and payments made under my policy. I direct the insurance company, health plan administrator or other third party payer to release such information to IMA. I agree that these provisions will remain in effect until otherwise revoked by me.

I understand that I must notify IMA if my illness or injury is work related prior to receiving any care. If I fail to notify IMA my claims will not be sent to the workers compensation carrier and I will be responsible for any charges. IMA will not file claims with the Worker's Compensation carrier if notified after care has been provided.

STATEMENT OF RIGHT TO A LIVING WILL/ADVANCED MEDICAL DIRECTIVES

I understand IMA recognizes a patient's right to accept or refuse medical treatment and their right to have a Living Will, Medical Power of Attorney or other form of advance written directive which serves as written instructions for the provision of health care in the event the patient becomes incapable of making their own medical decisions. I understand if I have any type of advance written directive, a copy should be given to IMA so that it can be placed in my medical record.

POLICY REGARDING OUTSIDE MEDICAL RECORDS AND RADIOLOGY FILMS

IMA will accept and may review written medical records, radiology films, or other materials from another healthcare institution if related to your care at IMA. At the completion of your episode of care IMA discards the remainder to the material unless otherwise directed by you. Medical record information mailed directly to IMA from may not be released to you without authorization. For radiology films that you bring to IMA please notify your physician and request their return prior to leaving. Films directly mailed to IMA by another healthcare institution will be returned by mail. I authorize IMA to request medical records, x-ray, labs and other tests from outside facilities for the purpose of medical treatment.

Patient Signature: _____ **Date:** _____

STATEMENT OF FINANCIAL RESPONSIBILITIY AND AUTHORIZATOIN TO RELEASE INFORMATION BY REPRESENTATIVE-IF OTHER THAN PATIENT:

I acknowledge that I am responsible for all charges for Internal Medicine of Arizona services provided to:

Patient Name: _____
Please Print

And authorize Internal Medicine of Arizona to proceed as stated above:

Signature: _____
Parent, Guardian, or Representative

Initial Clinical History Form

Patient Information Date: _____

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

Race: ◻ Caucasian ◻ African American ◻ Asian ◻ Hispanic ◻ Multi-Racial ◻ Other _____

Sex: ◻ Male ◻ Female Marital Status: ◻ Single ◻ Married ◻ Divorced ◻ Widowed # Children _____

Education (Please check highest level)
◻ Grade School ◻ High School ◻ College ◻ Post Graduate _____

Occupational History

Employer: _____ Job Title: _____

Past Medical History
(Please check all conditions that you have or have had)

◻ None	◻ Anxiety	◻ High Cholesterol	◻ Allergy: Food
◻ Heart Disease	◻ Bleeding Difficulties	◻ Seizure	◻ Allergy: Seasonal
◻ High Blood Pressure	◻ Hepatitis A B or C	◻ Loss of Consciousness	◻ TB
◻ Stroke/TIA	◻ HIV	◻ Arthritis (Type) _____	◻ Hypothyroid
◻ Obstructive Sleep Apnea	◻ Diabetes-Diet Controlled	◻ Asthma	◻ Hyperthyroid
◻ Coronary Artery Disease	◻ Diabetes-Oral Meds	◻ Emphysema	
◻ Depression	◻ Diabetes-On Insulin	◻ Osteoporosis	

◻ Cancer: Type/Treatment: _____ Other (Specify): _____

Colonoscopy ◻ Yes ◻ No Date Performed: _____ Performed by: _____

Past Surgical History
(Type of Surgery & Year)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Prescription Medications
(Medication/Dose/Number per day)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Non-Prescription Medications
(Medication/Dose/Number per day)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

What is your weight? _____ How long have you been at that weight? _____ What is your height? _____

Have you taken Cortisone type drugs? ◻ Yes ◻ No
If YES, When? _____

Have you ever had blood products transfused? ◻ Yes ◻ No
If YES, When? _____

Allergies/Type of Reaction ◻ Drug ◻ Food ◻ Latex ◻ Tape

1. _____ 2. _____ 3. _____
(Medication/food)

1. _____ 2. _____ 3. _____
(Reaction)

Patient name _____ **Date of Birth** _____

What is your main problem(s)? _____

_____

_____

For Females:

Are you pregnant? _____ Are you breastfeeding? _____ # of Pregnancies/Deliveries: ____/____ Type of Birth Control _____

Date of first menstrual period: _____ Date of last menstrual period: _____ Last Pap: _____

Last Mammogram: _____ Last Bone Density Scan: _____

Have you had a hysterectomy? ◻ Yes ◻ No Date _____ Reason _____

For Males:

Do you experience impotency? ◻ Yes ◻ No Erectile Problems? ◻ Yes ◻ No

Explain _____

Social History

(Please check the appropriate listings)

Tobacco Use
◻ Never
◻ Quit/When? _____
◻ Cigarettes/Pack per Day? _____
◻ Pipe ◻ Cigars
◻ Chewing Tobacco
How many years? _____

Alcohol Use
◻ None
◻ Socially
◻ Daily
◻ Heavy
Have you ever been treated for alcoholism?
◻ Yes ◻ No
If yes, when? _____

Drug Use
◻ None
◻ Marijuana
◻ Amphetamines
◻ Other _____
Have you ever been Treated for drug use?
◻ Yes ◻ No
If yes, when? _____

Exercise
◻ None
◻ 1-2x/week
◻ 3-4x/week
◻ 5-7/week
Type _____
_____
_____

Caffeine Use
◻ None
◻ Occasional
◻ Daily

How Much? _____
_____
_____

Family History

Father	◻ Living ◻ Deceased	Age: ____	Medical History or Cause of Death _____ _____	◻ High Blood Pressure ◻ Diabetes ◻ Cholesterol ◻ Cancer: Type _____ ◻ Other _____
Mother	◻ Living ◻ Deceased	Age: ____	Medical History or Cause of Death _____ _____	◻ High Blood Pressure ◻ Diabetes ◻ Cholesterol ◻ Cancer: Type _____ ◻ Other _____
Brothers	# Living ____ # Deceased ____	Age: ____	Medical History or Cause of Death _____ _____	◻ High Blood Pressure ◻ Diabetes ◻ Cholesterol ◻ Cancer: Type _____ ◻ Other _____
Sisters	# Living ____ # Deceased ____	Age: ____	Medical History or Cause of Death _____ _____	◻ High Blood Pressure ◻ Diabetes ◻ Cholesterol ◻ Cancer: Type _____ ◻ Other _____

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I, _____ authorize the release of my records from other medical facility:

Facility/ Dr Name: _____

Phone _____ Fax: _____

to the Physician/ PA listed below:
Wayne Kuhl, MD ___ , Jeff Nebelsieck, MD___, Tamara Lieberman, MD___, Greg Johns, MD___, Laura O'Malley, MD___, Rebecca Rowen, PA-C___

2. Effective Period This authorization for release of information covers the period of healthcare from: ____/____/____ to ____/____/____ **OR** □ all past, present, and future periods.

3. Extent of Authorization
a. □ I authorize the release of my complete health record including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.
OR
b. □ I authorize the release of my complete health record with the exception of the following information:
□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, orother purposes as I may direct.

5. This authorization shall be in force and effect until _____/_____/_____ at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature: _____ Date: ____/____/____

Printed name: _____ DOB: ____/____/____

*****IF MORE THAN 20 PAGES- PLEASE DO NOT FAX*****

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTERNAL MEDICINE OF ARIZONA, P.C.
Notice of Privacy Practices for Protected Health Information

I. Uses and Disclosures of Your Medical Information.

A. Treatment, Payment, and Operations. INTERNAL MEDICINE OF ARIZONA, P.C. (sometimes referred to as "we" or "us") is permitted to use your medical information for purposes of treating you, to obtain payment for providing medical services to you, and to assist in its health care operations. We may also use your medical records to assess the appropriateness and quality of care that you received, improve the quality of health care, and achieve better patient outcomes. An understanding of what is in your health records and how your health information is used helps you: ensure its accuracy and completeness; understand who, what, where, why, and how others may access your health information; and make informed decisions about authorizing disclosures to others.

(i) Use of your protected health information for treatment purposes. A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. We will also provide your primary physician, other health care professionals, or a subsequent health care provider, copies of your records to assist them in treating you.

(ii) Use and disclosure of your protected health information for purposes of payment. We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

(iii) Use and disclosure of your protected health information for healthcare operations. Health care operations consist of activities that are necessary to carry out our operations as a healthcare provider, such as quality assessment and improvement activities. For example, members of our medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

B. Appointment Reminders. We may contact you at home to provide appointment reminders unless you specify otherwise in writing to us.

C. Other purposes for which we can use your protected health information without written authorization from you. In addition to using your protected health information for purposes of treatment, payment, and health care operations, we may use or disclose your protected health information without your written authorization and without giving you an opportunity to object in the following situations:

(i) As Required by Law. We may use or disclose your protected health information as required by law. We will limit the disclosure to those portions relevant to the requirements of the law.

(ii) Public Health Activities. We may use or disclose your protected health information to public health entities authorized to collect information for the purposes of controlling or preventing disease (including sexually transmitted diseases), injury, or disability. We may also disclose to governmental agencies authorized to receive reports of child abuse or neglect. We may disclose protected health information to the Food and Drug Administration relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

(iii) Medical Surveillance of the Workplace and Work-related Injuries. We may provide your protected health information to your employer if we are asked by your employer to provide medical services to you for purposes of medical surveillance of the workplace or a work-related illness or injury.

(iv) Victims of Abuse, Neglect, or Domestic Violence. To the extent authorized or required by law, and in the exercise of our doctor's professional judgment, we believe the disclosure is necessary to prevent harm, we may disclose protected health information to law enforcement officials.

(v) Health Oversight Activities. We may disclose your protected health information to a governmental health oversight agency overseeing the health care system, governmental benefit programs, or compliance with governmental program standards.

(vi) Judicial and Administrative Proceedings. We may disclose your protected health information in response to an order of a court or a valid subpoena.

(vii) Law Enforcement Purposes. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or we may provide limited information for identification or location purposes.

(viii) Information About Deceased Individuals. We may disclose your protected health information to coroners and medical examiners to carry out their official duties, and to funeral directors as necessary to carry out their duties to the deceased individual.

(ix) Organ, Eye, or Tissue Donation. We may disclose protected health information to organ procurement agencies for the purpose of facilitating organ, eye, or tissue donation or transplantation.

(x) Research Purposes. We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

(xi) Avoidance of Serious Threat to Health or Safety. We may disclose protected health information if we believe in good faith that such disclosure is necessary to prevent or lessen a serious and immediate threat to health and safety of a person or the public.

(xii) Certain Specialized Governmental Functions. If you are Armed Forces or foreign military personnel, we may disclose your protected health information

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, HAVE RECEIVED A COPY OF INTERNAL MEDICINE OF ARIZONA'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE OF PATIENT: _____

DATE: _____

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INSTRUCTIONS FOR COMPLETE LABORATORY PROFILE

MORNING AND AFTERNOON APPOINTMENT:

Please have nothing to eat of a caloric nature for 8 hours prior to your appointment. You may drink water, black coffee or plain tea. We encourage you to maintain your hydration by drinking plenty of water. If you take medication, please take it as you normally do.

AFTERNOON APPOITMENT

It is not necessary to skip breakfast as long as you follow the **8 hour policy prior to your scheduled appointment.** If you take medication, please take it as you normally do.

YOU WILL BE ASKED TO LEAVE A URINE SPECIMEN AT THE TIME OF YOUR VISIT
*****PLEASE BE PREPARED TO DO SO*****