MOBILE PHYSICIANS DIVISION

9590 E Ironwood Square Dr #125, Scottsdale, AZ 85258

Tel: (480) 320-1171, Fax: (480) 718-8356

Date: ________________ Date of Birth: ___________________________

PATIENT NAME:

____

(Last) (First) (Middle initial)

Facility Name (If an AL or Group Home): ____

Address:____

Name of AL/Group home manger:____

Phone:________________Mobile:___________________Email:_________________________________

Billing address (if not same as above):

____

PHARMACY /phone:____

ALLERGIES: ____

MEDICATION (S): _______________________________ or please attach full list of current medications.

Living Status: Independent Assisted/GH Memory Private Home (circle)

Reason for referral: Circle one- PCP <u>or</u> Transitional Care Management

INSURANCE INFORMATION

PLEASE NOTE FOR "HMO" INSURANCE PLANS

We MUST be made the primary care physician (PCP) on file with that insurance company. **We cannot see patients who do not make this assignment.**

In order to change your PCP, simply **call** your insurance company, you will find the number on the back of your insurance card, and let them know that you want to change the PCP to either (with effective date):

HERNAN MEDINA, MD

JANET RINEHART, PhD, FNP-BC

GERALD BUSH, MD*

***Dr. Bush is also a hospitalist and there may be specialist fees that will apply.**

PRIMARY INSURANCE

INSURANCE: ___________________________________ID#___________________________________

GROUP#______________________________INSURED:_____________________________________

ADDRESS OF INSURANCE:____

SECONDARY INSURANCE

INSURANCE: ________________________________ID#______________________________________

GROUP#______________________________INSURED:______________________________________

ADDRESS OF INSURANCE: ____

**** PLEASE ATTACH FRONT & BACK OF INSURANCE CARDS ****

Have you recently been in the hospital or skilled nursing facility in the last 30 days?

YES NO (circle one)

Name of Facility____ Discharge Date: ________________________

Is the patient currently on home health services? YES NO (circle one)

Name of Company: ____

CONSENT FOR TREATMENT

I recognize that I need medical services. I voluntarily consent to treatment by the medical staff of:

4C Medical Group Mobile Physicians, as deemed necessary in their judgment. I am aware that the practice of medicine and surgery is not an exact science and that no guarantees have been made to me regarding the results of examinations, treatments, or tests.

I authorize 4C Medical Group Mobile Physicians' to submit claims on my behalf and authorize payments to be made directly to 4C Medical Group Mobile Physicians for services provided to me. I hereby accept responsibility for payment for any services provided to me that are not covered by my insurance coverage. I agree to pay all co-pays, coinsurance, and deductibles.

I acknowledge that this consent is voluntary and if I refuse to sign this consent, 4C Medical Group Mobile Physicians has the right to refuse to provide treatment to me. I understand that this authorization may be revoked in writing at any time. If I choose to revoke my consent, this in no way will affect any previous action that 4C Medical Group Mobile Physicians have taken prior to receiving my revocation.

Signature:____ Date:___________________________________

POWER OF ATTORNEY

Attestation

I am the legal Medical Power of Attorney who will be informed of all medical decisions and visits:

Signature: ____ Date:_______________________

Printed Name: ___________________________ Relationship to patient: _______________________

Phone:________________Mobile:__________________Email:_________________________________

**Please note that we do require the signed and dated Power of Attorney or legal guardian document within 30 days of intake to 4C Medical Group Mobile Docs.*

FINANCIAL RESPONSIBILITY AND INSURANCE

Thank you for choosing 4C Medical Group PLC as your health care provider. In an effort to avoid confusion and misunderstanding, we have adopted the following Financial Policy and require you to read and sign it prior to the commencement of any treatment.

Insurance-All Patients

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we will file claims for those plans with which we have an agreement. Please be advised that you are financially responsible for payment of any medical services rendered by this clinic, whether paid for by your insurance or not. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. 4C Medical Group PLC does not bill any third-party insurers. If you have received services that are payable by a third-party insurer, you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service.

Non-insured Patients

If your insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We will, as a convenience to you, provide a prepared claim form to allow the patient to submit for reimbursement if desired. We offer a competitive cash fee schedule for our patients with no insurance.

I understand the above statements regarding 4C's financial policy and insurance coverage:

I authorize the release of medical information for the sole purpose of medical care and reimbursement of those services from insurance carrier.

Signature:____ Date:___________________________________

Paperwork Services

Any paperwork filled out by our providers such as Short-term disability, of FMLA are subject to a **$25.00 charge.**

Collection Agency

Any account turned over to a collection agency is subject to a fee amounting to 30% of the total amount turned over. This financial policy supersedes all prior written financial policies, contracts, or verbal agreements.

Assignment of Benefits

I request that payment of authorized insurance or Medicare benefits be made to 4c Medical Group Plc for any services furnished me by the physician. I authorize any holder of medical information about me to release to the insurance company or to CMS (centers for Medicare and Medicaid services, formerly known as HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, whether or not paid by said insurance.

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review carefully.

We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information. (PHI) We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in the office.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy with respect to your PHI
- Follow the terms of the notice that is currently in effect

For treatment: we may use health information about you to provide you with health care treatment or services. We may disclose health information about you to physicians, nurses, technicians, health students, or other personnel who are involved in taking care of you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment before you receive it so that we can obtain prior approval of determine if you plan will cover the treatment.

Notification of Family: In the event of an emergency, we may use or disclose your personal health information in situations deemed emergent to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, about your general condition or your death.

Appointment reminders: we may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule.

Public Health Risks- We may disclose health information about you for public health activities. These activities generally include the following:

- The prevention or control of disease, injury, or disability
- The reporting of births and deaths
- The reporting of child abuse or neglect
- The reporting of reactions to medications or problems with products
- The notification of people about recalls of products they may be using
- The notification of a person or organization required to receive information on FDA regulated products
- The notification of a person who may have been exposed to a disease or may be at risk for contracting or spreading disease.
- The notification of the appropriate authority, if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank or to organizations that handle organ procurement or organ, eye, or tissue transplantation, as necessary to facilitate organ or tissue donation and transplantation

As required by law: We will disclose health information about you when required to do so by federal, state, or local law.

To avert a serious threat to health or safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans': If you are a member of the armed forces or separated or discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans' Affairs as may be applicable.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Disaster Relief: We may use and disclose your health information to assisting disaster relief efforts.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court of administrative order.

Law Enforcement: We may release health information if asked to do so by a law enforcement official.

In reporting certain injuries, as required by law: gunshot wounds, burns, dog bites, and injuries to perpetrators of crime.

We may release information in response to a court order, subpoena, warrant, summons or similar process.

To identify or locate a suspect, fugitive, material witness, or missing person. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.

About a death we believe may be the result of criminal conduct and/or at our facility.

In emergency circumstances to report a crime; the location of a crime or victims; or the identity, description, or location of a person who committed the crime.

Coroners, Health Examiners, and Funeral Directors': We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to inspect and copy: You have the right to inspect and copy health information that may be used to make decisions about your care, usually, this includes health and billing records. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the office.

We may deny your request to inspect and copy in certain very limited circumstances. These circumstances may include:

If disclosing the information will endanger your life of the life of another individual named in the record.

If the medical record references the name of another individual and disclosing such information would violate their privacy rights.

Psychotherapy notes cannot be viewed or copied.

If information has been collected and compiled in anticipation of legal action or proceeding.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing and submitted to this office's practice manager. We may deny your request for an amendment if it is not in writing or does not include a reason for the request.

In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information kept by or for our practice.
- Is not part of the information you would be permitted to inspect a copy.
- Is accurate and complete.
- Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment and health care operations, as previously described,.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment of health care operation. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not disclose information to your spouse a surgery you had. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

Right to a paper copy of this notice: You have the right to obtain a paper copy of the notice at any time.

Changes to This Notice: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information and we already have about as well as any

information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain, in the page footer, the effective date. You may request a copy of our most current notice at any time.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services in Washington DC. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Acknowledgment of this Notice

We will request that you sign this form acknowledging that you have read this notice. If you choose, or are not able to sign, a staff member will sign his or her name and date. This acknowledgment will be filed with your records.

X_____________________________________   _______________________________________

Signature of Patient (or PoA)   **Date**