New Patient Letter

Thank you for choosing Healthy Outlook Family Medicine, P.C.

1835 W Missouri Avenue
Phoenix, AZ 85015
602-230-0777
602-230-0008 (Fax)

Your appointment is scheduled at _____ on _____ with _____. Please arrive 15 minutes prior to your appointment. You will need to bring the enclosed paperwork with you on the day of your appointment. You must have your insurance card. If your card does not have one of our providers listed on it, please call your insurance company and have it corrected before your visit.

If you are scheduled for a complete physical and were told you need to fast, stop eating 12 hours before your scheduled appointment time. Do not drink anything other than plain tea, black coffee, or water. Continue taking all vitamins and ***medications*** as usual. If you are diabetic, you may call the office for fasting instructions.

If you can not make your appointment, call the office 24 hours prior to your appointment to cancel. There is a $50 charge for missed appointments. Thank you.

Remember: Co-pays are due at time of service.
We accept cash, check, Visa and MasterCard as forms of payment.

Patient Information

fill in **ALL** blanks (use same or N/A if needed)

If you were preregistered by phone, only fill in information you did not have available during preregistration.

PATIENT

Last Name _____ **First Name** _____ **MI** ___ **Jr./Sr. (if used)** _____

Mailing Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ ext _____

Date of Birth ___ / ___ / _____ Sex ___ □ Single □ Married □ Other □ Employed □ FT Student □ PT Student □ Other

Social Security Number _____ Email _____

Race □ White □ Hispanic □ African American □ Asian □ American Indian □ Pacific Island □ Other

Ethnicity □ Not Hispanic □ Hispanic or Latino

Language Preference □ English □ Spanish □ Other _____

If patient is a minor, fill in this section. If insurance is in another person's name, fill in this section.
If it's okay to mail your family's statements together, fill in this section.

Who are statements sent to?

Last Name _____ First Name _____ Is this an established patient? □ Y □ N

Mailing Address _____ City _____ State ____ Zip _____

Home Phone _____ Other Phone _____ ext _____

Relationship _____ SSN _____

INSURANCE

Primary Insurance Company _____ ID # _____ Group _____

Relationship to Cardholder □ Self □ Spouse □ Child □ Other _____

If "self" was not selected above, fill in this section.

Is cardholder a patient at this office? □ Y □ N

Cardholder's Last Name _____ First Name _____ MI ___ Jr./Sr. _____

Mailing Address _____ City _____ State ____ Zip _____

Phone _____ Date of Birth ___ / ___ / _____ Sex ___

If insurance is through an employer, name of employer _____

Secondary Insurance Company _____ ID # _____ Group _____

How did you find out about our office? □ Family □ Co-Worker □ Friend
□ Another Doctor □ Insurance □ Other _____

CONTACT

State Law requires the following information for emergency contact.

If your mailing address listed above is a PO Box, you must provide your physical address.

Physical Address _____ City _____ State ____ Zip _____

Emergency Contact:

Spouse/Partner's Name _____ Emergency Phone _____

Closest relative living at a different address:

Last Name _____ First Name _____ Relationship _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Other Phone _____ ext _____

Patient or Authorized Signer _____ Date ___ / ___ / _____

Healthy Outlook
Family Medicine PC

Health Database

Name _____ Today's Date ___ / ___ / _____

Height _____ Weight _____ Race _____ Date of Birth ___ / ___ / _____

Past Illnesses (Circle those you have experienced)

Diabetes	TB/Emphysema	Thyroid	Sexually Transmitted Disease
Kidney Disease	Asthma	Bleeding Tendency/Transfusions	Neurologic Disorder/Seizures
Heart Disease	Kidney Disease	Ulcers	Digestive Problems
Hypertension	Arthritis	Eye Problems	Other _____
Heart Murmur	Rheum. Fever	Depression/Anxiety	
Stroke	Cancer _____	Bipolar	

List All Surgeries/Hospitalizations: _____
_____
_____

Social History

Relationship status _____ Occupation _____

Age(s) of children _____ Vaginal or Caesarian birth(s)? _____

If patient is a child, were there any complications during birth? _____

Do you have a living will/advanced directives? _____

Do you have a religious/spiritual preference? _____

Use of	Circle
Tobacco	Y N
Cigarettes	Y N
Vaping	Y N
Former tobacco	Y N
Alcohol	Y N
Illegal Drugs	Y N
Caffeine	Y N
Guns in home	Y N
Pool at home	Y N

Medications

Medications you are using or have used in the past year (name, dose, frequency): _____
_____
_____
_____

Allergic or sensitivity reactions to any medication, product, or food:
None __ List _____

Adult immunizations (Circle those done in the past 10 years – children must have their immunization records):
Flu COVID Shingrix Pneumonia Tetanus Others: _____

Family History

Family Member	Health Problems	Cause of Death
Father		
Mother		
Brothers		
Sisters		
Children		
Grandparents		

Is there any history of sudden unexplained death in your family? _____
Is there any history of breast cancer in your family? _____

Names of other family members seen in our office _____

Financial Agreement

Please review carefully. Fees are subject to change.

Appointment Late Cancellation (24 hour notice required, excluding weekends) .....$25.00 - $50.00
Appointment Late Arrival (cannot be seen for appointment) .....$25.00 - $50.00
Appointment No Show $50.00

Forms (complete all patient sections before submitting)

Disability / FMLA ..... $25.00 - $50.00
We do not complete forms for conditions being treated by a specialist. Allow 5 business days for completion or rejection. Additional visits may be required.

Biometric Screening .....$15.00 - $25.00
Medical Necessity Letters $50.00
Nursing School $25.00
Additional visits may be required.

Mission Physicals .....$50.00 - $75.00
Miscellaneous Form Not Listed ..... $varies
There may be a charge for your particular form not listed here.

Medical Records from Patient Portal.....free
Medical Records Provided by Office..... $varies
Allow two weeks. Mailing fees apply.

Fees are payable when the forms are dropped off. Forms are completed at the provider's discretion. If your form cannot be completed, the fee will be refunded or placed as a credit on your account.

After billing is complete (select one): ** Does not apply to amounts due on date of visit **

☐ Bill my insurance. When the amount due is determined, charge my CREDIT CARD automatically.

☐ Bill my insurance. When the amount due is determined, send me a bill. I will pay by CHECK within 15 days. I understand that $20 late fees will be added each month.

_____ _____ ___ / ___ / _____
Last Name– **print neatly** First Name Date of Birth

I authorize this provider and its assignees to communicate with me by telephone, e-mail, text message, fax, or other means. I authorize any provider to give treatment. I authorize the release of medical records or other information necessary to process claims. I authorize insurance to pay the provider directly for services rendered. Insurance is billed one time as a courtesy. However, **payment for all services is my responsibility.** Furthermore, **I agree to pay any amount denied or not covered by insurance.**
State law requires payment of medical claims within 30 days. **45 days after service has been rendered, insurance coverage is deemed waived and the patient is responsible for all billed charges without adjustment. $20 monthly late fees and an interest rate of 16% annually apply to all unpaid amounts. There is a $50 charge for missed appointments. Collection agency fees of 40% plus court costs and reasonable attorneys' fees are my responsibility.**
I have received a copy of the Patient Rights and Responsibilities.

Patient or Authorized Signer _____ Date ___ / ___ / _____

Healthy Outlook Family Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Healthy Outlook Family Medicine, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this Acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF STATEWIDE HEALTH INFORMATION EXCHANGE NOTICE

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

ACKNOWLEDGEMENT OF HEALTH INFORMATION EXCHANGE

I acknowledge that Healthy Outlook Family Medicine may use or may add new data exchange capabilities with other networks, exchanges, hospitals, physicians, or other medical providers or companies. I acknowledge that this form serves as notice for any current or future exchange capabilities. I may request copies of any relevant notice.

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge that I have received a copy of the Patient Rights and Responsibilities. These are posted in the lobby and I may review them at any time.

_____ _____

Date Signature of Patient or Patient's Representative

_____

Patient Name (Print)