Family Health Center of Sierra Vista

1800 E Wilcox Drive

Sierra Vista, AZ 85635

Tel: (520) 459-3116 Fax: (520) 459-7397

TO: _____

APPOINTMENT DATE: _____

TIME: _____

PROVIDER: _____

Thank you for selecting Family Health Center of Sierra Vista to provide your primary medical care services.

We are sending you the NEW PATIENT forms for you to **complete before your appointment**. Please bring these completed forms with you so we can expedite your initial visit. Also, we ask that you **arrive 30 minutes** prior to your appointment time.

The Providers ask that you bring the following items with you:

1. **All medications prescribed or over the counter**
2. **Immunization records if available**
3. **All medical insurance cards**
4. **Be prepared to pay any copay, coinsurance or deductible at time of service.**

Please feel free to contact our office if you have any questions or concerns. You should receive a reminder call from our office the day before your scheduled appointment.

We look forward to seeing you.

Family Health Center of Sierra Vista

Notice of Privacy Practices

May 29, 2013

TO OUR PATIENTS: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY: Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances: The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court of administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials. If you are an inmate or under the custody of a law enforcement official.
8. For Workers compensation and similar programs.

Your rights regarding your health information:

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decision about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Family Health Center of Sierra Vista, 1800 E Wilcox Drive, Sierra vista, AZ 85635. You may also ask for a Medical Records Release Form from our office.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request amendment, you request must be made in writing and submitted to the Family Health Center of Sierra Vista. You must also provide a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please let us know.

Family Health Center of Sierra Vista

Initial History Form

Please read first:

Welcome to our practice! To provide you with the best possible care, we need the following information from you. All information is strictly confidential and is released only with your written consent. Please be as thorough as possible in your answers. Try not to leave blanks (write "non" or "O"). If you do not understand a question, leave it blank. We realize that some questions may seem too personal or private, but each question is designed to help us keep you healthy. If you are uncomfortable answering certain questions, leave them blank.

Patient Name: **Today's Date:**

Personal History & Habits

Date of Birth: Sex:

Nationality: Religion:

Marital Status: Education Level:

Occupations:

Residence Past 5 Years:

Exercise (type): Frequency:

Sleep (usual hrs): Aids to Sleep:

Hobbies:

Average Amount Per Day:

Alcohol (type):

Recreational Drugs:

Tobacco (type):

Tea, Coffee, Soda:

Allergies to Medicine (list):

Medications Taken Regularly (list):

Prescriptions	*Dose*	*How Often?*

Non-Prescription (Over the Counter):

Your Family Health History Please list all major illnesses. Write "none" if completely healthy.

Maternal:

Grandfather:

Grandmother:

Paternal:

Grandfather:

Grandmother:

Your Mother:

Your Father:

Your Brother(s):

Your Sister(s):

Your Son(s):

Your Daughter(s):

Immunizations Received:	**Yes**	**No**	**Year Last**
Tetanus			
Pneumonia			
Flu			
Hepatitis B			
Measles			
Rubella			
TB Test			

Have You Ever Had:	**Yes**	**No**		**Yes**	**No**
Measles			Pneumonia		
Mumps			Pleurisy		
Chicken Pox			Asthma		
Whooping Cough			Emphysema		
Polio			Rheumatic Fever		
Scarlet Fever			High Blood Pressure		
Diphtheria			Heart Disease		
Meningitis			Anemia		
HIV			Bleeding Tendency		
Infection Mono			Blood Transfusion		
Valley Fever			Hepatitis		
Tuberculosis			(yellow jaundice)		
Exposure to TB			Ulcer		
Malaria			Hemorrhoids		
Hives			Bladder Infections		
Cancer			Kidney Disease		
Venereal Disease			Hay Fever/Sinusitis		
Arthritis			Glaucoma		
Back Trouble			Nose Bleeds		
Bronchitis			Hernia		

Procedures/Screening Tests:	**Most Recent Date**
Mammogram	
PAP/Pelvic Exam	
Breast Exam	
Prostate/Rectal Exam	
Cholesterol	
Flexible Sigmoidoscopy (Colon Test)	
Complete Physical Exam	
Glaucoma Test	
Chest X-ray	
Blood Transfusions	

Your Health History (please include approximate dates):

Major or Ongoing Illness(es):

OB/GYN (females only):

Number of Living Children:

Number of Pregnancies:

Last Menstrual Period:

Have you ever had an abnormal PAP test?

Completed By_____ **Signature**_____

Family Health Center of Sierra Vista

1800 E Wilcox Drive
Sierra Vista, AZ 85635
Tel: (520) 459-3116
Fax: (520) 459-7397

Date: 11/10/2021

To: All Patients and Local Pharmacies

From: Family Health Center of Sierra Vista

Re: **Prescription Refill Policy**

The medical providers of Family Health Center will require 48 hours notice in order to respond to requests for prescription refills. Requests received on Fridays will be responded to on the next working day. This advance notice will allow the staff to manage patient care more efficiently.

Please contact your pharmacy to initiate the refill process, or if there are no refills left on the medication. Your pharmacy will send the request to our office electronically or by fax. This will allow a more timely and accurate processing of your request. If you have access to the Patient Portal, you may request expired refills directly to our clinic.

***Please remember to call your pharmacy or use the patient portal to request medication refills in advance to avoid emergency situations. ***

Thank you for your understanding and cooperation with this request. Please call if you experience delays in responses beyond 48 hours.

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1800 E Wilcox Drive
Sierra Vista, AZ 85635
Phone (520) 459-3116

PLEASE PRINT ALL INFORMATION COMPLETELY **DATE**_____

Last Name_____First_____MI_____
Date of Birth___/___/___ Age____ Race_____ Male____ Female____
If minor, name of Parent/Guardian_____
Street Address:_____
City_____State_____Zip_____Phone #_____Cell # _____
Mailing Address:_____
Employer:_____Work Phone #_____
Social Security # ____-___-_____ Driver's License #_____ State _____

Name of Spouse:_____ Phone # _____
Street Address:_____
City_____State_____Zip_____ Social Security # _____-____-_____

Name of person not living with you in case of and emergency:
Name_____Relationship_____
Address_____ City_____
State_____Zip_____ Phone # _____

Name of Primary Insurance_____
Address_____Phone #_____
Insured's Name_____ **Relationship**_____**DOB**_____
ID #_____Group #_____Co-pay_____

Name of Secondary Insurance_____
Address_____ Phone #_____
Insured's Name_____ Relationship_____ DOB_____
ID #_____Group #_____Co-pay_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim.
SIGN_____
DATE_____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to Family Health Center of Sierra Vista for services provided.

SIGN_____

Preferred Reminder Method: TEXT _____ Phone Call_____ Email _____

How Did you Hear About Us? (Please Check all that apply) **Facebook/ Webpage**_____ **Newspaper**_____ **Phone Book**_____ **Insurance Company**_____ **Friend/Family**_____ **Other**_____

FAMILY HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been presented with a copy of Family Health Center of Sierra Vista's Notice of Privacy Practices.

_____ _____

Signature of Patient or Guardian (if minor) Today's Date

_____ _____

Print Name of Patient Date of Birth

INFORMATION RELEASE

I give my permission for _____ to receive
(Name)
information about my medical condition and to make any doctor

appointments for me at Family Health Center of Sierra Vista.

_____ _____

Signature of Patient Date

PATIENT PORTAL AUTHORIZATION

I am requesting the privilege of access to my electronic health record through the Patient Portal established by Family Health Center of Sierra Vista. I have provided a valid email address to the facility in order to receive information from the clinic.

My email address is: _____

I understand that this is a secure portal and is accessed by a login and password which I will select and it will not be available to the staff of Family Health Center of Sierra Vista.

_____ _____

Patient Name (Print) Date

_____

Signature of Patient or Legal Guardian

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OUR FINANCIAL POLICY

Thank you for choosing Family Health Center as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bills is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our "Patient Information Form" before seeing the provider.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA OR MASTERCARD.

REGARDING INSURANCE

Participation Plans – There are a number of insurance companies with which we participate. If you are insured by one of these plans, you are responsible for payment of applicable co-pays, deductibles, cost shares, etc. at the time of service. Please do not ask us to bill you for your co-payment.

Non-Participation Plans – Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and payment is expected at the time of service. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payments in full regardless of any insurance company's arbitrary determination of usual and customary rate.

FINANCIAL RESPONSIBILITY

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor and the parents (or guardian) are responsible for full payment at the time of service.

***MISSED APPOINTMENTS – Please allow us to help you better by keeping scheduled appointments. Please notify our office of any changes in appointments at least 24 hours in advance. Failure to notify the office may result in a $30.00 charge. ***

There is a $25.00 fee for returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the above Financial Policy. I understand and agree to this Financial Policy.

_____ _____

Signature of Patient or Guardian Date

Print Patient Name