81 W Guadalupe Road, Ste 111
Gilbert, AZ 85233
Phone: 480-366-4490
Fax: 480-854-3618

New Patient Intake Packet

Patient Name: ____ Date: __________________________

Date of Birth (MM/DD/YYYY): ______/______/________ Social Security #: _________-________-__________________

Gender (please check): ☐ Male ☐ Female ☐ Transgender ☐ Other: ________________________________

Street Address: ____ Apt #: ___________________

City: ____ State: ____________ Zip Code: _________________

Home Phone Number: _______________________________________ Primary: ☐ Y ☐ N

Cell Phone Number: ____ Primary: ☐ Y ☐ N

Email Address: _________________________________

How did you hear about us? ____

Were you referred by a current patient? ☐ Y ☐ N (Name): _______________________________________

Emergency Contact Info (Required)

Contact Name: ____ Relationship:____________________

Home Phone Number: _______________________________________ Primary: ☐ Y ☐ N

Cell Phone Number: ____ Primary: ☐ Y ☐ N

Street Address: ____ Apt #: ___________________

City: ____ State: ____________ Zip Code: _________________

Insurance Information (Required)

Primary Insurance Company: ____

Group Number: ________________________________ ID Number: ____________________________

Subscriber Name: ____ Subscriber DOB: _____/_____/________

Subscriber SSN: _________-________-_________________

Secondary Insurance Company: ____

Group Number: ________________________________ ID Number: ____________________________

Subscriber Name: ____ Subscriber DOB: _____/_____/________

Subscriber SSN: _________-________-_________________

Primary Care Physician: ______________________________________ Phone: _________________________

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Harmony MEDICAL CARE

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HIPAA Compliance Form

I understand that I have certain rights to privacy regarding my health information, as outlined in the **Health Insurance and Accountability Act of 1996 (HIPAA)**. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and also assist with following-up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have read and understand Harmony Medical Care's Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that Harmony Medical Care has the right to change its Notice of Privacy Practices from time to time and that I may contact Harmony Medical Care at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, a requisition of particular restrictions that I would like applied to use and disclosure of my private information as it is used to carry out treatment and payment of healthcare options. I also understand that Harmony Medical Care is not required to agree to my requested restrictions. However, if Harmony Medical Care does agree, Harmony Medical Care is bound to abide by such restrictions.

Any individuals or entities I wish to have permission to my medical information must be listed below or submitted in writing to Harmony Medical Care so that they may have it on file.

Individuals or Entities:

____ Relationship: ____________________

____ Relationship: ____________________

____ Relationship: ____________________

Additionally, please indicate if you consent to our office leaving detailed voicemails on your phone regarding laboratory or imaging results.

☐ I DO consent to detailed voicemails

☐ I DO NOT consent to detailed voicemails

Patient Signature: ______________________________ Date: ____________________

Patient Name: ______________________________

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Media Consent and Release

For good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, I irrevocably grant to Wellspring MSO, LLC d/b/a Harmony Medical Care, its affiliates, subsidiaries, and its and their respective agents, employees, and officers (“Harmony Medical Care”), the perpetual, worldwide, exclusive royalty free license, right, and permission to copyright and/or trademark in the name of Harmony Medical Care and to videotape, film, audio record, electronically record, mechanically reproduce, photograph, web cast, edit, alter, copy, publish, broadcast, and otherwise use or disseminate in any form or fashion, including but not limited to, illustrations, bulletins, exhibitions, advertisements, educational materials, promotions, and all other purposes deemed appropriate by Harmony Medical Care, my name, signature, picture, video, voice, image, likeness, poses, appearances, movements, or any other indicia of my identity or activity of any nature created, depicted, captured, or recorded by or at the direction of Harmony Medical Care (collectively, “Materials”), in or in connection with any and all media of any kind and nature now known or developed in the future (collectively, “Media”), for any legal purpose, in any manner, and without further notification or authorization.

I agree that Harmony Medical Care may use, reuse, copy, publish, display, exhibit, reproduce, license to third parties, and distribute all Materials at its sole discretion and that I do not have any right to inspect or approve the use of the Materials in any Media, whether the use is known to me or unknown. Instead, Harmony Medical Care will have sole discretion in the manner in which the Materials may appear (for example, size, color, format, style) and be used. Harmony Medical Care may transfer all of the rights granted by this Media Consent and Release. I further waive, assign, and release to Harmony Medical Care all rights, title, and interest of any kind that I may have in the Materials produced and agree to release and hold harmless Harmony Medical Care and its owners, employees, contractors, and agents from any claims, damages, or liability from or related to the use of the Material, including but not limited to claims of libel, false light, invasion of privacy, moral rights, and rights of publicity, associated with the Materials or Harmony Medical Care’s use of the Materials in any Media. Further, I hereby waive any rights I may have to royalties, payment or other compensation that I may otherwise be entitled to for the Materials.

I am over eighteen (18) years of age and I have full legal capacity to grant this consent and release, and have read and understood the above consent and release prior to its execution. This release is made on behalf of myself, my heirs, executors, administrators, and assigns and is governed in accordance with the substantive laws of the State of Arizona without regard to the state’s conflict of laws rules.

Signature: ____ Date: ________________________

Print Name: ____

Relationship: ____

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Multiple Provider Approach Form

All of us at Harmony Medical Care are striving to give you the very best possible healthcare. Part of our integrative approach to patient care involves multiple providers. In order for your care to be as streamlined, accurate and efficient as possible, a provider from our staff may check in with that is not your general or referring provider. We promise that all information and content obtained in your visits will be handled professionally and confidentially for your treatment benefit by each provider and professional on staff. If you have any questions regarding this policy or confidentiality, please discuss them with your provider.

By signing below, I indicate that I have read and understand the above policy.

Patient Signature: ____ Date: ____________________________

Patient Name: ____

Date of Birth (MM/DD/YYYY): _____/_____/___________

Demographic Information

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Pacific Islander
- ☐ African American
- ☐ White
- ☐ Hispanic
- ☐ Other: ________________________________
- ☐ Decline to specify

Ethnicity:

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Decline to specify

Language:

☐ English ☐ Spanish ☐ Other: ____________________________________

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Billing and Financial Policy

Due to increased insurance company demands, the following policy has been established for our office. There are no exceptions to this policy. Please read and understand this form completely before signing.

We make every attempt to ensure that all services are compatible with your special insurance requirements. However, all policies have different benefits, depending on the requests and desires of the employer or applicant. Benefits are not always available to all employees, even if they have the same insurance company. Your insurance company informs all participants that it is ultimately your responsibility to know and understand your policy. We do not have the capability to know each individual policy, as it varies per patient. We cannot guarantee all services will be covered. It is your responsibility to verify all benefits and coverage information prior to having any services rendered.

Insurance companies require that we submit all claims within a specified time. We do our best to follow all guidelines set forth by the insurance company. If your insurance changes, however, and you fail to inform us, we may not be able to bill the appropriate company within those time limits. Insurance denials due to changed policy or company are not typically returned to us within a billable window. Therefore, if you do not notify us of any changes, you may be responsible for payment services. For your benefit, please notify us of any changes as soon as possible.

You will be responsible for payment of all services if any of the following applies:

- If you do not have insurance;
- If you do not have a referral when required and have elected to be seen;
- If you are with an insurance company that we are not contracted with;
- If your insurance company denies your claim for any reason that is not resolvable.

We have specific guidelines that apply to payment plans. If your balance is not paid in full within 90 days of receiving a statement, we reserve the right to turn your account to a collection agency. The responsible party or guarantor of the account will be responsible for all collection fees and legal expenses in the event that this becomes necessary. *A $25.00 fee will be applied to all returned checks.*

A fee will be charged to patients requesting medical records for personal use, FMLA form completion, and physician-dictated letters for personal reasons.

By signing this form, you agree to follow the policies listed above, authorize the release of any medical information necessary to process your claims, and authorize payment of medical benefits to Harmony Health Care, PLLC, or supplier for services rendered.

Patient Signature: ______________________________ Date: ____________________

Patient Name: ______________________________

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No-Show and Cancellation Policy

Please provide us with advanced notice if you are not able to keep your appointment. Not only does this allow us to reschedule you in a timely fashion, but it allows your appointment time to be opened to someone else that needs it.

We require at least 24-hour notice if you need to cancel or reschedule your appointment. We require 48-hour notice if you need to cancel or reschedule a Comprehensive Physical Exam.

If you do not show up for your appointment, nor cancel/reschedule in advance, you will be subject to a $25.00 fee. Due to the increased number of staff members/ office space required for completion of the Comprehensive Physical Exam, you will be charged a $50.00 fee if you do not provide advanced notice that you are unable to make your Comprehensive Physical Exam appointment.

We do recognize that there are unforeseeable circumstances that may not allow strict adherence to this policy. If an emergency arises, please notify the office as soon as possible if you have already passed the above mentioned time frame.

In addition to fees, we reserve the right to discharge a patient from the practice due to continued No-Shows or late cancellations. We believe that, in order to best serve you and maintain your health, we need to see you in office at regular intervals. **You may be discharged from the practice after 3 unexplained No-Shows.**

Please do not sign this form until you have read and fully understand the above policies.

Patient Signature: ____ Date: ____________________________

Patient Name: ____

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Medical History

Please indicate the date of your most recent evaluation:

	Evaluation	Date	Normal	Abnormal
☐	Physical Exam	Date: ______	☐ Normal	☐ Abnormal
☐	Colonoscopy	Date: ______	☐ Normal	☐ Abnormal
☐	Vision exam	Date: ______	☐ Normal	☐ Abnormal
☐	Dental exam	Date: ______	☐ Normal	☐ Abnormal
☐	DEXA	Date: ______	☐ Normal	☐ Abnormal
☐	Aortic Ultrasound	Date: ______	☐ Normal	☐ Abnormal
☐	Carotid Ultrasound	Date: ______	☐ Normal	☐ Abnormal
☐	Shingles Vaccine	Date: ______		
☐	Flu Vaccine	Date: ______		
☐	Pneumonia Vaccine	Date: ______		

Please indicate the date of your most recent evaluation (Females):

	Evaluation	Date	Normal	Abnormal
☐	Mammogram	Date: ______	☐ Normal	☐ Abnormal
☐	History of Hysterectomy	Date: ______	☐ Normal	☐ Abnormal
☐	Pap/Pelvic Exam	Date: ______	☐ Normal	☐ Abnormal
☐	Last Menstrual Period	Date: ______	☐ Normal	☐ Abnormal

Please list all current medications that you are taking, including medications that you may only be taking as needed: (frequency indicates number of tablets and how many times per day taken, ex: 1 tablet twice daily)

Medication: ______ Dose: ______ Frequency: ______

Medication: ______ Dose: ______ Frequency: ______

Medication: ______ Dose: ______ Frequency: ______

Medication: ______ Dose: ______ Frequency: ______

Medication: ______ Dose: ______ Frequency: ______

Medication: ______ Dose: ______ Frequency: ______

Do we have consent to pull your external prescription history from the pharmacy?: ☐ Y ☐ N

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Personal Health History:

- ☐ Heart Disease ☐ Hyperlipidemia ☐ Diabetes
- ☐ Cancer ☐ Asthma ☐ Kidney Disease
- ☐ Psychiatric Disorder ☐ Stroke ☐ Thyroid Disease
- ☐ Osteoporosis ☐ Hypertension ☐ Other: ______________________________

Please list all allergies that you are aware of, and your reaction to those allergens:

Drug Allergies: ____

____

Environmental Allergies: ____

____

Gynecology Information (Female):

Methods of Contraception: ____

Age of Menarche: ___________ Irregular Periods: ☐ Y ☐ N

Menopausal: ☐ Y ☐ N If yes, hormone replacement: ☐ Y ☐ N

Pregnancies:

Year: _______ Gender: ☐ M ☐ F Delivery Type: ___________________ Complications: _____________________

Year: _______ Gender: ☐ M ☐ F Delivery Type: ___________________ Complications: _____________________

Year: _______ Gender: ☐ M ☐ F Delivery Type: ___________________ Complications: _____________________

Year: _______ Gender: ☐ M ☐ F Delivery Type: ___________________ Complications: _____________________

Year: _______ Gender: ☐ M ☐ F Delivery Type: ___________________ Complications: _____________________

Year: _______ Gender: ☐ M ☐ F Delivery Type: ___________________ Complications: _____________________

Year: _______ Gender: ☐ M ☐ F Delivery Type: ___________________ Complications: _____________________

Surgical History:

Surgery: ____ Date: ______________________________

Surgery: ____ Date: ______________________________

Surgery: ____ Date: ______________________________

Surgery: ____ Date: ______________________________

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Hospitalization History:

Have you been hospitalized in the last 1 year? ☐ Y ☐ N

If yes, explain: ______________________________

____

Family Medical History:

Do you have a Family History of any of the following? Check the appropriate boxes and if yes, specify relative:

☐ Heart Disease ____________ ☐ High blood pressure ____________
☐ Diabetes ____________ ☐ High cholesterol ____________
☐ Cancer ____________ ☐ Asthma ____________
☐ Kidney Disease ____________ ☐ Psychiatric Disorder ____________
☐ Stroke ____________ ☐ Thyroid Disease ____________
☐ Endometriosis ____________ ☐ Osteoporosis ____________
☐ Autoimmune Disease ____________ ☐ Blood Disorder ____________
☐ Other ____________

Social History:

Tobacco Use:

☐ Non-Smoker

☐ Current Smoker ☐ Heavy (20-39 cigs/day) ☐ Moderate (10-19 cigs/day) ☐ Light (1-9 cigs/day)

Have you tried to quit? ☐ Y ☐ N Are you interested in quitting? ☐ Y ☐ N

☐ Former Smoker ☐ <1 mo. ☐ 1-3 mo. ☐ 3-6 mo. ☐ 6-12 mo. ☐ 1-5 years ☐ 5-10 years ☐ >10 years

Sexual History:

Have you had sex in the past 12 months? ☐ Y ☐ N

If yes, with: ☐ Men only ☐ Women only ☐ Both men and women

Are you monogamous (having sexual relations with ONE person at a time): ☐ Y ☐ N

Have you ever had a sexually transmitted disease? ☐ Y ☐ N

If yes, please specify what STD and when:______________________________

Recreational drug use:

Have you used any recreational drugs in the past 12 mo.? ☐ Y ☐ N

If yes, please specify which drug(s)? ______________________________

Do you have a medical marijuana card? ☐ Y ☐ N

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Alcohol Use:

How often do you drink alcohol?

- ☐ No use
- ☐ Monthly or less
- ☐ 2-4 times a month
- ☐ 2-3 times a week
- ☐ 4 or more times a week

How many drinks on a typical day when drinking?

- ☐ 1-2 drink
- ☐ 3-4 drinks
- ☐ 5-6 drinks
- ☐ 7-9 drinks
- ☐ 10 or more

How often do you have 6 drinks or more on one occasion?

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Caffeine Use:

☐ Never ☐ Daily 1-2 cups ☐ Daily 2-3 cups ☐ Daily 3-4 cups ☐ Daily 4+ cups

If there is any other medical information, of which you would like your provider to be aware, please indicate this below:

____

____

____

____

____

____

Pharmacy preference:

Name of pharmacy: ____

Crossroads: ____

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Review of Systems

Please check the box to indicate any of these symptoms that currently apply to you.

Constitutional
- ☐ Chills
- ☐ Hot/Cold Intolerance
- ☐ Fever
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue

Cardiac
- ☐ Dizziness
- ☐ Chest Pain
- ☐ Fast Heart Rate
- ☐ Leg Edema
- ☐ Palpitations

Endocrine
- ☐ Diabetes
- ☐ Hair Loss
- ☐ Thyroid Problems
- ☐ Excessive Thirst
- ☐ Excessive sweating

Ear, Nose, Throat
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Cough
- ☐ Sore throat
- ☐ Ear pressure/Pain
- ☐ Nose Bleed
- ☐ Swollen Glands
- ☐ Difficulty swallowing

Gastroenterology
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody stool

Male Reproduction
- ☐ Difficulty with Erection
- ☐ Diminished sex drive
- ☐ History of low testosterone

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Anger/Irritability
- ☐ Physical abuse
- ☐ Thoughts of self-harm
- ☐ Thoughts of harming others

Musculoskeletal
- ☐ Joint Stiffness
- ☐ Joint Swelling
- ☐ Joint pain
- ☐ Sciatica

Neurology
- ☐ Migraines
- ☐ Tension headache
- ☐ Numbness
- ☐ Seizures
- ☐ Insomnia
- ☐ Memory loss

Ophthalmology
- ☐ Decreased vision
- ☐ Eye irritation
- ☐ Blurred vision

Respiratory
- ☐ Shortness of breath
- ☐ Chest Pain
- ☐ Chest Congestion
- ☐ Cough

Dermatology
- ☐ Rash
- ☐ Acne
- ☐ Mole
- ☐ Lumps
- ☐ Hives
- ☐ Dry Skin
- ☐ Itching
- ☐ Eczema

Urology
- ☐ Difficulty urinating
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Urinary incontinence
- ☐ Voiding dysfunction

Gynecology
- ☐ Heavy periods
- ☐ Irregular periods
- ☐ Pelvic Pain
- ☐ Breast pain or lump
- ☐ Hot flashes
- ☐ Osteoporosis

Blood Disorders
- ☐ Anemia
- ☐ Swollen Glands
- ☐ Easy Bruising

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Authorization for Release of Medical Records

Patient Name: ____ DOB _____/_____/___________

Address: ____ Apt #: ____________________

City: ____ State: _____________ Zip Code: __________________

Home Phone Number: ___________________________ Email Address: ________________________________

Please fax records to Harmony Medical Care: 480-854-3618 – or by mail to the address above.

Requesting Records From:

Office/ Physician: ____

Phone: _______________________________________ Fax #: _______________________________________

Address: ____ Suite: ____________________

City: ____ State: _____________ Zip Code: __________________

Please release all medical records unless a specific date, procedure or other items are listed below:

____

Reason for requesting records: ____

I authorize the release of the above requested records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, confidential information related to mental health, drug and/or alcohol use, or sexual history, and that the records be forwarded to the above name and address.

I further authorize that these medical records be faxed or mailed if necessary.

I understand that I may revoke this authorization at any time, except to the extent that action based upon this authorization has already been taken. I have given my consent freely, voluntarily, and without coercion.

Signature: ____ Date: ___________________________

Relationship: ____