81 W Guadalupe Rd 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 circle): Male Female Transgender

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? (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: __________________

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

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ____ Date of Birth: ________________

Address: __________________________________ City: ______________ State: _____ Zip: ________

Phone Number: _______________________________ Email: _________________________________

Please send records to Harmony Medical Care at our fax number: 480-854-3618, or by mail to the address above.

Requesting Records From:

Office/ Physician Name: ____

Phone Number: _______________________________ Fax Number: __________________________

Address: _______________________________ City: _____________ State: ______ Zip: __________

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: _________________________________ Relationship: ___________ Date: _______________

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

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: ___________________________________ Date of Birth: _____/_____/_________

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

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: ____________________________________ Date of Birth: _____/_____/_________

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

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 $50.00 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 three (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: ____________________________________ Date of Birth: _____/_____/_________

Harmony MEDICAL CARE

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

Zero Tolerance Policy

Harmony Medical Care- Gilbert aims to provide quality care to all of our patients. We understand that there may be circumstances that lead to frustration regarding your situation, symptoms, or medical care. We attempt to provide quality care for every one of our patients, but we have zero tolerance for abuse and violence towards our staff.

We will not tolerate the following:

- Multiple missed appointments without cancelling at least 24 hours prior
- Disrespectful behavior, cursing, or yelling
- Verbal or physical abuse
- Threats
- Non-compliance with provider instructions/ recommendations
- Giving false information
- Abuse of controlled substances

We believe that any of the behaviors above undermine a successful provider-patient relationship and compromise our ability to provide quality care. Any infraction of this zero tolerance policy will result in your being discharged from our practice. Should this become necessary, you will be notified in writing by certified mail. Not accepting or receiving this letter does not preclude the patient from being discharged.

By signing below, you indicate that you have read, understood, and agree to the above policy.

Patient Signature: ________________________________ Date: ___________________________

Patient Name: ___________________________________ Date of Birth: _____/_____/_________

Harmony MEDICAL CARE

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

Patient Name: ___________________________

Medical History

Date of Birth: ________/________/___________

Please list the date of your most recent:

Evaluation:	Date:	Normal (N) vs Abnormal (A):
Date of last physical exam		
Colonoscopy		
Vision exam		
Dental exam		
DEXA		
Aortic Ultrasound		
Carotid Ultrasound		
Shingles Vaccine		
Flu Vaccine		
Pneumonia - Prevnar - Pneumovax		

Females:

Mammogram		
History of Hysterectomy		
Pap/Pelvic Exam		
Last Menstrual Period		

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

Harmony MEDICAL CARE

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

Personal Health History: (Please check whichever conditions apply)

☐ Heart Disease	☐ Cancer	☐ Stroke
☐ Hypertension	☐ Asthma	☐ Thyroid Disease
☐ Hyperlipidemia	☐ Kidney Disease	☐ Osteoporosis
☐ Diabetes	☐ Psychiatric Disorder	☐ Other, ___________

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

Drug Allergies: ____

____

Environmental Allergies: ____

____

Female - Gyn Information:

Methods of Contraception: ____

Age of Menarche: _____ Irregular Periods: ☐ Yes ☐ No

Menopausal: ☐ Yes ☐ No If yes, hormone replacement: ☐ Yes ☐ No

Pregnancies:

Year: _____ Gender: ___ Delivery Type: ___________ Complications: ___________________

Year: _____ Gender: ___ Delivery Type: ___________ Complications: ___________________

Year: _____ Gender: ___ Delivery Type: ___________ Complications: ___________________

Year: _____ Gender: ___ Delivery Type: ___________ Complications: ___________________

Year: _____ Gender: ___ Delivery Type: ___________ Complications: ___________________

Year: _____ Gender: ___ Delivery Type: ___________ Complications: ___________________

Surgical History:

Surgery: ____ Date: ________________

Surgery: ____ Date: ________________

Surgery: ____ Date: ________________

Surgery: ____ Date: ________________

Harmony MEDICAL CARE

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

Hospitalization History:

Have you been hospitalized in the last 1 year? ☐ Yes ☐ No

If yes, explain: ____

____

Family Medical History:

Do you have a Family History of any of the following? Check the appropriate boxes, if yes and 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) ☐ Mod. (10-19 cigs/day) ☐ Light (1-9 cigs/day)

Have you tried to quit? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

☐ 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? ☐ Yes ☐ No

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

Are you monogamous (having sexual relations with ONE person at a time) ☐ Yes ☐ No

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No

If yes, please specify what STD and when: ___________________________________

Recreational drug use:

Have you used any recreational drugs in the past 12 mo? ☐ Yes ☐ No

If yes, please specify which drug? ___________________________________

Do you have a medical marijuana card? ☐ Yes ☐ No

Harmony MEDICAL CARE

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

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 drinks
- ☐ 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: ____

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

Informed Consent for Chronic Care Management and Program Policies

As a patient of Harmony Medical Care, you agree to participate in our Chronic Care management (CCM) program.

The purpose of this program is to allow us to provide the follow-up, education, and coordination of care that your provider may feel is essential for your health situation. Our CCM team will be instrumental in providing you with care, education, and various materials you need to make the most of your experience with us. They will also help by coordinating with other specialists in your care team to share the most up to date information regarding your health. A team member will be available 24/7 via phone or other non-face-to-face means for urgent needs.

Please review the following:

- As needed, we will share your health information electronically with others involved in your care. Harmony Medical Care is compliant with all HIPAA laws related to the privacy and security of your health information.
- We will bill your insurance for chronic care management as necessary for your ongoing care. Insurance cost sharing, co-pay, and/or deductible obligations may apply.
- Only one provider may furnish and bill for CCM services per month. If you are participating in a CCM Program at another office, but would like to switch to our office, you must terminate your participation with the other provider prior to beginning the program with us.
- We will provide you with a written or electronic Comprehensive Care Plan to assist you in understanding how to care for your conditions. If you no longer wish to be a Harmony CCM patient, you may discontinue this service at any time for any reason.

Our goal is to provide you with comprehensive service and care as we manage your chronic conditions and improve your overall health and well-being.

I agree to allow my assigned medical provider to provide me with Chronic Care Management services.

Patient Signature: ________________________________ Date: ___________________________

Patient Name: ___________________________________ Date of Birth: _____/_____/_________