Desert Podiatric Medical Specialists, a campus of ARIZONA COMMUNITY SURGEONS, PC

Dr Bradley Whitaker DPM
Dr Christopher Funk DPM
Dr Peter Merrill DPM

Patient Intake Form

Patient Name:_____ Birthdate:_____ Age:_____
Last First MI

Address:_____
Street City State Zip Code

Primary Phone #_____ Cell #_____ Social Security #_____

Email Address:_____

Birth Sex_____ Current Gender_____ Gender Identity_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed Spouse Name_____

Race_____ Ethnicity □ Hispanic □ Non-Hispanic: Preferred Language_____

Referred by_____ Primary Care Provider_____

Employer_____ Occupation_____ Employer Phone #_____

Emergency Contact #_____ Relationship_____

Preferred Pharmacy Name and Address or Cross Streets_____

_____

Insurance Information

Primary Insurance_____ ID #_____ Group #_____

Insured Person's Name_____ Birthdate_____

Secondary Insurance_____ ID #_____ Group #_____

Insured Person's Name_____ Birthdate_____

MEDICAL HISTORY FORM

Patient's Name_____ DOB _____ Age_____ Referring Dr._____

Why are you here to see the doctor today? _____

Height _____ Weight _____ Occupation _____

If needed, I consent to the transfusion of any Blood/Blood products ☐ **YES** ☐ **NO**

Do you have an active or a history of MRSA/VRE infection: ☐ **YES** ☐ **NO** ___ **Current** ___ **History of**

Have you ever been diagnosed with: C-Diff: Y N HIV: Y N Hepatitis B: Y N Hepatitis C: Y N

MEDICATIONS TAKEN REGULARLY	REASON	DOSE	HOW OFTEN	START DATE

MEDICINE ALLERGIES	REACTION

MEDICAL PROBLEMS (e.g. high blood pressure, diabetes)

PAST MEDICAL AND SURGICAL HISTORY

DISEASE/ILLNESS	YEAR DIAGNOSED	PROCEDURE/SURGERY	YEAR OF PROCEDURE

YOUR FAMILY HISTORY (e.g. cancer, heart disease, diabetes, etc. for mother, father, sister, brother, children)

DIAGNOSIS	FAMILY MEMBER	AGE	COMMENTS

TOBACCO USE: ☐ YES ☐ NO ☐ FORMER

Type _____ Years used _____ Units per day _____

Age started____ Age quit _____

☐ Current every day smoker ☐ Current someday smoker

Passive smoker exposure? ☐ YES ☐ NO

Ever tried to quit? ☐ YES ☐ NO

Longest tobacco free: _____

VAPING? ☐ YES ☐ NO Device type _____

Frequency _____ Strength _____ Reason _____

ALCOHOL USE: ☐ YES ☐ NO ☐ FORMER

Type _____ Amount _____

Frequency _____ Last drink _____

DRUG USE/ABUSE: ☐ YES ☐ NO ☐ FORMER

Type _____ Frequency _____

Quit _____

EXERCISE: ☐ YES ☐ NO

Can you walk up 2 flights of stairs? ☐ YES ☐ NO

REVIEW OF SYSTEMS

Check "yes" for any current illness and/or disease. Check "no" for all others. TODAY'S DATE _____

CONSTITUTIONAL

NO YES
- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Malaise
- ☐ ☐ Night sweats
- ☐ ☐ Weight gain
- ☐ ☐ Weight loss

Other: _____

HEENT
- ☐ ☐ Ear drainage
- ☐ ☐ Ear pain
- ☐ ☐ Eye discharge
- ☐ ☐ Eye pain
- ☐ ☐ Hearing loss
- ☐ ☐ Nasal drainage
- ☐ ☐ Sinus pressure
- ☐ ☐ Sore throat
- ☐ ☐ Visual changes

Other: _____

RESPIRATORY
- ☐ ☐ Chronic cough
- ☐ ☐ Cough
- ☐ ☐ TB exposure
- ☐ ☐ Shortness of breath
- ☐ ☐ Wheezing

Other: _____

CARDIOVASCULAR
- ☐ ☐ Chest pain
- ☐ ☐ Claudication (leg weakness with circulation problems)
- ☐ ☐ Edema (swelling)
- ☐ ☐ Palpitations

Other: _____

GASTROINTESTINAL
- ☐ ☐ Abdominal pain
- ☐ ☐ Blood in stools
- ☐ ☐ Change in stools
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Heartburn
- ☐ ☐ Loss of appetite
- ☐ ☐ Nausea
- ☐ ☐ Vomiting

Other: _____

GENITOURINARY – FEMALE
- ☐ ☐ Dysuria (difficult/ painful urination)
- ☐ ☐ Hematuria (blood in urine
- ☐ ☐ Polyuria (excessive urination
- ☐ ☐ Urinary frequency
- ☐ ☐ Urinary incontinence
- ☐ ☐ Urinary retention

Other: _____

REPRODUCTIVE – FEMALE

NO YES
- ☐ ☐ Abnormal pap
- ☐ ☐ Dysmenorrhea (painfulmenstruation
- ☐ ☐ Dyspareunia (painful intercourse)
- ☐ ☐ Hot flashes
- ☐ ☐ Irregular menses
- ☐ ☐ Vaginal discharge

Other: _____

GENITOURINARY – MALE
- ☐ ☐ Dribbling
- ☐ ☐ Dysuria (difficult/painful urination)
- ☐ ☐ Hematuria (blood in urine
- ☐ ☐ Polyuria (excessive urination
- ☐ ☐ Slow stream
- ☐ ☐ Urinary frequency
- ☐ ☐ Urinary incontinence
- ☐ ☐ Urinary retention

Other: _____

REPRODUCTIVE – MALE
- ☐ ☐ Erectile dysfunction
- ☐ ☐ Penile discharge
- ☐ ☐ Sexual dysfunction

Other: _____

INTEGUMENTARY
- ☐ ☐ Breast discharge
- ☐ ☐ Breast lump
- ☐ ☐ Brittle hair
- ☐ ☐ Brittle nails
- ☐ ☐ Hair loss
- ☐ ☐ Hirsutism (excessive body hair
- ☐ ☐ Hives
- ☐ ☐ Pruritus (itching)
- ☐ ☐ Mole changes
- ☐ ☐ Rash
- ☐ ☐ Skin lesión

Other: _____

NEUROLOGICAL
- ☐ ☐ Dizziness
- ☐ ☐ Extremity numbness
- ☐ ☐ Extremity weakness
- ☐ ☐ Gait disturbance
- ☐ ☐ Headache
- ☐ ☐ Memory loss
- ☐ ☐ Seizures
- ☐ ☐ Tremors

Other: _____

PSYCHIATRIC

NO YES
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Insomnia

Other: _____

METABOLIC/ENDOCRINE
- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance
- ☐ ☐ Polydipsia (excessive thirst
- ☐ ☐ Polyphagia (over eating

Other: _____

MUSCULOSKELETAL
- ☐ ☐ Back pain
- ☐ ☐ Joint pain
- ☐ ☐ Joint swelling
- ☐ ☐ Muscle weakness
- ☐ ☐ Neck pain

Other: _____

HEMATOLOGIC
- ☐ ☐ Easy bleeding
- ☐ ☐ Easy bruising
- ☐ ☐ Lymphadenopathy (swelling of lymph nodes)

Other: _____

IMMUNOLOGIC
- ☐ ☐ Contact allergy
- ☐ ☐ Environmental allergies
- ☐ ☐ Food allergies
- ☐ ☐ Seasonal allergies

Other: _____

Colonoscopy:
☐ **Yes** ☐ **No**
Date_____

Mammogram:
☐ **Yes** ☐ **No**
Date_____

PAST TESTS/DIAGNOSTICS/LABS:

DATE	TYPE

Immunizations:

Flu Shot Date: _____
Pneumonia Date: _____
Tetanus Date: _____
Patient Initials _____

Patient Name: _____ **Date of Birth:** _____

ARIZONA COMMUNITY SURGEONS, PC

NOTICE OF PRIVACY PRACTICES

PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Omnibus Rules of 2013, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

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

I acknowledge that I have received or had the opportunity to review the Notice of Privacy Practices from Arizona Community Surgeons, PC ("ACS"), which contains a more complete description of the uses and disclosures of my health information. I understand that ACS has the right to change its Notice of Privacy Practices from time to time and that I may contact ACS at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that ACS restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand ACS is not required to agree to my requested restrictions, but if ACS does agree then ACS is bound to abide by such restrictions.

Patient Name: _____ **Patient Date of Birth:** _____

Signature: _____ **Date Signed:** _____

REQUEST FOR CONFIDENTIAL COMMUNICATION

HIPAA privacy rules give certain individuals the right to request confidential medical information. In that regard, you may select the method in which this confidential medical information is communicated. Also, ACS may need to communicate with you regarding your confidential medical information. Please select your preferred method of contact. If you would like to change your contact information in the future, please provide your request in writing to the address contained within the Privacy Practice Notice.

I give permission to disclose my confidential medical information to the following individuals:

Printed Name: _____ Relationship: _____

Printed Name: _____ Relationship: _____

Printed Name: _____ Relationship: _____

My EMERGENCY contact is: _____ **Phone #** _____

I prefer to be contacted in the following manner (check all that apply):

☐ Home Phone: ☐ Detailed Message OR ☐ Callback Number Only

☐ Work Phone: ☐ Detailed Message OR ☐ Callback Number Only

☐ Written Communication: I give my consent to be contacted in the following ways:

☐ Mail to Home ☐ Email to: _____ ☐ Fax to: _____

Signature: _____ **Date Signed:** _____

ACS OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Employee Name: _____

Reason: _____

_____

ARIZONA COMMUNITY SURGEONS, PC

Patient Payment & Financial Policies

Arizona Community Surgeons, PC is committed to providing comprehensive, compassionate and expert surgical care for our patients, without compromise. Our fee schedules are representative of the usual and customary charges for this area. There are many different insurance plans and within each of those plans, there are different benefits according to each person's type of coverage. It is extremely important that you understand exactly what your benefits are when you access health care services. Please take the time to read the policies below and check with your insurance provider if you have any questions about your coverage.

Be familiar with your insurance benefits and how to access care to maximize your coverage and minimize unnecessary out-of-pocket expenses for care that is covered when all patient responsibilities are observed.

Patients with Insurance: Insurance cards must be presented at time of check in at every visit. We also ask for some form of government photo identification (such as a driver's license or passport) to confirm your identity. This is to protect your benefits so that no one else may fraudulently access your health insurance. As our participation with insurance plans changes occasionally, it is your responsibility to call your insurance company before each appointment to verify we still accept your plan. Copayments will be collected at check in prior to your visit with the doctor. If you are not prepared to pay your copay at check in, and it is a non-urgent appointment, we reserve the right to reschedule your appointment. **Please be advised that your insurance company may determine that you are also responsible to pay more than the office copay if the surgeon performs certain diagnostic or therapeutic procedures in the office during your visit, depending upon your insurance benefits.** Some examples are injections, excision of lesions, biopsies, fracture care, anoscopies, x-rays or ultrasounds and DME equipment. We may request a deposit for these procedures if it appears you will bear additional financial responsibility based on your plan, but we will not know your exact responsibility until after the insurance company has processed your claim. Also, if you are seeing one of our providers out-of-network, some or all of the office visit charges may become your responsibility according to the terms of your insurance coverage.

Patients with Medicare: Medicare will cover 80% of their allowable charges; you will be responsible for the remaining 20% plus any applicable deductible. Non-covered medical charges are also your responsibility. You will be notified of those services that may not be a Medicare covered benefit in advance and be allowed to decline those services. In these circumstances, you will be asked to sign an Advanced Beneficiary Notice (ABN) that describes the service(s) the doctor is recommending that may not be covered by Medicare. If you have secondary insurance we will be happy to bill them on your behalf. If your secondary insurance does not pay within 60 days the balance becomes your responsibility.

Medicare Replacement Plans: Many patients that qualify for Medicare have chosen to sign up for a Medicare Replacement Plan, which functions as an HMO. Some of these plans are: Humana Medicare, United Healthcare Medicare Complete, and Health Net Medicare, to name a few. If you have one of these plans, you do NOT have Medicare; you have a Medicare Replacement Plan. This is an important difference because each of these plans has different requirements for how you access your health care – which doctors you can see and which hospitals you can use, for example. Please make sure you know your benefits and your responsibilities with these plans. These plans typically have a copay, which will be collected at check in for each appointment.

Insurance Referrals and Authorizations: Many Medicare Replacement Plans and HMO insurance plans require a referral from your Primary Care Provider (PCP) to cover most specialist services. If you do not have the appropriate referral or authorization, you will be responsible for the cost of your services. Please check with your insurance company or PCP to confirm that you have the correct referral or authorization for each visit.

Private Pay and Patients without Insurance: Payment is due at time of service. If you require surgery, prepayment arrangements can be made with our Billing Office.

Patients with Worker's Compensation: You may be covered by insurance if your injury is work related and verified by your employer. You are responsible for providing billing information from your employer's industrial insurance. You are ultimately responsible for the balance for any services not covered by your employer's insurance.

Personal Injury (Accident): Our office will bill the appropriate insurance company. If we are unable to obtain payment after 60 days, the charges will become your responsibility. (This does NOT include motor vehicle accidents; see below.)

Motor Vehicle Accidents: Arizona Community Surgeons, PC does not do third party billing of auto insurance, therefore care related to motor vehicle accidents is treated as "private pay" and is the patient's responsibility. We will provide you with documentation that you can submit to your insurance company and/or attorney for reimbursement.

Returned Checks: There is a $35 fee for every check that is returned from the bank unpaid for any reason.

Forms Completion/Medical Records: There is a $25 fee for the completion of disability and FMLA forms, payable at the time they are requested. There may also be a charge for other forms and letters, according to the complexity and time required to prepare them.

Assignment of Benefits: I, the patient, assign the benefits from the insurance carrier(s) to Arizona Community Surgeons, PC for the medical/surgical services for which I am entitled.

Release of Information: I authorize Arizona Community Surgeons, PC to release and/or request any information needed to determine benefits or benefits payable for related services.

Patient Responsibility: I understand that I am responsible for advising Arizona Community Surgeons, PC of any changes to my address, phone number, insurance plan, payor or coverage.

ALL PATIENTS MUST COMPLETE AND SIGN THIS PAYMENT POLICY, ASSIGNMENT AND RELEASE OF INFORMATION AGREEMENT WITH THE PATIENT REGISTRATION FORM PRIOR TO RECEIVING CARE BY AN ARIZONA COMMUNITY SURGEONS, PC PROVIDER.

I have read and agree to this Payment Policy, Assignment and Release of Information paragraphs stated above.

_____ _____

Patient or Responsible Party Signature Date

Duplicates of this release and assignment are as valid as the original.

If you have any questions about the Arizona Community Surgeons, PC payment and financial policies, please call our Billing Office at (520) 750-7160.

ARIZONA COMMUNITY SURGEONS, PC

Prescriptions for Narcotics and Other Controlled Substances

Print Patient's Name: _____ Date of Birth: _____

Narcotics, or medications containing opioids and related substances, can be used to treat severe pain. It is sometimes appropriate to use these medications for severely painful conditions or following surgery to help alleviate pain. However, these medications can be dangerous if not used properly. It is now well-known that there is growing opioid abuse epidemic in our country, and all doctors are making efforts to reduce their use in order to help prevent abuse, addiction, tolerance, complications, and deaths that result from their inappropriate use.

We would like to do our part to reduce the use and misuse of opiates and related controlled substances, and this requires cooperation and good communication between our providers and you, our patients. We have established some guidelines for prescribing controlled substances from our office.

1. As a general rule, we prefer that medications be prescribed by your primary care provider (PCP), whenever possible. Your PCP is your health care manager, and needs to be aware of any and all medications you are taking.

2. After surgeries performed by one of our doctors, a reasonable amount of pain medication will be provided to you at the surgeon's discretion. This is based on the type of surgery you are having, and what typically is required for pain control after that particular surgery. Sometimes this is one day's worth of medication for minor surgeries, and sometimes it is provided for a longer period of time for more extensive surgeries.

3. Narcotic pain medication is not typically prescribed by our doctors for treatment of pre-operative pain. In addition, we do not provide long-term pain medication, or prescribe pain medication for chronic pain. Under no circumstances will we provided long-acting narcotic pain medications such as MS Contin, Oxycontin, or Fentanyl patches, etc. Prescriptions in all of these situations can be requested through your PCP or a pain management specialist. Please notify us, or annotate on your intake paperwork, if you are on a "pain contract". If you are, all of your pain medication MUST be prescribed by the provider designated on your pain contract.

4. If you are in need of a refill of your pain medication following surgery, you can call the office during normal working hours and leave a message with the office staff. Your surgeon will review your situation and determine if a refill is required, and if so, will refill your prescription at the earliest opportunity. This is usually possible within 48 hours, but sometimes your surgeon may not be available within that time frame, and it may take longer. In those situations, the medical assistants will try to review your case with another available provider and attempt to get your prescription refilled. In summary, we will do the best we can to refill your prescriptions as quickly as possible. We do not refill prescriptions for controlled substances after normal office hours or on the weekends. In those instances, you may wait until the next office work day, or go to an Urgent Care or Emergency Room if necessary.

5. When a prescription is refilled you must pick up the signed prescription from our office. We cannot call in or electronically send controlled substances to your pharmacy. The refilled prescription can only be written for a **5-day** supply.

6. We understand the importance of managing your pain, and want to do everything we can to assist you with this. We all want to prevent the serious problems that can sometimes result from misuse of narcotic pain medications. Your cooperation and understanding of this is greatly appreciated.

_____ _____

Patient Signature Date