The Maxwell Group

PATIENT REGISTRATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

DOB: ___ /___ /___ **Sex:** ☐ ***Male*** ☐ ***Female*** **SS#:** ____ - ____ - _____

Marital Status: ☐ ***Single*** ☐ ***Married*** ☐ ***Divorced*** ☐ ***Widowed*** ☐ ***Other:*** _____

Home Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Home #:(_____**)**_____ **Work #:(**_____**)**_____ **EXT:** _____ **Cell #:(**_____**)**_____

Preferred Daytime Phone: ☐ **Home** ☐ **Cell** ☐ **Work**

Email: _____ **Employer:** _____

IF WINTER VISITOR, PLEASE LIST YOUR PERMANENT ADDRESS

Address: **City:** **State:** **Zip:**

_____

ADDITIONAL INFORMATION

Race: ☐ American Indian ☐ Asain ☐ African American ☐ Caucasian ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

☐ **I do not want to provide this information**

EMERGENCY CONACT INFORMATION

Name: _____ **Relationship:** _____

Home #: (_____**)** _____ **Work #: (**_____**)**_____

PREFERRED PHARMACY

Name: _____ **Phone #: (**_____**)** _____

Address: _____

Mail- Order Pharmacy: _____

PREVIOUS PHYSICIAN INFORMATION

Physician Name: _____

Last Annual Wellness or Physical: ___ /___ /___

Office Address: _____

Phone #: (_____**)** _____ **Fax #: (**_____**)** _____

Name: _____ DOB:___/___/___

Financial/Insurance Information

PRIMARY INSURANCE

Insurance Name: _____

Policy Holder's Name: _____ **Employer:** _____

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other:_____

Policy Holder's DOB: ___ /___ /___ **SS#:** ___ - ___ - ___ **Sex:** ☐ ***Male*** ☐ ***Female***

Member ID#: _____ **Group #:** _____

SECONDARY INSURANCE

Insurance Name: _____

Policy Holder's Name: _____ **Employer:** _____

Policy Holder's Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other:_____

Policy Holder's DOB: ___ /___ /___ **SS#:** ___ - ___ - ___ **Sex:** ☐ ***Male*** ☐ ***Female***

Member ID#: _____ **Group #:** _____

COMPLETE IF RESPONSIBLE PARTY IS OTHER THAN PATIENT

Responsible Party Name: _____ **DOB:** ___ /___ /___ **SS#:** ___ - ___ - ___

Address: _____ **Relationship to Patient:** _____

City: _____ **State:** _____ **Zip:** _____ **Employer:** _____

Home #:(_____**)**_____ **Work #:(**_____**)** _____ **Cell #:(**_____**)** _____

BENEFIT ASSIGNMENT / ACKNOWLEDGMENT OF PRIVACY PRACTICES

I hereby authorize The Maxwell Medical Group to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning the patient's illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to my dependents or myself. I understand that I am financially responsible for any amounts not covered by health insurance. It is my responsibility to notify the office of changes in information.

Signature: _____ Date:___/___/___

Name: _____ DOB:___/___/___

Medical History

MEDICATIONS

Medication Name:	*Strength:*	*Dose:*	*Frequency:*

ALLERGIES

☐ Penicillin ☐ Latex ☐ Keflex ☐ Sulfa ☐ Ciprofloxin ☐ Iodine ☐ Eggs

☐ No known allergy ☐ No known ***drug*** allergy

☐ Other: _____

PAST / PRESENT MEDICAL CONDITIONS

Cardiac: ☐ Heart Attack ☐ A-fib ☐ Congestive Heart Failure ☐ Hypertension ☐ Irregular Heart Beat
Neurologic: ☐ Stroke ☐ Seizures/Epilepsy ☐ Dementia ☐ Alzheimer's ☐ Parkinson's
Endocrine: ☐ Diabetes ☐ Thyroid Disorder ☐ Osteoprosis ☐ Elevated Cholesterol
Pulmonary: ☐ Asthma ☐ COPD ☐ Valley Fever ☐ Sleep Apnea
Gastrointestinal: ☐ GERD ☐ IBS ☐ Cirrhosis/Liver Disease
Urinary: ☐ Kidney Stones ☐ Kidney Failure ☐ Enlarged Prostate
Rheumatology: ☐ Arthritis ☐ Fibromyalgia ☐ Lupus
Blood: ☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Bleeding Disorder
Psychiatric: ☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia
Circulation: ☐ DVT ☐ Pulmonary Embolus ☐ Peripheral Vascular Disease ☐ Carotid Atrery Disease
Cancer: _____
Other Condition(s) <u>not</u> listed: _____
☐ ***None***

HOSPITAL / SURGERY

Date:	*Reason:*

Name: _____ DOB:___/___/___

FAMILY HISTORY

FAMILY MEMBER:	AGE:	ALIVE *OR* DECEASED:	ANY MEDICAL CONDITION(S):
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

SOCIAL HISTORY

Caffeine: ☐ Yes ☐ No If yes, how much? _____

Alcohol: ☐ Yes ☐ No If yes, how much/often? _____

Smoking: ☐ Yes ☐ No If yes, how many/often? _____

***Marijuana*:** ☐ Yes ☐ No If yes, how often? _____

Exercise: ☐ Yes ☐ No If yes, what and how often? _____

Retired: ☐ Yes ☐ No ***Living Will:*** ☐ Yes ☐ No ***POA:*** ☐ Yes ☐ No ***DNR:*** ☐ Yes ☐ No

PREVENTATIVE CARE

Date of last Mammogram: _____

Date of last Colonoscopy: _____

Date of last Bone Density (DEXA): _____

Date of last Pap Smear: _____

Date of last PSA: _____

Date of last Stool Test: _____

IMMUNIZATIONS

Hep. A: ☐ Yes ☐ No Date received: _____

Hep. B: ☐ Yes ☐ No Date received: _____

Influenza: ☐ Yes ☐ No Date received: _____

Pneumonia: ☐ Yes ☐ No Date received: _____

Prevnar 13: ☐ Yes ☐ No Date received: _____

Tetanus: ☐ Yes ☐ No Date received: _____

Shingles: ☐ Yes ☐ No Date received: _____

TB: ☐ Yes ☐ No Date received: _____

MMR: ☐ Yes ☐ No Date received: _____

COVID-19: ☐ Yes ☐ No Date received: _____

FINANCIAL POLICY

THE MAXWELL GROUP

Thank you for choosing The Maxwell Group as your primary care physician office. Please carefully read and sign below. This policy has been put in place to ensure that financial payments due are recovered. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager and billing department will be glad to discuss these policies with you.

1. I understand that all copayments and outstanding balances are due at the time of service. If I do not have my insurance card, and/or copayment, my appointment may be rescheduled based on availability until such time that I can provide the required documents or payments.

2. I understand that although we are contracted with several insurance companies, it is my responsibility to know my insurance benefits.

3. I understand that if I do not have the correct PCP assigned by my insurance company that my appointment will be rescheduled.

4. I understand that if my insurance company has not paid a claim on my behalf within 90 days because of information that I have not provided, the balance will be transferred to my account and I will be responsible for payment. If we receive payment at a later date, we will reimburse you.

5. I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order or cash).

6. I understand that there is a charge of $35 for any forms that I request the doctor to complete on my behalf. The payment for completion of these forms will be paid when the forms are accepted for the doctor to complete. These forms include but are not limited to FMLA paperwork, Life Insurance forms, Assisted Living forms and any other form requiring doctor completion when the patient is not present. Document completion could require you to be seen by a provider. Please allow 7-10 business days for completion.

7. I understand that there may be fees associated with medical records requests and that I may be responsible for these fees.

8. I have read and I understand the above Financial Policy and I agree to abide by its terms.

_____ _____

Printed Name (patient or guarantor) Relationship

_____ _____

Signature (patient or guarantor) Date

OFFICE POLICY

THE MAXWELL GROUP

These policies at The Maxwell Group are designed to make the care we provide more streamlined, efficient and patient-centered for you.

1. APPOINTMENTS

To accommodate everyone's needs, we offer appointments days, weeks or months in advance as well as same day scheduling. If you have an urgent need please call us and we will get you in as soon as possible.

2. LATE/ NO SHOW POLICY

We pride ourselves on taking your time seriously and hope you will do the same for us. If you are running 10 or more minutes late, we will have to reschedule you to a different day. We do ask that you call at least 24 hours in advance if you cannot make your appointment. After your 3rd No Show appointment we can dismiss you from the practice.

3. MEDICATION REFILLS

- If possible, it is best to get refills during your regular office visit. For your convenience we can e-prescribe or fax your prescriptions directly to your pharmacy.
- We encourage patients to contact their pharmacy for refills or use the Patient Portal to request refills.
- Please allow our office 72 hours to complete the refill process.
- Please note that no prescription refills, routine OR controlled substances are done after hours or on weekends.
- If your medications need prior authorization, please note this may take 5-7 business days for processing.

4. AFTER HOURS CARE

If you have an emergency, please call 911 or go directly to the nearest emergency room. For less urgent medical concerns please call our answering service at (602) 433-3419 and the on call Provider will respond. Routine calls, such as, medication refills or referrals will be handled during regular office hours.

5. GROUNDS FOR TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

A physician may terminate a relationship with a patient by giving 30 day notice, during which the physician is responsible only for responding to urgent medical matters. We will reserve this action for patients who demonstrate repeated non-compliance with medical advice, missing multiple appointments, failing to pay their balances, disregarding the stated policies of the practice or acting in a way this is deceptive, dishonest or abusive.

6. REFERRALS/ PRE-CERTIFICATIONS

If you need to see a specialist, your insurance company may require a referral. It is your responsibility as the patient to determine if your insurance requires a referral, to verify that the specialist is on your plan and to obtain a referral from our office before visiting the specialist. New referrals require an office visit for documentation of medical necessity. Referral requests require one to two weeks' notice before your visit with the specialist.

THE MAXWELL GROUP
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test result, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among other health professionals who contribute to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that *The Maxwell Group* reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that *The Maxwell Group* is not required to agree to the restrictions requested. I understand and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

_____ _____

Printed Name of Patient **Date of Birth**

_____ _____

Signature of Patient or Legal Representative **Description of Personal Representatives Authority**

_____

Date of Signing

THE MAXWELL GROUP
NOTICE OF HEALTH INFORMATION PRACTICES

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit your healthcare provider i.e.: physician, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you and a third-party payer can verify that services billed were actually provided
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- Ensure its accuracy
- Better understand who, what, when, where, and why others may access your health information
- Make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (*Federal Register 65,* no.250)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and copy your health record as proved for in 45 CFR 164.524 (*Federal Register)* [Ariz. Rev. Stat ' 12-2293]
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR.528 (*Federal Register)* [Ariz. Rev. Stat. ' 12-2291]
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- Maintain the privacy of your health information
- Provide you with the notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the office manager at 623-933-8289.

If you believe your privacy rights have been violated, you can file a complaint with the office manager or with the secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment and Health Operations (TPO)

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his expectations of the members of your health care team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide subsequent healthcare providers with copies of various reports that should assist him or her in treating you once you've been referred to them for further treatment.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your heath information to our business associate so that they can perform the jobs we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: We may disclose to a family member, other relative, close personal friend or any other person you identify, heath information relevant to that person's involvement in your care or payment related to your care.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof heath information necessary for your health and the health and safety or other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Effective Date: January 1, 2002

THE MAXWELL GROUP
14678 N DEL WEBB BLVD. SUN CITY, AZ 85351-2137
PHONE (623) 933-8289 FAX (623) 933-2596

AUTHORIZATION TO RELEASE RECORDS

Please fill out and send to your previous Primary Care Physician prior to your appointment

Patient Name _____ D.O.B._____

Social Security # _____ Phone _____

Address: _____
(City) (State) (Zip)

FROM DR: **SEND TO:**

NAME NAME

(Address) (Address)

(City, State, Zip) (City, State, Zip)

(Phone, Fax) (Phone, Fax)

Purpose of Release

☐ Specialist (we send) NO charge ☐ Leaving Practice(new PCP,we send) NO charge
☐ Personal/Attorney/Life Insurance (printed) $25 /plus .10per pg/postage ☐ CD $25 plus postage

Information to be Released **(2 years maximum unless requested)** **Method of Delivery**

☐ Office Notes ☐ Colonoscopy ☐ Paper
☐ Laboratory Tests ☐ Mammogram ☐ Disc
☐ Imaging Reports ☐ Dexa Scan ☐ Fax 623-933-2569

I understand this consent is voluntary and that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Revocation must be a written, dated and signed communication. Unless I revoke this authorization in writing, it will remain in effect with no expiration. I understand that my health record may include Behavioral Health Information, Drug/Alcohol information, Sexually Transmitted Disease information, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable disease information. My signature authorizes release of any such information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer protected by the federal HIPAA Privacy Rule.

I may refuse to sign this authorization form. I understand that The Maxwell Group will not condition or deny treatment on my signing this authorization. I understand that I have a right to receive a copy of this authorization.

_____ _____
Patient Signature Date