Review of Systems

Are you currently experiencing any of the following:

Please mark **YES** or **NO** for each

Patient Name: _____ DOB: _____ Date: _____

Date/Year of Last Mammogram: _____

Date/Year of Last Colonoscopy: _____

Y	N	Constitution
		Activity Change
		Appetite Change
		Chills
		Excessive sweating
		Fatigue
		Fever
		Unexpected weight change

Y	N	HENT
		Congestion
		Dental problem
		Drooling
		Ear discharge
		Ear pain
		Facial swelling
		Hearing loss
		Mouth sores
		Nosebleeds
		Postnasal drip
		Rhinorrhea (runny nose)
		Sinus pressure
		Sneezing
		Sore throat
		Ringing in Ears
		Trouble swallowing
		Voice change

Y	N	Eyes
		Eye discharge
		Eye itching
		Eye pain
		Eye redness
		Photophobia (light sensitivity)
		Visual discharge

Y	N	Respiratory
		Apnea
		Chest tightness
		Choking
		Cough
		SOB
		Stridor (noise when breathing)
		Wheezing

Y	N	Cardio
		Chest pain
		Leg swelling
		Palpitations

Y	N	GI
		Abdominal distention (swelling)
		Abdominal pain
		Anal bleeding
		Blood in stool
		Constipation
		Diarrhea
		Nausea
		Rectal pain
		Vomiting

Y	N	Endocrine
		Cold intolerance
		Heat intolerance
		Increased thirst
		Increased hunger
		Increased urination

Y	N	GU
		Difficulty urinating
		Involuntary urination
		Flank pain (side pain)
		Frequency
		Genital sore
		Blood in urine
		Penile discharge
		Penile pain
		Scrotal swelling
		Testicular pain
		Urgency
		Urine decreased

Y	N	Musculoskeletal
		Arthralgias (stiffness)
		Back pain
		Gait problem
		Joint swelling
		Muscle Pain
		Neck pain
		Neck stiffness

Y	N	Skin
		Color Change
		Pallor (paleness)
		Rash
		Wound

Y	N	Allergy/Immunology
		Environmental Allergies
		Food Allergies
		Immunocompromised

Y	N	Neurological
		Dizziness
		Facial asymmetry
		Headaches
		Light headedness
		Numbness
		Seizures
		Speech difficulty
		Syncope (fainting)
		Tremors
		Weakness

Y	N	Hematologic
		Enlarged lymph nodes
		Bruises/bleeds easily

Y	N	Psychiatric
		Agitation
		Behavior problem
		Confusion
		Decrease in Concentration
		Unease (dysphoric mood)
		Hallucinations
		Hyperactive
		Nervous/anxious
		Self-injury
		Sleep Disturbance
		Suicidal Ideas

ARIZONA COMMUNITY SPECIALISTS

MEDICAL HISTORY FORM

Please fill out the form in its entirety if not applicable please mark N/A

Patient's Name_____ DOB_____Age_____**Height**_____**Weight**_____

Reason for your visit today? _____ Referring Doctor_____

Is the reason for visit accident related (provide details):_____

If needed, I consent to the transfusion of a Blood/Blood products: YES_____ NO_____

Have you ever been diagnosed with: **C-Diff** Y___N___ HIV Y___N___ **Hep B** Y____N____ **Hep C** Y____N____

Do you have an active or history of MRSA/VRE infection: YES ____ NO____ Current_____ History of_____

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

MEDICATIONS/SUPPLEMENTS TAKEN REGULARLY	**AND**	**REASON**

MEDICINE/FOOD ALLERGIES	**AND**	**REACTION**

PAST MEDICAL AND SURGICAL HISTORY

DISEASE/ILLNESS	YEAR DIAGNOSED	PROCEDURE/SURGERY	YEAR OF PROCEDURE

FAMILY HISTORY (e.g. cancer, heart disease, diabetes for **maternal/paternal** grandparent, parent, sibling, children)

FAMILY MEMBER	**DISEASE**

TOBACCO USE: ☐ YES ☐ NO ☐ FORMER ☐ Never

Type_____ Years used_____ Units per day_____

VAPING: ☐ YES ☐ NO ☐ Never Frequency_____

ALCOHOL USE: ☐ YES ☐ NO ☐ FORMER ☐ Never: Frequency _____

PHARMACY

NAME

CROSS STREETS

PHONE NUMBER

ARIZONA COMMUNITY SPECIALISTS

PATIENT PAYMENT AND FINANCIAL POLICY

Arizona Community Specialists, PC (ACS) is committed to providing exceptional care and service without exception. We encourage you to understand your insurance benefits, coverage, and your financial responsibility for the care provided by our doctors and providers.

Be sure you understand the following information:

- Insurance plans and benefits vary. Verify ACS services are in-network to avoid additional charges. Call your insurance carrier to ensure you understand your financial obligation for the care you are receiving. Provide secondary insurance information, if applicable, at check-in.
- If you do not have insurance, payment is due at the time of service. Payment plans can be arranged, ask at the front desk for assistance.
- You will need to present a government issued identification (state driver's license, passport, etc.) along with your insurance card, if insured, at every visit. This protects your identity and prevents someone else from using your insurance.
- You will be asked to pay your co-payment, co-insurance, and deductible at the time of check-in. Be prepared to pay the amounts requested. If you are unable to pay at the time of your appointment, we reserve the right to reschedule non-urgent care. Payment plans can be arranged, ask at the front desk.
- Certain procedures or tests may require a higher co-payment amount. Know your benefits and be prepared to pay the required amounts. Payment is due at the time of service.
- Total out-of-pocket requirements are not always known at the time of service. You will be billed for all uncovered expenses incurred and not paid by your insurance plan.
- If you have an unplanned surgical procedure, your insurance may or may not pay for all charges. ACS will contact you AFTER your surgery has been scheduled. Your signature below is your acknowledgment you are responsible to pay the balance upon receipt of the invoice post-surgery. Failure to pay or no payment arrangement made will result in the account going to a collection agency and additional 18% in fees assessed to your account.

Medicare:

- Typically covers 80% of allowed charges.
- You are responsible to pay the 20% not covered.
- Medicare requires an Advanced Beneficiary Notice (ABN) be signed for those treatments or test that may not be covered under Medicare covered treatment or services.

Medicare Replacement Plans:

- Medicare Replacement Plans have varying degrees of coverage.
- Know your plan and your financial obligations for care, co-payments, and deductibles which are not covered and will be your responsibility to pay.

Referrals and Authorization:

- Some insurance plans require a referral and/or authorization for specialty services from your Primary Care Provider (PCP) in order to pay for the services received at ACS.
- You will be responsible to pay for services provided if appropriate referrals or authorizations is not obtained, or if the claim is denied.

Worker's Compensation:

- You are responsible for providing correct billing information from your employer's industrial insurance.
- You are ultimately responsible to pay for the services received but not covered by your employer.

Personal Injury:

- You must provide the appropriate insurance company for billing. If the insurance company does not pay within 60 days, you will be billed and are responsible to pay the total amount on your account.

Motor Vehicle Accidents:

- Care related to a motor vehicle accident will be treated as "private pay". You are responsible to pay for care at the time of service.
- You will receive documentation that you can submit to your insurance company or attorney upon request.

Returned checks: There is a $35 fee for every check that is returned from the bank unpaid for any reason.
Additional fees: There is a $25 fee for completion of FMLA documents payable at the time of your request. We reserve the right to charge for other forms or letters requested on your behalf depending on the complexity of the request.
No show policy: There may be a $35 fee assessed for not providing a 24-hour notice to cancel and/or reschedule an appointment.
Assignment of Benefits: I, the patient, assign the benefits from the insurance carrier (s) to Arizona Community Specialists, PC for the medical/surgical services for which I am entitled.
Release of Information: I authorize Arizona Community Specialists, 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 Specialists, PC of any changes to my address, phone number, insurance plan or coverage.
Non-Payment: ACS uses a collection agency should you fail to comply with our financial policy, which will charge an 18% collection fee.

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 SPECIALISTS, PROVIDER.

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 Specialists, payment and financial policies, please call our Central Billing Office at (520) 750-7160.

ARIZONA COMMUNITY SPECIALISTS

Patient Registration

PATIENT INFORMATION-PLEASE MAKE SURE EVERY LINE IS COMPLETE

Patient Name: (First, Middle Initial, Last) _____

Preferred Name: _____ DOB: _____

Address: _____ Zip: _____

Cell phone: _____ Home: _____

Email address for My Chart Patient Portal: _____

Birth sex: _____ Current Gender: _____ Gender Identity: _____Preferred Pronoun:_____

Marital Status: _____ Spouse's Name: _____

Primary Care Physician: _____PCP Phone Number:_____

Referred By: _____Other Providers Involved in Your Care:_____

Employer: _____ Occupation: _____

Employment status: _____

Emergency Contact:_____ **Phone number:**_____**Relationship:**_____

I prefer to be contacted in the following manner (check all that apply): Appointment reminders will be texted to your cell phone:

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

Pharmacy Name:_____Cross Streets:_____

_____ **(Initials)** ACS providers may prescribe medications electronically. By initialing, you give ACS permission to access your prescribed medications.

INSURANCE INFORMATION-PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST

Primary Insurance: _____ ID: _____ Group: _____

Insurance Company Address:_____

Policy Holder: _____ **DOB**: _____ Relationship to patient: _____
(If other than the patient)

Secondary Insurance: _____ ID: _____ Group: _____

Policy Holder: _____ DOB: _____ Relationship to patient: _____
(If other than the patient)

Date of injury: _____ Do you have AHCCCS? _____ Yes ____ No
(If Workers Comp)

ARIZONA COMMUNITY SPECIALISTS

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 Specialists ("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.

ACS does not discriminate based on race, age, sex, sexual orientation, or ethnicity.

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: _____

I attest that the information provided above is true and accurate. I acknowledge that I have read, signed, and will abide by the Arizona Community Specialists, P.C. "Patient Payment and Financial Policies". I give ACS my consent to access my pharmacy/medication records.

Patient's signature: _____ Date: _____
(Parent/guardian if patient is a minor)

_____

Patient Printed Name

ARIZONA COMMUNITY SURGEONS, PC

https://acssurgeons.com
Concerns about this notice?
Privacy Office Lisa Cummings
lcummings@acssurgeons.com
(520) 750-7255

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/ privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example: We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example: We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: ▪ Preventing disease ▪ Helping with product recalls ▪ Reporting adverse reactions to medications ▪ Reporting suspected abuse, neglect, or domestic violence ▪ Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ▪ For workers' compensation claims ▪ For law enforcement purposes or with a law enforcement official ▪ With health oversight agencies for activities authorized by law ▪ For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

HEALTH CURRENT INFORMATION

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors can access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinical and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared? People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future if the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted use.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from federally assisted substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share the substance abuse treatment records it receives from these programs in two cases.

One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

<u>Your Rights Regarding Secure Electronic Information Sharing</u>

You have the right to:

- Ask for a copy of your health information that is available through Health Current. Contact your healthcare provider and you can get a copy within 30 days.
- Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
- Ask for a list of people who have viewed your information through Health Current. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

- You may "opt out" of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
- **Caution:** If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.
- You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
- **Caution:** If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.
- If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.
- If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective September 23, 2013, updated February 1, 2020.

Privacy Officer: Lisa Cummings lcummings@acssurgeons.com (520) 750-7255

MAP OF LA CHOLLA CORPORATE CENTER