Please Attach with New Patient Packet

- **Driver's License or Identification Card**

- **FRONT and BACK of your Current Insurance Card or Cards.**

Thank You

PRIOLA PRIMARY AND PALLIATIVE CARE

Patient's Name: Date of Birth:

Mailing Address: Gender: ☐ Male ☐ Female

City: State: Zip:

Street Address: ☐ Same as mailing

City: State: Zip:

Home #: Cell #: Work #:

E-Mail Address: Patient Portal Access? ☐ Yes ☐ No

Insurance:

Preferred method of contact? ☐ Home ☐ Cell ☐ Work Message Content: ☐ Brief ☐ Extended

Appointment reminder: ☐ Voice message ☐ Text message Lab results: ☐ Voice message ☐ Text message

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Employment Status: ☐ Retired ☐ Employed full-time ☐ Employed part-time ☐ Self-employed

Employer: Occupation:

Emergency Contact: Relationship: Phone:

Authorization to release information to family/friends or others

I authorize Priola Primary Care to release any information regarding my treatment; including lab results, imaging, medical conditions and medications to the following individuals/entities:

Name: Relationship:

Name: Relationship:

Signature: Date:

Preferred Local Pharmacy:

Mail Order Pharmacy:

Patient Name: _____ HEALTH HISTORY (Confidential)

CURRENT MEDICATIONS

Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medications:

1) _____ 6) _____

2) _____ 7) _____

3) _____ 8) _____

4) _____ 9) _____

5) _____ 10) _____

ALLERGIES

Are you allergic to any prescription medications? ☐ Yes ☐ No

Are you allergic to food/products? ☐ Yes ☐ No

List medications/foods/products to which you are allergic:

What kind of reaction did you have?

1) _____

2) _____

3) _____

4) _____

5) _____

HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

☐ Anemia or blood disorder

☐ Asthma or COPD

☐ Diabetes Type I or Type II

☐ Heart Disease/Heart Attach

☐ Kidney Disease

☐ Cancer Type: _____

☐ Hepatitis Type: _____

☐ Arthritis/Joint Pain

☐ Liver Disease

☐ Pneumonia

☐ Thyroid Disease

☐ GERD/Stomach Ulcers

☐ Stroke or CVA

☐ Hypertension/High Blood Pressure

☐ Rash/Skin Problems

☐ Depression and/or Anxiety

☐ Mental Illness/Dementia

☐ Seizures/Epilepsy

☐ Sexually Transmitted Disease

☐ Other _____

Patient Name: _____

GYN HISTORY (Females Only)

At what age did you begin menstruation? _____

Date of your last menstrual period: _____ How long was your last menstrual period? ____ (# of days)

Are your menstrual periods: ☐ Regular ☐ Irregular How many days between your periods? _____ (# of days)

What was the severity of your last menstrual period? ☐ Average ☐ Light ☐ Heavy

SURGICAL HISTORY (Include dates)

☐ Tonsillectomy _____ ☐ Appendectomy ____ ☐ Heart Bypass/Heart Surgery ____

☐ Gallbladder Surgery ____ ☐ Back/Neck Surgery ____ ☐ Angiogram/Pacemaker/Stent Placement ____

☐ Hernia Repair ____ ☐ Breast Surgery ____ ☐ Skin Cancer Removal ____

☐ Orthopedic Surgery _____ Type: _____ ☐ Other: _____

☐ Hysterectomy/D&C/Uterine Ablation/Tubal Ligation ☐ Other: _____

☐ Colonoscopy/Upper GI ____

HOSPITALIZATIONS HISTORY

Recent hospitalization and reason for admitting: _____

PREVENTIVE SCREENINGS AND IMMUNIZATION HISTORY (most recent date)

Colonoscopy: _____ Flu Shot: _____

Mammogram: _____ Pneumonia Shot: _____

Prostate Exam: _____ Tetanus/Pertussis: _____

Diabetic Eye Exam: _____ Zostavax (shingles): _____

DEXA Scan: _____ Other: _____

DEPRESSION SCREENING: (PHQ2)

Little Interest or pleasure in doing things ☐ No ☐ Yes

Feeling down, depressed or hopeless ☐ No ☐ Yes

HEALTH HISTORY Cont'd
(Confidential)

Patient Name: _____

FAMILY HISTORY

	Alive or Decease	Year of Birth	Alzheimers/ Dementia	Alcoholism/ Drug Addiction	Arthritis	Asthma	Cancer: ____ Type	Diabetes	Heart Disease	High blood pressure	Kidney Disease	Liver Disease	Mental Illness	Stroke	Unknown
Father															
Mother															
Siblings															
Siblings															
Paternal Grandfather															
Paternal Grandmother															
Paternal Uncle															
Paternal Aunt															
Maternal Grandfather															
Maternal Grandmother															
Maternal Uncle															
Maternal Aunt															

SOCIAL HISTORY

Tobacco Use/Smoking	☐ Never ☐ Former (year quit): _____ ☐ Current (year and/ or age started): _____ ☐ Smokeless
Alcohol Use	☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Beer/Wine ☐ Liquor Number of Drinks: _____
Recreational Drug Use	☐ Never ☐ Former ☐ Current (drug name): _____ (date last used): _____
IV/Street Drug Use	☐ Never ☐ Former ☐ Current (drug name): _____ (date last used): _____
Diet	☐ Regular ☐ Low Fat ☐ Low Carb ☐ Low Sugar ☐ Low Sodium ☐ Gluten Free ☐ Vegetarian ☐ Vegan
Caffeine /Energy Drinks	☐ Coffee ☐ Tea ☐ Soda ☐ Entergy Drinks How many Drinks per day: _____
Exercise	Do you exercise 3 or more days a week for 20 mins or more? ☐ Yes ☐ No
Types of Exercise	☐ Walking ☐ Running ☐ Hiking ☐ Cycling/Spinning ☐ Yoga ☐ Aerobic/Cross Fit ☐ Weight Training ☐ Other: _____
Handedness	☐ Right ☐ Left ☐ Ambidextrous
Assisted Devices	☐ Glasses or Contracts ☐ Hearing aids ☐ Dentures ☐ Cane ☐ Walker ☐ Wheelchair
Education	☐ High School ☐ College/Bachelors ☐ Grad School/Masters
Occupation- Current or Previous and/or Hobbies	: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

A2663B 10-04-2005

STARTING JULY 1ST 2022

1. ANY Patients that have a DEDUCTIBLE Will be charged $50.00 at time of service.

2. ANY Patients with CO-PAYS will need to be paid at time of service.

3. ANY Patient with a BALANCE will have to pay at least half at time of service.

   - If unable to or refuse to, you will need to be rescheduled.

Printed Name: _____ DOB: _____

Signature : _____ Date: _____

PATIENT RIGHTS AND RESPONSIBILITIES

We respect your rights as a patient and recognize that you as an individual have unique healthcare needs. Therefore, we respect your personal dignity and want to provide care based upon your individual needs. Not only do you have rights and responsibilities, but this rights and responsibilities also apply to the people who are legally responsible for making your healthcare decisions. These people may include parents of patients under the age of 18, legal guardians and those you have given decision-making responsibility in a Durable Power of Attorney for Health Care.

PATIENT RIGHTS

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
- Patients have the right to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients have the right to access care easily and in a timely fashion.
- Patients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the right to share in developing their plan of care.
- Patients have the right to the delivery of services in a culturally competent manner.
- Patients have the right to information about the organization, its providers, services, and role in the treatment process.
- Patients have the right to information about provider work history and training.
- Patients have the right to information about clinical guidelines used in providing and managing their care.
- Patients have a right to know about advocacy and community groups and prevention services.
- Patients have a right to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients have the right to know about laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.

PATIENT RESPONSIBILITIES

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to give providers the information they need, in order to provide the best possible care.
- Patients have the responsibility to ask their providers questions about their care.
- Patients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to let their provider know about their insurance coverage, and any changes to it.
- Patients have the responsibility to let their provider know about problems with paying fees.
- Patients have the responsibility not to take actions that could harm others.
- Patients have the responsibility to report fraud and abuse.
- Patients have the responsibility to openly report concerns about quality of care.
- Patients have the responsibility to let their provider know about any changes to their contact information (name, address, phone, etc).
- Patients have the right and the responsibility to understand and help develop plans and goals to improve their health.

I have read and understood my rights and responsibilities.

Patient Signature | Printed Name | Date

PRIOLA PRIMARY AND PALLIATIVE CARE

FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Priola Primary and Palliative Care (PPPC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Priola Primary and Palliative Care's Notice of Privacy Practices provides a more complete description of such uses and disclosures.) I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Additionally, I give my consent for Priola Primary and Palliative Care to access information on my prescription history from pharmacy networks, if needed, to reconcile strengths, dosages, or medications I have taken.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Priola Primary and Palliative Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Priola Primary Care, Attn: Privacy Officer at 3105 Clearwater Dr. Ste B, Prescott, AZ 86305

I have the right to request that Priola Primary and Palliative Care restrict how Priola Primary and Palliative Care uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT BILL OF RIGHTS

I have received a copy of the Priola Primary and Palliative Care's Patient Bill of Rights & Responsibilities.

PERMISSION TO RENDER SERVICES/ACKNOWLEDGEMENT OF FINANCIAL POLICY

By presenting for treatment, I hereby employ Priola Primary and Palliative Care to provide medical services to me. I agree to pay for all services rendered on my behalf at the rates established by Priola Primary and Palliative Care or those rates as established by Priola Primary and Palliative Care and my insurance carrier if such a contractual relationship exists. I remain fully responsible for all treatments, services and out-of-pocket expenses incurred on my behalf. I have been given a copy of Priola Primary and Palliative Care's Financial Policy and Procedures and acknowledge my responsibility to notify Priola Primary and Palliative Care of any changes in my insurance plan or status.

I also understand and acknowledge that I am personally responsible to pay Priola Primary and Palliative Care in full for services that my health insurer will not cover due to non-payment of my health insurance premiums.

I have received a copy of Priola Primary and Palliative Care's Financial Policy and Procedures and understand that all bills are due and payable upon presentation. PPPC reserves the right to charge interest on any bills not paid when due from the date thereof at the rate of up to 18% per annum. If a check is not honored upon presentation to the bank for payment, I agree to pay a $30.00 handling fee, which may be charged to my account. If legal action is instituted to collect any amount due, I agree to pay all court costs and reasonable attorney's fees. If my immediate family and I are discharged due to nonpayment on our account, I agree to pay all delinquent balances along with a $30.00 reinstatement fee before being seen again in the clinic.

I understand that Priola Primary and Palliative Care requests 24 hours' notice of cancellation, whenever possible. I agree to notify in advance of my scheduled appointment whenever I am unable to keep it.

INSURANCE ASSIGNMENT OF BENEFITS AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to Priola Primary and Palliative Care at: 3105 Clearwater Dr. Ste B, Prescott, AZ 86305 for any or all medical services furnished which were not paid by me in full at the time services were rendered. I further authorize the release of medical information about me or my insured dependents to my health insurance carrier (s), if applicable, as needed to determine this benefits payable for related services.

If I do not sign this consent, or later revoke it, Priola Primary and Palliative Care reserves the right to deny medical treatment to me.

Patient Signature | Printed Name | Date