Up 2 Par Medical Clinic, reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Up 2 Par Medical Clinic.

_____	_____
Signature of Patient	Date
_____	_____
Name of Patient Printed	Date
_____	_____
Relationship to Patient Representative	Date
_____	_____
Signature of Patient Representative	Date

(Required if the patient is a minor or an adult who is unable to sign this form)

2775 S 8th Ave Yuma, AZ 84364 PH: (928) 341-0700 Fax: (928) 341-0900

24 Hour Cancellation/Reschedule & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Up 2 Par Medical Clinic reserves the right to charge a fee of $50.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled or rescheduled with a 24-hour advance notice.

"No-show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. If your account is sent to collections, 40% of the total bill will be added for collection fees.

Multiple "no-shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name Date

_____

Signature

Financial Responsibility

Verification of eligibility and benefits are conducted every time you have an office visit. However, per your insurance, this is not a guarantee of payment.
A copayment may apply if an illness is evaluated or procedure is performed during a Well Exam.
Please, be advised that you may be subject to a deductible, co-insurance amount or co-payment which we may not be aware of until the claim for the office visit has been processed by your insurance carrier.
Should there be a remaining balance due after your insurance carrier has processed the claim; a statement will be sent to you for payment.
Also, please be advised that failure to provide correct, new or additional insurance information in a timely manner may result in additional financial charges. This includes any private insurance coverage as well as AHCCCS.

In the event that I have failed to pay for the services provided by this office, and the account is placed for collection, I understand and agree that an additional amount equal to 40% of the balance owing at the time the account is placed for collection, will be added to the current balance owing. In addition to a collection fee of 40% of the balanced owed, I agree to pay interest at the rate of (10%) ten percent per annum until the amount owed is paid in full. I further agree to pay all attorneys fees and court costs, necessary to collect this balance.

I have read the above statement and understand my financial responsibility.

_____ _____

Signature of Patient Date

Up 2 Par Medical Clinic

PATIENT INFORMATION

Patient's last name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Mailing address	City	State	Zip

Street address (if same leave blank)	Home Phone	Cell Phone

Birth date	Sex	Social Security no.	Race (circle one)	Preferred Language
/ /	❑ M ❑ F		Hispanic / White / Asian / African American / Indian / Other	

Email address:	Preferred Pharmacy:

Occupation	Employer	Employer phone no.
		( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family (specify)	❑ Friend (specify)	❑ Internet	❑ Other (specify)

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance	❑ Medicare	❑ Blue Cross	❑ AZ Physicians IPA	❑ Health Choice	❑ Cigna

❑ Aetna	❑ Tricare	❑ Self Pay	❑ Other (specify)

Subscriber's name	Subscriber's S.S. no.	Birth date	Subscriber no.	Group no.	Co-payment
		/ /			$

Subscriber's mailing address	City	State	Zip

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other (specify)

Name of secondary insurance (if applicable)	Subscriber's name	Subscriber no.	Group no.

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other (specify)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Up 2 Par Medical Clinic or my insurance company to release any information required to process my claims.

Patient signature *Date*

Health History Questionnaire

Patient Name:_____ **Date:**_____

Current medical problems (i.e. High blood pressure, pain, Diabetes, etc.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current medications (prescribed and over the counter) and supplements

Name of medication	What do you take it for?	Dose/Strength	How often

Personal & Family History

Self	**Family** If checked, which family member	MEDICAL HISTORY: Check all that apply	Additional information: (diagnosis, treatment, etc.)
☐	☐	Abnormal Pap test	
☐	☐	Sexually transmitted infection such as chlamydia, gonorrhea, herpes, syphilis	
☐	☐	Headaches,migraine,headaches	
☐	☐	Mental Health disorder: depression, bipolar	
☐	☐	Thyroid disorder	
☐	☐	Neurological disorder: Seizures, stroke, weakness, numbness, back pain	
☐	☐	Heart disorder: chest pain, heart attack, arrhythmia, congenital defect	
☐	☐	Lung disorder: asthma, chronic bronchitis	
☐	☐	Breast problems or implants	
☐	☐	Liver disorder: hepatitis, gall bladder problems, jaundice	
☐	☐	Stomach, bowel problems, heartburn, GERD	
☐	☐	Kidney or bladder problems	
☐	☐	Blood disorder: anemia, thrombophilia	
☐	☐	Blood transfusion	
☐	☐	Cancer (type of…)	
☐	☐	Diabetes: Type 1, Type 2, diet controlled, pills, insulin	
☐	☐	Birth defect or inherited disorder	
☐	☐	Sleep apnea	

Medication allergies/intolerance: **Type of reaction**

_____ _____
_____ _____
_____ _____
_____ _____

Surgeries:
List any surgeries and dates.

_____ _____
_____ _____
_____ _____
_____ _____

Hospitalizations:
List any hospitalizations, other than for surgeries, and dates.

_____ _____
_____ _____
_____ _____
_____ _____

Social history

Smoker: Y ___ N____ Previous_____
If yes, how many packs per day? _____
How many years did you smoke? _____
When did you quit? _____
Do you drink alcohol? Y____ N____
How many drinks per week? _____ Marital Status: Are you sexually active? Y___ N____ # of sexual partners in the past year_____
Employed? Y____ N____ Retired____ Occupation_____
Any present or past Occupational exposures to dangerous substances?
_____
Recreational drug use? Y____ N____
Specify_____
Married ____ Single _____ Divorced ____ Widowed ____
Do you travel outside the USA? Y____ N____ Where? _____

<u>Immunizations (Vaccines)</u>

Have you had a flu shot this year? Y ___ N ___
Have you had a pneumonia shot ever? Y ___ N ___ How many? _____
Have you had a Tetanus Shot within the last 10 years ? Y ___ N ___
Have you had a booster for whooping cough? Y ___ N ___ Unknown ____
Have you had a shingles shot? Y ___ N ___
Have you had a HPV shot (against cervical cancer)? Y ___ N ___ How many? _____
Have you had a meningitis shot? Y ___ N ____

Preventative Health History

Have you had a colonoscopy? Y__ N__ When was the last one done? _____
Where? _____
Results: Normal ____ Benign polyps ____ Pre-cancerous polyps ____ Cancer ____
Diverticulosis ___ Hemorrhoids____ Unknown _____

Have you had a bone density (DEXA) scan? Y __ N __ When was the last one done?
_____ Where? _____
Results: Normal ____ Osteopenia ____ Osteoporosis ____

Women
Have your had a mammogram? Y ___ N___ When was the last one done?_____
Where? _____
Results: Normal ____ Abnormal ____ What abnormalities where noticed?
_____

Have you had a PAP smear done? Y __ N ___ When was your last PAP smear?
_____ Where? _____
Results: Normal ____ Abnormal ____ What abnormalities where noted?
_____

Men
When was your last PSA (prostatic specific antigen) in blood? _____
Normal _____ Abnormal _____ Unknown _____

_____ _____
Signature Date