Sierra Vista Medical Group

Welcome to Sierra Vista Medical Group

Dear New Patient:

Thank you for allowing us to serve your health care needs. The following information is provided to introduce you to our practice and our practice policies.

We strive to see all patients at their scheduled appointment time. There are times when our schedule is delayed due to caring for an emergency. Please accept our apology in advance should this occur.

We ask that you check in for your appointment on time with needed referrals and copay or coinsurance. If you arrive late or without the needed information, you may be rescheduled. Our office reserves the right to charge a broken appointment fee of $25.00 for any missed appointment without prior notice of cancelation.

We ask that when it is time to have any prescriptions refilled, that you contact your pharmacy 48 hours in advance who will in turn notify your provider. This process will ensure timely attention to all patients' refill needs. For patients requiring a written controlled substance prescription, those requests should be submitted 48 hours in advance and will be written for pick up Monday-Thursday, 8 am-5pm. On call physicians will not provide these prescriptions after hours.

We strive to ensure that each patient has a positive experience when visiting our providers. To this end, please take the time to complete a patient satisfaction survey after your visits.

Thank you for allowing us to be of service.

Sincerely,

The Sierra Vista Medical Group Leadership Team

Sierra Vista Medical Group

Internal Medicine History Form

Date / /	Patient Name	Birthdate / /	Age	Social Security Number

Marital Status:
Single___ Married___ Divorced___ Separated___ Widowed___

Occupation:

PAST MEDICAL HISTORY: **Circle** any of the following diseases or problems you have had.

Cancer	Stroke	Blood Disorder
Cardiac Disease	Lung Disease	Kidney Disease
Diabetes	Mental Illness	Arthritis
Hypertension	Digestive Disease	Other

HOSPITALIZATIONS: List and indicate approximate dates:_____

_____

_____

_____

_____

MEDICATIONS: Please list all your medications, including over the counter and, if applicable, contraceptive medications. Bring them with you to your appointment.

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY

PERSONAL HABITS:

Do you smoke? Yes No Cigarettes Pipe Cigars How long have you been smoking? _____ years.
Do you drink alcohol? Yes No Occasionally Is alcohol a problem for you? _____
Do you exercise? Yes No How often? _____

FAMILY HISTORY: Do you know of any blood relative who has or has had:

	Relationship		Relationship		Relationship
Cancer	_____	Stroke	_____	Blood Disorder	_____
Cardiac Disease	_____	Lung Disease	_____	Kidney Disease	_____
Diabetes	_____	Mental Illness	_____	Arthritis	_____
Hypertension	_____	Digestive Disease	_____	Other	_____

Family Member	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers/Sisters Circle one M F				
M F				
M F				
M F				
M F				
Sons/Daughters				
M F				
M F				
M F				
M F				

Sierra Vista Medical Group

Internal Medicine

Review of Systems

Patient Name: _____

Do you have a concern about?

A. General:

Fever	Yes	No
Chills	Yes	No
Sweats	Yes	No
Appetite changes?	Yes	No
Weight changes?	Yes	No
Excessive worries about your health?	Yes	No
Depression?	Yes	No
The sensation of hearing voices?	Yes	No
The urge to commit suicide?	Yes	No

B. Eyes:

Change in vision?	Yes	No
Eye pain?	Yes	No
Double vision?	Yes	No
Dry eyes?	Yes	No

C. Ear/Nose/Throat:

Change in hearing?	Yes	No
Ear pain?	Yes	No
Hoarseness?	Yes	No
Nosebleeds?	Yes	No
Drainage?	Yes	No

D. Cardiovascular:

Chest pains?	Yes	No
Palpitations?	Yes	No
Shortness of Breath?	Yes	No
Swelling?	Yes	No
Loss of consciousness?	Yes	No
Leg pain with walking?	Yes	No

E. Respiratory:

Cough or bloody sputum?	Yes	No
Shortness of breath?	Yes	No
Wheezing?	Yes	No

F. Gastrointestinal:

Nausea, vomiting or diarrhea?	Yes	No
Changes in bowel habits?	Yes	No
Abdominal pain?	Yes	No
Black or bloody stools?	Yes	No
Heartburn?	Yes	No

G. Genitourinary:

Change in urinary habits?	Yes	No
Frequent nighttime urination?	Yes	No
Incontinence or loss of bladder?	Yes	No

H. Genitourinary/Female:

Vaginal discharge/bleeding?	Yes	No
Menstrual Irregularity?	Yes	No
Menopause?	Yes	No

I. Musculoskeletal:

Back pain?	Yes	No
Joint pain or swelling?	Yes	No
Muscular weakness?	Yes	No

J. Skin:

Itching?	Yes	No
Dry skin?	Yes	No
Worrisome spots?	Yes	No
Color changes?	Yes	No

K. Neurologic:

Weakness in a portion of your body?	Yes	No
Numbness or tingling?	Yes	No
History of seizures?	Yes	No

L. Endocrine:

Cold intolerance?	Yes	No
Heat intolerance?	Yes	No
Hot flashes?	Yes	No
Excessive thirst?	Yes	No

M. Hematology/Blood:

History of anemia?	Yes	No
Easy bruising?	Yes	No
Enlarged glands?	Yes	No

N. Allergies:

Hay fever?	Yes	No
Frequent infections?	Yes	No
Hives?	Yes	No

ALLERGIES:

Are you allergic to any medications? Yes No

If yes, please list medications and the reaction (s) you had to them:

Describe any other allergies you have: _____

Sierra Vista Medical Group

Patient Name: _____ Date of Birth: _____

Consent to Treatment: I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of SVMG. I may refuse or withdraw consent for treatment before treatment is rendered.

Payment Policy: I understand that I am financially responsible for all charges, co-payments and deductibles remaining after insurance payments, and all charges not covered by my insurance company (ies), Medicare or third party payor.

Assignment of Benefits: I assign to the treating physician of SVMG. all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

Privacy Policy: I hereby acknowledge that I have received the Notice of Privacy Practices for SVMG.

Authorization for Release of Medical Information: I authorize SVMG to release medical information acquired in the course of my, or the above named patient, examination or treatment necessary to process all claims.

_____ _____

Patient or Guardian Signature Date

I authorize that messages may be left for the patient about appointment reminders and/or medical information regarding patient care:

At work ____ On home answering machine ____ With spouse or other family member ____

Initial Initial Initial

On a cell phone____ Number of cell phone_____ Initial

I authorize disclosure of my medical information and may speak to the following person(s):

Name _____ Relationship _____Phone #_____

Name _____ Relationship_____Phone #_____

Name _____ Relationship_____Phone # _____

I may revoke consent for any or all of the above initialed items at any time in writing. I certify that all information provided to SVMG is correct.

_____ _____

Patient or Guardian Signature Date

Consent for Medical Treatment

I/we voluntarily consent to medical treatment and diagnostic procedures provided by SVMG and its associated physicians, clinicians and other personnel. I/we may refuse or withdraw consent for treatment before treatment is initiated. I/we consent to the testing for infectious diseases, such as, but not limited to syphilis, AIDS, hepatitis and testing for drugs if deemed advisable by my physician. I/we am/are aware that the practice of medicine and surgery is not an exact science and I/we acknowledge that no guarantees have been made as to the result of treatments or examinations

Assignment of Insurance Benefits

I/we guarantee payment of all charges made for or on account of the patient and I/we assign our rights in any insurance benefits or other funding to the physician and SVMG. I/we understand that I/we am/are responsible for any charges not covered by insurance or other forms of benefits. I/we understand that SVMG can obtain my/our credit report for review in collection of this debt. In the event that this account is placed with a collection agency or attorney for collection or collected, I/we shall pay all collections fees and cost, including reasonable attorney's fees. For Medicare beneficiaries: I/we have provided all necessary information for proper assignment of Medicare benefits.

_____ _____

Signature of patient or responsible adult Date

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PATIENT

Patient name (Last, First, M.I.)	Gender	Date of Birth	Age	Marital Status
	M or F			S M D W

Mailing Address: City State Zip Code

Street Address *(if different)*:

Social Security #	Home Phone	Cell Phone	Work Phone

Contact Preference: (circle one)

Home phone Cell phone Work phone Mail Email

Email Address

Race: *(Optional)*

_____White/Caucasian _____Black/African American
_____American Indian _____Other (Specify) _____

Ethnicity: *(Optional)*

_____ Mexican _____ Not Hispanic or Latino
_____ Hispanic or Latino/Spanish _____ Latin American/Latin,Latino
_____ Puerto Rican _____ Central American _____ Spaniard
_____ South American _____ Dominican _____ Cuban

Language Preference	Primary Care Physician	HOW DID YOU HEAR ABOUT US?

Contact name if different from patient — Phone

Person to notify in case of EMERGENCY — Relationship — Phone

Person RESPONSIBLE FOR PAYMENT of services — Address

Social Security #: — Date of Birth — Phone

GUARDIAN

Parent/Guardian Name	Relationship to Child:	Non-Custodial Name	Home Phone

Home Address	Home Address	Work/Cell Phone

INSURANCE

PRIMARY Insurance Name			**SECONDARY** Insurance Name		
Policy Holder's Name		Date of Birth	Policy Holder's Name		Date of Birth
Policy Holder's Address			Policy Holder's Address		
Policy ID # - Suffix #		Group #	Policy ID # - Suffix #		Group #
Group Name		Relationship to Patient	Group Name		Relationship to Patient
Social Security #	Subscriber Suffix #	Effective Date	Social Security #	Subscriber Suffix #	Effective Date

NOTE: ***For Treatment Purposes*** – If any special Parental or Custodial relationships exist, please describe below.

Please bring paperwork with you a day prior or the day of your appointment.

What Pharmacy do you use? _____

Home Health? _____

Referring Physician? _____

Please bring a current list of medications at each visit.

Sierra Vista Medical Group

Acknowledgement of Medication Risks

Medications are drugs. They are prescribed because of their intended benefit. However all drugs may cause unwanted side effects. Fortunately, most patients experience no side effects or minor side effects. Medication side effects can occur with the start, dosage change and or cessation of a medication.

Medication side effects can range from minor to severe. These side effects can even result in death and/or serious problems in extreme cases. Fortunately, side effects are rarely life threatening. The doctor will inform you of the most likely and serious side effects when he starts you on the medication.

Medication can also have very serious interactions with other medications. It is very important that you keep all your doctors informed of all current medications.

There are numerous possible rare and usually mild side effects to medications. When your prescription is filled your pharmacist should give you a printout about the medication including possible side effects. These can include bone thinning, blood abnormalities, rash, and liver dysfunction.

Your likelihood of having side effects may be related to your age, weight, sex, disease, medical condition and other drugs you are taking.

Pregnancy is a unique condition in that most medications can affect the normal course of development of the embryo/fetus. Many women are not aware of their pregnancy in its early stages.

Unfortunately, this is when the embryo/fetus is most vulnerable to harm. This harm can be extreme resulting in the loss of the pregnancy or fetus malformations resulting in permanent birth defects.

Therefore it is essential that you tell the doctor if there is any possibility of pregnancy. This includes any changes in that risk of pregnancy, at any time during treatment by your provider.

Changes in medications prescribed by other physicians while under the care of your provider:

1. If you are having suspected medication side effects you should talk to provider or the nurse.
2. Do not stop taking your medication without talking to your physician first.
3. If you think you are having a serious reaction to your medication call 911 or go to the local emergency room.

I have read the above statement of risk and understand the risks of taking medications. I agree to follow its conditions.

Your provider may withhold treatment if you do not agree.

If you have any questions about any of the above, please discuss them with your provider or the nurse.

_____	_____	_____
Signature of patient or guardian	Date of Birth	Date

Sierra Vista Medical Group

Authorization for Release of Protected Health Information (PHI)

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via: fax, E-mail, Internet, or Data Transfer System. _____ (please initial)

I understand that my prescriptions will be electronically transmitted by my physician or his/her staff to my pharmacy. Additionally, my physician or his/her staff may also receive a complete active medication list from pharmacy. _____ (please initial)

I understand that SVMG cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or the SVMG Privacy Officer.

Signature: _____ Date :_____

Sierra Vista Medical Group

Patients' Rights and Responsibilities

As a patient I have the right:

- To know about my rights and to have my rights respected by the clinic and people who work there. I have a right to know about hospital rules that affect me and my treatment.
- To be called by the name I like and to know the names and jobs of people caring for me.
- To communicate with people taking care of me in a language I can understand.
- To have the same choice and respect no matter what race, color, belief, religion, disability, age or sex I am. I will get the same care even though I might be disabled or come from another country. I will be treated the same as anyone else even if I am unable to pay for my care.
- To have thoughtful, kind, and considerate care given to me in a safe place. I have a right to be free from any kind of abuse or neglect.
- To make choices about my care.
- To talk with my doctor to learn about my illness or injury. I have the right to read papers that they give me to make it clearer.
- To talk with my doctor about the treatment choices I have and what might happen if I choose each one. Then I can decide to give or not give my ok to have care. This is called "informed consent."
- To know if my care has turned out different than what I was told might happen.
- To decide which treatments I want or do not want as long as my choice is allowed by law.
- To have care that is appropriate for me.
- To have my beliefs and way of life thought about when planning for my care.
- To write down what care I want in case I cannot tell anyone what I want later. These pieces of paper are called "advanced directives."
- To be able to see and read my medical record. I will need to ask to see my records and give the staff enough time to get the information ready for me.
- To have my information shared only when it is needed to help me. This information can be shared with my family if they are involved in my care. Those taking care of me will follow a law called "HIPAA" to make sure that information about me is kept private. These rights are described in greater detail in the practices' Notice of Privacy Practices.
- To privacy and dignity. I have the right to have my body seen or touched only when it is needed to help me.
- To know how much I will need to pay the clinic for my care.
- To complain about what I don't like.
- To not be subject to abuse, neglect, exploitation, coercion, manipulation, sexual abuse/assault, seclusion and freedom from restraints or retaliation if a complaint is submitted to the department.

As a patient, I have the responsibility:

- To tell the people taking care of me about my health.
- I need to tell them about why I am here now.
- I need to tell them about the other times I have been seen.
- I need to tell them about what diseases or illnesses I have right now and have had in the past.
- I need to tell them about the medicines I am taking – medicines from the doctor, from the store, vitamins, herbals, or any other drugs. I need to remember the names of the medicines, how much I take and when I take them.
- To ask questions if I don't understand something.
- To talk to the people taking care of me. I should tell them if I am not sure I can do all of the things that I have been asked to do. They might be able to change the plan so that it works better for me. If I choose not to follow the plan, I will be told what can happen.
- To be responsible for what happens when I do not follow the plans that have been set for my care.
- To follow the clinic's rules for how I should behave.
- To arrange with the clinic a way to pay for my care. I am responsible for sticking to that payment plan.

Complaints and Grievances:

Should you have a concern about your rights as a patient or the care you've received at Sierra Vista Medical Group, you may file a complaint immediately with the Director of Practice Management at (520) 263-3970. Should your complaint not be resolved here, a grievance may be filed directly with:

Arizona Department of Health Services
Division of Licensing Services
150 N. 18th Ave
Phoenix, AZ 85007
Phone# (602) 364-3030

Fee schedule and/or the Arizona Department of Health Services State inspection report are available upon request. Please see any Sierra Vista Medical Group staff member.

Patient Signature	Print Name	DOB:	Date

Sierra Vista Medical Group

RegionalCare HOSPITAL PARTNERS

SIERRA VISTA MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

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.**

You have the right to obtain a paper copy of this Notice upon request.

This Notice describes the privacy practices of SIERRA VISTA MEDICAL GROUP and the physicians who provide services to patients at this Clinic.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, Treatment, and related medical information. Your Health Information also includes Payment, billing, and insurance information.

How We Use Your Patient Health Information

We use Health Information about you for Treatment, to obtain Payment, and for Health Care Operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your Health Information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other Health Care Providers who are participating in your Treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your Health Information for Payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of Treatment. We will submit bills and maintain records of Payments from your Health Plan. If you have a legal claim against a third party for causing your injuries, we may file a Facility lien in court to collect Payment from them.

Health Care Operations: We will use and disclose your Health Information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of Treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about Treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable Health Information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out Health Information without your permission for the following purposes:

- Required by Law: We may be required by Law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities*: As Required by Law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- *Health oversight*: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- *Judicial and administrative proceedings*: We may disclose information in response to an appropriate subpoena or court order.
- *Law enforcement purposes*: Subject to certain restrictions, we may disclose information Required by Law Enforcement Officials.
- *Deaths*: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- *Serious threat to health or safety*: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- *Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to Correctional Institutions or for national security purposes.
- *Research:* We may use or disclose information for approved medical Research.
- *Workers Compensation*: We may release information about you to workers compensation agencies and your employer to provide benefits for work-related injuries or illness.
- *Fundraising:* We may contact you, or allow an institutionally-related foundation to contact you, for fundraising purposes. You have the right to opt out of receiving any fundraising communications.

We may also ask if we can disclose limited information about you to clergy or include it in the Facility directory. Under limited circumstances, we may disclose information to notify or locate your relatives or to assist disaster relief agencies. Most uses and disclosures of psychotherapy notes, uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information will only be made with your written authorization. In any other situation not described in this Notice, we will ask for your written authorization before using or disclosing any identifiable Health Information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and Disclosures.

Individual Rights

You have the following rights with regard to your Health Information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: The Facility is not required to grant a request for restrictions in all circumstances. However, the Facility must agree to a request for a restriction on the Disclosure of Protected Health Information to a Health Plan, or a Business Associate of a Health Plan, if the Disclosure is for the purposes or carrying out Payment or Health Care operation and is not otherwise Required by Law; and the Facility is paid out of pocket in full. In regards to other requests, restrictions will be granted only as follows: (a) it is the facility's policy not to agree to any restrictions on uses or Disclosures for Treatment or Health Care Operations, except as stated above. The Privacy Officer must approve any exceptions in writing; (b) the facility is not allowed to grant requests to restrict Disclosures required for public health, law enforcement, or to comply with any other laws or regulations.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your Health Information. There may be a charge for the copies based on state established rates.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed Health Information about you.

Our Legal Duty

We are Required by Law to protect and maintain the privacy of your Health Information, to provide this Notice about our legal duties and privacy practices regarding Protected Health Information, to notify you of any breach of your Health Information that we are required by law to report, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact the Facility Privacy Officer at: **(520) 417-3527**, or HIPAA@svrhc.org.