Fountains Family Care, P.C.
Dr. Richard Le, DO
Phone: 480-726-6632
Fax: 480-726-3868

Patient Intake Form

Name:_____ Gender:_____ Age:_____ DOB:_____

Current Medications: (use back of page if needed)

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Name:_____ Dose:_____ Frequency:_____

Allergies:

Name: _____ **Reaction:**_____
Name: _____ **Reaction:**_____

Past Medical History:

__Cancer
__Diabetes
__Heart Disease
__Hepatitis A, B, or C
__High Blood Pressure
__High Cholesterol
__Other _____

Hospitalizations/Surgeries:

Reason:_____ Date:_____
Reason:_____ Date:_____
Reason:_____ Date:_____

Family History:

__Cancer
__Diabetes
__Heart Disease
__Hepatitis
__Other _____

Women Only:

Number of Pregnancies _____
Number of Living Children ___
Date of last Pap Smear _____
Date of last Mammogram ____

Social History:

-Are you sexually active? __Yes __No Number of partners in the last year? ___
-Do you wish to be checked for STDs? __Yes __No
-What is your occupation? __Work __Student Type of work:_____
-Have you ever smoked? __Yes __No # of years: ____ Packs per day: ____
-Do you smoke now? __Yes __No
-Do you use recreational drugs? __Yes __No
-How much alcohol do you drink in one week? _____
-How much caffeine do you drink in one day? _____
-How Often do you exercise?_____

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Patient Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone:_____ Other Phone:_____

Marital Status: __Married __Single __Child Sex: _____

DOB: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Work Address: _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Parent/Guardian Information (If under the age of 18)

Parent/Guardian Name: _____

Relationship to child: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone:_____ Other Phone:_____

Sex: ____ DOB: _____Social Security Number: _____

Employer: _____ Occupation: _____

Work Address: _____

Pharmacy

Name: _____ Address: _____

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Insurance Information

Primary Insurance (subscriber): _____

Insurance company: _____

Relationship to patient: _____ DOB: _____

Subscriber ID Number: _____

Subscriber Employer or Plan Sponsor: _____

Group Number: _____

Additional(secondary) Insurance:

Relationship to Patient: _____ DOB: _____

Subscriber ID: _____

Subscriber Employer or Plan Sponsor: _____

Group Number: _____

Secondary Insured (Subscriber): _____

Insurance Company: _____

Authorization to bill insurance
I authorize my insurance company to pay Fountains Family Care P.C. all insurance benefits otherwise payable to me for services rendered.

Name: _____ Signature:_____ Date: _____

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Acknowledgement of Receipt of Our Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Fountains Family Care P.C. Notice of Privacy Practices, I have therefore been advised of how health information about me may be used and disclosed by Fountains Family Care P.C. I have also been informed how I may obtain access to and control this information.

Print Name of Patient or Personal Representative: _____

Signature of Patient or Personal Representative: _____

Date: _____

Please list who you want to have access to your pertinent medical information. (i.e. family member, spouse, significant other)

_____
_____
_____
_____

May we leave a message on your answering machine? __Yes __No

Preferred method of contact: __Home __Cell __Work

Phone Numbers:
Home: _____
Cell: _____
Work: _____

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Financial Policy

-It is your responsibility to provide us with your most current insurance information
-If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
-We must emphasize that as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
-We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
-Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment however, is due in full at the time of service.
-Co-Payments, Co-Insurance and/or Deductibles are due at the time of service. We will estimate the amount you owe based on information we received from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim-regardless of our estimation.
-**It is your responsibility to provide us with your most current billing information.**
-You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
-We will send a statement (to the billing address you provide) notifying you of any balances you may owe, If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after Receipt of the initial statement.
-**Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a 3% monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
-If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
-If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Fountains Family Care P.C. Failure to accept this certified letter (and/or pick it up at the post office) serves as notice of termination of services.
-In the event you submit payment by check and the bank returns the check unpaid for any reasons, we will add $25 to your original balance. In addition, we may seek all additional legal remedies provided to us under Arizona law.
-We may charge you a "No Show" fee of $25 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment. 3 or more No Shows in a one year time frame may result in you being discharged from the practice.
-Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Full payment is due at the time of service. We accept cash, checks and credit cards. By signing this, I attest that I have read and understood this Financial Policy.

WOULD LIKE ACCOUNT STATEMENTS(circle one): MAILED or EMAIL (email address below)

Email: _____

Patient Name: _____ DOB: _____

Printed Name of Responsible Party (if different) : _____Date: _____

Signature of Responsible Party: _____

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Authorization to Release Medical Information

This form is to request records from any *other* health care provider(s). If you have any pertinent records please fill out that office's info below.

If you have no records you wish to request please fill out the name/signature on the bottom should our office need to request any future records that are not sent to us.
(*)Minimally we will need the doctor's or office's name and phone number

*To:_____

*Office Phone:_____Fax:_____

Office Address:_____

This information will be used for the purpose of:

- ❏ Legal
- ❏ Continued Care
- ❏ Insurance
- ❏ Workman's Compensation
- ❏ Personal
- ❏ Other_____

Please send patient's medical notes, lab results, imaging reports, etc

- ❏ Full records
- ❏ Specifically:_____

I understand that I have a right to revoke the authorization at any time. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date:_____

If I fail to specify an expiration date, this authorization will expire in one year.

Name:_____ DOB:_____

Signature:_____ Date:_____

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Wellness/Physical Exam
Financial Agreement:

Insurance concerns, requirements and coverage are ever changing. We are making every effort to be in compliance and to reduce payment denials before they occur. Your insurance plan MAY OR MAY NOT - cover routine preventative services.

We are legally obligated to assign procedurę codes based on the services provided to you, whether it is a wellness/physical or a visit to take care of problems or both. We cannot change the coding later to cause the insurance to pay for a non-covered service.

Based on the kind of coverage you have, some or all of this cost may have to be billed to you.

Please keep in mind that while the appointment may be just for a physical or just for problems, if both; kinds of services are provided during a visit, then both services may be billed. If both services are billed; you may be responsible for paying a co-payment for each service, depending on your insurance coverage.

Lab fees are additional fees and are billed out separately. **Please inform the back office and the phlebotomist if your Insurance requires the use of a lab other than Sonora Quest.**

Patient's Printed Name: _____ Date:_____

Patient's Signature: _____

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Advance Directive

To my family, my physician, my clergy, my substitute decision maker in the Durable Power of Attorney:

I, _____, being of sound mind, make this statement as an indication of my choice of medical care and as a directive to be followed if I become unable to participate in decisions regarding my health care. These instructions reflect my commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only to prolong the process of my dying if I should be in an incurable or irreversible physical condition with no reasonable expectation of recovery.

These instructions apply if I am: (a) in a terminal condition; or (b) permanently unconscious; or (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding and withdrawing treatment.

If I am in any one of the conditions described above, I have indicated my wishes in regard to the following forms of treatment: (Please check your choices)

Cardiac Resuscitation:	I Do Want: (__)	I Do Not Want: (__)
Mechanical Respiration:	I Do Want: (__)	I Do Not Want: (__)
Feeding Tubes:	I Do Want: (__)	I Do Not Want: (__)
Kidney Dialysis:	I Do Want: (__)	I Do Not Want: (__)
Chemotherapy:	I Do Want: (__)	I Do Not Want: (__)
Antibiotics:	I Do Want: (__)	I Do Not Want: (__)
Intravenous Fluids:	I Do Want: (__)	I Do Not Want: (__)

These directives express my right to refuse treatment and they are instructions to my substitute decision maker as constituted in the Durable Power Of Attorney instrument. I intend that my instructions be carried out unless I have rescinded them in a new written declaration or by a clear oral expression that I have changed my mind.

Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Witness: My designated decision maker is _____.
Whose address is: _____. Phone:_____

The standard operating procedures of most healthcare facilities assume that you would want life-sustaining procedures unless you indicate otherwise.