TOTAL PRIMARY CARE

Patient Registration Form

Today's Date: _____

Patient Information:

Last_____First_____ Middle _____

Date of Birth: _____ Age: _____ Sex: M_____ F_____

Home address: _____

City:_____ State:_____ Zip Code:_____

Home phone: _____Cell: _____ Email: _____

Occupation: _____ Marital Status: M_____ S_____W_____

Employer: _____Employer phone: _____

Insurance Information:

Name of Subscriber: _____ DOB: _____ Phone#: _____

Name of Insured: _____ Relationship to Subscriber: _____

Primary Ins Carrier: _____ Policy #: _____ Group #: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Emergency Contact:

Name of local friend or relative not living with you: _____

Relationship to patient: _____ Home# _____ Cell# _____

Pharmacy Information:

Name _____

Address_____

City_____ State_____ Zip code_____

Phone #_____

Total Primary Care
9188 E San Salvador Dr
Suite 201
Scottsdale, AZ 85258
(480) 305-5640

PATIENT INTAKE: MEDICAL HISTORY

Current or past medical conditions (check all that apply)
If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**

( ) Asthma/respiratory ( ) Cardiovascular (heart attack, high cholesterol, angina)

( ) Hypertension ( ) Epilepsy or seizure disorder ( ) Gstrointestinal disease

( ) Head trauma ( ) HIV/AIDS ( ) Diabetes

( ) Liver problems ( ) STDs ( ) Thyroid disease

Other (Please describe) _____

_____

Have you ever had **surgery** or been **hospitalized**? (Please describe) _____

_____

Have you or a family member ever been diagnosed with any **psychiatric illness**? (Please describe)

_____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason _____

Medication(s) and dates of use _____ Why stopped _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 250mg 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

_____

_____

Please list all current **herbal medicines**, **vitamin supplements**, etc. and how often you take them

_____

Please list any **medication allergies** you have

_____

Tobacco use: Now? ( ) N ( ) Y In the past? ( ) N ( ) Y

How many per day on average? _____ For how many years? _____

Have you ever been **treated for substance misuse**? ( ) N (Please describe when, where and for how long)

_____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine							
Cocaine							
Methamphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Opioids							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							

Did you ever stop using any of the above because of dependence? ( ) N (Please list) _____

_____

_____

What was your longest period of abstinence? _____

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PATIENT INTAKE: SOCIAL/FAMILY HISTORY

Patient Name _____

(Circle one) Married Single Long-term relationship Divorced/Separated

Years married/ in long-term relationship _____Times Married _____Times Divorced _____

Children? ( ) N ( ) Y Current ages (list) _____

Residing with you? ( ) N ( ) Y If no, where? _____

Where are you currently living? _____

Do you have family nearby? ( ) N (Please describe) _____

Education (check most recent degree):

( ) Graduate school ( ) College ( ) Professional or Vocational School

( ) High School Grade _____

Are you currently employed? ( ) N Where (if "no," where were you last employed?) _____

What type of work do/did you do? _____ How long have/did you work (ed) there? _____

Have you ever been arrested or convicted? ( ) N

( ) DWI ( ) Drug-related ( ) Domestic violence ( ) Other

Have you ever been abused? ( ) N

( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally ( ) Emotionally

Have you ever attended:

AA ( ) Current ( ) Past **NA** ( ) Current ( ) Past **CA** ( ) Current ( ) Past

ACOA ( ) Current ( ) Past **OA** ( ) Current ( ) Past

If you are not currently attending meetings, what factors led you to stop? _____

Have you ever been in counseling or therapy? Y N (Please describe) _____

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PATIENT TREATMENT CONTRACT

Patient Name _____ Date _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.

2. I agree to adhere to all other office and financial policies outlined by this office.

3. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

4. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.

5. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.

6. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost or stolen.

7. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.

8. I understand that mixing buprenorphine with other medications, especially alcohol or benzodiazepines (e.g. Valium, Klonopin, or Xanax), can be dangerous, especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses.

9. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

10. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling, peer support meetings or other psychosocial support as discussed and agreed upon with my doctor and specified in my treatment plan.

11. I give consent for my treating physician to speak with my behavioral health specialist and/or other physicians and health care providers as needed for coordination of care.

12. I agree to abstain from all illicit substances.

13. I agree to provide random and/or scheduled urine samples for the purpose of drug screening. Your insurance company may or may not cover the cost of these screenings (usually depends on if you have met your deductible). Please be aware that if your insurance company does not cover the cost of these screenings, that you will be responsible for payment.

14. I understand that violations of the above may be grounds for termination of treatment.

_____ Date _____

Patient Signature

TOTAL PRIMARY CARE OFFICE POLICIES

Thank you for choosing Total Primary Care as your primary care specialist. We are committed to providing the finest personalized and professional care possible for our patients. We hope the following information will help answer some of your questions and help you understand how our office operates.

Office Hours
Monday through Thursday 8:30 am to 4:30 pm/Friday 8:30 am - 3:30 pm
We are closed for lunch from 12 to 1 pm M-Th.

Scheduling Appointments
Appointments can be scheduled by phone, in person at the office, or via on-line request. We ask that you arrive 15 minutes before your scheduled appointment. Patients arriving late for their appointment may be rescheduled and will be subject to a $75 cancellation fee so please contact the office ahead of time if you cannot make your appointment on time.

Cancellation Policy
We realize patients may need to change their appointments; however, **we require 1 full business day notification** of cancellation for appointments so we may offer that time to another patient. If you fail to cancel, you will be billed the cancellation fee.

After Hours
Under no circumstances will refill requests be processed during non-office hours. All refill requests should be made prior to noon on Fridays or prior to holidays. Prescription refills, appointment scheduling, and lab/test results will be handled only during routine office hours.

Dr. Ahmann does not attempt to make diagnoses during non-business hours. We recommend utilizing your local urgent care facility for minor emergencies during non-office hours. If you have a life-threatening emergency, call 911 or go immediately to the nearest emergency room.

Medication Refills
Please allow at least 2 business days to process refills. Please take the **"no refills"** message on the prescription bottle as a reminder to schedule your next office visit. Please understand that this policy is for your safety and in your best interest. Some medications require laboratory monitoring and some require more frequent visits (such as controlled substances). We care enough to be sure that you are being treated properly for your ongoing medical needs.

Medical Forms
There will be a fee charged for filling out a variety of health related forms. The fee will be $25.00 for up to 3 pages and $5.00 per page thereafter. Forms cannot be filled out while you wait. A visit with the Dr. may be required.

Patient Signature: _____

TOTAL PRIMARY CARE FINANCIAL POLICIES

Thank you for choosing TPC. We are committed to providing you with quality and affordable health care. The following is a summary of our financial policies.

FORMS OF PAYMENT: We accept ***most major credit cards*** or ***cash***. We **DO NOT ACCEPT PERSONAL CHECKS.**

INSURANCE: We participate in most insurance plans, including Medicare, but not currently Medicaid. It is your responsibility alone to determine whether we are contracted with your insurance company and your plan. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we are contracted, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your insurance eligibility.

CO-PAYMENTS AND DEDUCTIBLES: All co-pays and/or deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

NON-COVERED SERVICES: *Please be aware that some or maybe all of the services that you receive may not be covered* or considered reasonable or necessary by Medicare or other insurers*. It is the patient's responsibility to pay for these services either at the time of service or upon receipt of an invoice sent to you from TPC.*

PROOF OF INSURANCE: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and a current, valid insurance card or information in order to verify insurance eligibility and benefits. If you do not provide us with current and correct insurance information in a timely manner then you may be responsible for the balance of the claim.

CLAIMS SUBMISSION: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that *the balance of your claim is your responsibility whether or not your insurance company accepts your claim*. Your insurance benefit is a private contract between you and the insurance company and TPC is not a part of that contract.

COVERAGE CHANGES: If your insurance changes, please notify us before your next visit so we can make the appropriate changes. This will help you receive the maximum insurance benefit as well as assist you in getting your claims paid promptly.

NONPAYMENT: If your account is more than 60 days past due, you will receive a letter stating that you have 10 days to pay the full amount. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged as patients from this practice. You will be responsible for any and all legal, collection, and late fees. If this is to occur, you will be notified by mail

that you have 30 days to find alternate medical care. During that 30-day period, Dr. Ahmann will only be able to treat you or your family members on a ***cash or credit card only*** basis for those services rendered.

MISSED APPOINTMENTS: We require at least **1 full business day** of notice if you are unable to make your scheduled appointment. You will be charged **$75.00** if we are not notified of the cancellation within that time frame.

TPC is committed to providing the best service for all of our patients. Our prices are representative of the usual and customary charges for our area. Thank you for taking the time to read and understand our payment policy. Please feel free to ask us any questions or to share any concerns you may have.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

Signature of Patient: _____Date:_____

Signature of responsible party: _____Date:_____

TOTAL PRIMARY CARE

NOTICE OF PRIVACY POLICIES (HIPPA)

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms of that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Except as otherwise permitted or required as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

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

_____ _____

Patient Signature Date

I authorize Total Primary Care to use and disclose my protected health information to the following person (people): _____, _____

_____ _____

Patient Signature Date