WRIGHT FAMILY MEDICINE PATIENT PACKET

PATIENT INFORMATION Please print clearly Today's Date:_____

Patient Last Name:_____ First Name:_____ Middle Initial:_____

DOB:_____ Gender: ☐M ☐F Email for Patient Portal:_____

Address:_____

Best Phone:_____ Secondary Phone:_____

Language Preference_____ Social Security#:_____ Driver's License#:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

Patient Employer:_____ Occupation:_____

Pharmacy Name:_____ Pharmacy Phone:_____

Pharmacy Address or Cross Streets:_____

PRIMARY INSURANCE INFORMATION

If you do not have insurance, please circle: SELF-PAY

Insurance Company:_____ Insurance Phone:_____

Insurance Address:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy Holder Social Security #:_____ Policy Holder Phone:_____

Policy Holder Email:_____

Policy Holder Address:_____

Policy Holder Employer:_____ Policy Holder Relationship to Patient:_____

ID/Subscriber #:_____ Group#_____

SECONDARY INSURANCE INFORMATION

Insurance Company:_____ Insurance Phone:_____

Insurance Address:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Policy Holder Social Security #:_____ Policy Holder Phone:_____

Policy Holder Email:_____

Policy Holder Address:_____

Policy Holder Employer:_____ Policy Holder Relationship to Patient:_____

ID/Subscriber #:_____ Group#_____

HEALTH HISTORY INFORMATION Patient Name:_____

Medications

_____ _____

_____ _____

_____ _____

_____ _____

Allergies_____

Screening

Colonoscopy	Y ☐	N ☐	Date:_____	Tetanus	Y ☐	N ☐	Date:_____
Dexa	Y ☐	N ☐	Date:_____	Influenza	Y ☐	N ☐	Date:_____
Pap	Y ☐	N ☐	Date:_____	Pneumonia-13	Y ☐	N ☐	Date:_____
Mammogram	Y ☐	N ☐	Date:_____	Pneumonia-23	Y ☐	N ☐	Date:_____
Shingles	Y ☐	N ☐	Date:_____				

Immunizations

Social History

Tobacco	Y ☐	N ☐	Quantity	Quit ☐
Alcohol	Y ☐	N ☐	Quantity	Quit ☐
Illegal Drug Use	Y ☐	N ☐	If yes, what drugs:_____	

Last Menstrual Period Date:_____

Family History

Heart Disease, Diabetes, High Blood Pressure, High Cholesterol

Father _____

Mother _____

Siblings _____

Other Relatives _____

Patient Past Medical History

Heart Disease, Diabetes, High Blood Pressure, High Cholesterol, Other

_____ _____

_____ _____

Surgical History

_____ _____

_____ _____

WRIGHT FAMILY MEDICINE - Caring for body, mind and spirit

NEW PATIENT CONTRACT

Agreement to Adhere: I agree to adhere to all the policies stated within the Wright Family Medicine Patient Packet.

Appointments: I understand that clinical time of healthcare providers is scheduled by appointment only. It is best to arrive 15 minutes early to my appointment. If my appointment cannot by kept, I will notify my provider at least 24 hours in advance. It is office policy to assess a $25.00 fee for any missed appointment without giving a 24 hour notice. This fee will not be covered by insurance and must be paid prior to scheduling a future appointment.

Authorization to Treat: I hereby authorize the healthcare providers of Wright Family Medicine to give routine medical care for myself or my child or the person for whom I am guardian. I understand that I have the right to ask healthcare providers any medical or healthcare related questions. I will follow all treatment and post treatment instructions as explained and directed to me by healthcare providers.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed in any form, whether electronically, on paper or orally are kept properly confidential. "The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice. Individuals have a right to access this PHI for as long as the information is maintained by a covered entity, or by a business associate on behalf of a covered entity, regardless of the date the information was created; whether the information is maintained in paper or electronic systems onsite, remotely, or is archived; or where the PHI originated (e.g., whether the covered entity, another provider, the patient, etc.)." https://www.hhs.gov I understand that more information regarding HIPPA may be found at https://www.hhs.gov.

Medical Records: Medical records may be disclosed only if prior authorization from patient is obtained. Parents or guardians are entitled to the medical records of their children under the age of 18 years old. All original medical records are the property of the healthcare providers. Patients may obtain copies of their medical records with a written request.

Paperwork: A $25.00 fee will be required to fill out FMLA or other paperwork or medical forms. Some forms will require an appointment. Insurance does not cover this service. Please allow10 to14 days for the completion of these forms.

Payment: I understand that I am liable for paying all charges for the services provided by Wright Family Medicine. I hereby agree to pay for health insurance deductibles, co-insurance and copays. It is my responsibility to know what is covered by my insurance company. A $50 payment will be required at the time of scheduled appointment if patient has a deductible remaining according to their insurance company. In the event that I fail to fulfill any of these obligations within 120 days, I agree to pay any collection costs incurred by the healthcare providers in the enforcement of this section. Wright Family Medicine will bill my insurance company based on the information I give them at the time of service. Any problems that arise are my responsibility to handle and make sure that Wright Family Medicine is paid in a timely manner.

Personal and Medical Information: I have provided an accurate and complete personal and medical history, including family history, allergies and the use of antibiotics, drugs or other medications I am currently taking. It is my responsibility to give updated personal and medical information to Wright Family Medicine if any changes occur.

Right to Dismiss: The healthcare providers maintain the right to discontinue treatment. Patients will be notified of discontinued treatment by receiving a letter of dismissal. If dismissed, it is the patient's full responsibility to pursue alternate professional medical care.

PERSONAL HEALTH INFORMATION DISCLOSURE

I hereby authorize the healthcare providers of Wright Family Medicine to release personal health information for myself or my child or the person for whom I am guardian to the following people: all Wright Family Medicine staff, all referred physicians and their staff and the following people.

Name:_____ Phone:_____ Email:_____

Name:_____ Phone:_____ Email:_____

I authorize Wright Family Medicine to contact me or my emergency contact or the persons listed above via phone, mail, email, or in person to discuss any and all of my healthcare information or the healthcare information of my child or the person for whom I am guardian. I have read and understand the Wright Family Medicine Patient Packet. I have filled out each page to the best of my knowledge. By signing below, I agree to the terms stated within.

Patient Last Name:_____ First Name:_____ Middle Initial:_____

Parent or Guardian Name (if applicable):_____

Patient or Parent/Guardian Signature:_____ Today's Date:_____

WRIGHT FAMILY MEDICINE
3800 W. Ray Rd., Ste. 21 - Chandler, AZ 85226
Phone: (480) 889-0508 - Fax: (408) 889-0511

AUTHORIZATION TO RELEASE RECORDS

Patient Name:_____ DOB:_____

(Please initial)

____I authorize Wright Family Medicine to receive medical records from the provider listed below.

____I authorize Wright Family Medicine to send medical records to the provider listed below

____I authorize Wright Family Medicine to release records to myself. (A $25.00 fee will be assessed to obtain paper records.)

Facility/Physician Name:_____

Facility/Physician Address:_____

Facility/Physician Telephone:_____ Facility/Physician Fax:_____

Medical Records to be released (circle only one):

All Records ◯ OR ◯ Other (please specify):_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse and genetic testing.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by the federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand the revocation will not apply to the information already based on this authorization.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure medical treatment.

Patient/Guardian Signature:_____ Today's Date:_____

ADVANCE DIRECTIVES

Do you have a Living Will? Y ☐ N ☐

Do you have a Healthcare Proxy? Y ☐ N ☐ If yes, Name:_____ Phone:_____

Do you have a Power of Attorney? Y ☐ N ☐ If yes, Name:_____ Phone:_____

Have you issued an order indicating "Do Not Resuscitate" (DNR)? Y ☐ N ☐

If you would like a DNR form, please ask your provider. This orange form must be signed by patient, provider and an adult witness or notary. A witness must be 18 years or older, who is unrelated by blood, marriage or adoption, not entitled to any part of your estate, not appointed as a representative nor involved in providing your health care at the time this form is signed.

It is my will that if I am close to death: (Please circle your choice.)

Life Support: Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

Feeding Tube: Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

It is my will that if I am permanently unconscious: (Please circle your choice.)

Life Support Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

Feeding Tube Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

It is my will that if I have an advanced progressive disease: (Please circle your choice.)

Life Support: Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

Feeding Tube: Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

It is my will that if I have extraordinary suffering: (Please circle your choice.)

Life Support: Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

Feeding Tube: Accept ◯ Accept only with Physician recommendation ◯ Decline ◯

In the event I am unable to make medical decisions for myself, I hereby appoint the person named below as my Healthcare Power of Attorney.

Healthcare Power of Attorney Name:_____

Healthcare Power of Attorney Address:_____

Healthcare Power of Attorney Phone:_____

Healthcare Power of Attorney Email:_____

Healthcare Power of Attorney Signature:_____ Today's Date:_____

Patient Name:_____ Patient Date of Birth:_____

Patient/Guardian Signature:_____ Witness Signature:_____

Please include a copy of any documentation you have available regarding your advanced directives.

PATIENT PORTAL REGISTRATION AGREEMENT

In an effort to improve and update patient care, Wright Family Medicine is currently implementing a Patient Portal. Patients will have access to their personal health information through this secure application. Please provide an email address or cell phone for us to register you and provide you access to the Patient Portal. Only those authorized by Wright Family Medicine and those who have access to your email account will be able to access your personal healthcare information. You will receive a link via your email account or text that will instruct you how to access the Patient Portal.

By signing below, I give my permission for Wright Family Medicine Staff to register me with the Patient Portal. I understand that anyone who has access to my email account will be able to access my personal healthcare information through the Patient Portal. I understand that online communications should never be used for emergencies or urgent matters.

Today's Date:_____

Patient Date of Birth:_____

Cell Phone:_____

Cell Phone Carrier Company:_____

Patient Email Address:_____

Patient Name: _____

Patient/Guardian Signature:_____