I, _____, give permission for the following person/persons to receive information concerning my medical care:

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

SIGNATURE DATE

Patient Registration Form

PATIENT INFORMATION ***(please print)***

{ }Dr. { }Miss { }Mr. { } Mrs. { }Ms. { }Sir

Patient's Name (Last): _____ (First) _____ (MI) ____ Previous Name _____

Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: MM _____ DD _____ YYYY_____ Sex: { } Female { } Male { } Transgender

Race: { } American Indian or Alaska Native { } Asian { } Native Hawaiian or Other Pacific Islander { } Black or African American { } White { }Declined

Language: { } English { } Spanish { } Indian { } Japanese { } Chinese { } Korean { } French { } German { } Russian { } Other _____

Marital Status: { } Married { } Single { } Divorced { } Widowed/Widower { } Legally Separated { } Partner

Social Security No: _____-_____-_____ Employer Name/Phone #: _____

Employment Status: { } Full-Time { } Part-Time { } Not Employed { } Self Employed { } Retired { }Active Military

Student Status: { } Full-Time Student { } Part-Time Student { } Not a student

Emergency Contact: Last Name _____ First Name _____

Phone No: _____ Emergency Contact Relationship to Patient: _____

Address: _____

Do you have a living will? { } YES { } NO Do you have a Power of Attorney? { } YES { } NO

PRIMARY INSURANCE INFORMATION: ***(provide your insurance card to the front desk at check-in)***

Primary Insurance Carrier: _____ Phone No: _____

Member/Subscriber ID #: _____ Group #_____

SECONDARY INSURANCE INFORMATION: ***(provide your insurance card to the front desk at check-in)***

Secondary Insurance Carrier: _____ Phone No: _____

Member/Subscriber ID #: _____ Group #_____

PHARMACY TO SUBMIT ANY PRESCRIPTIONS: _____

PHARMACY ADDRESS/CROSSROADS: _____

I agree that this information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsibility Party) Signature _____ **Date:** _____

PATIENT'S NAME: _____ DOB: _____ DATE: _____

If you are not the patient, what is your relationship: _____

Check "YES" if symptoms are current or have occurred in the past 6 months or "YES" for any illness/disease/surgery at any time.

REVIEW OF SYMPTOMS

GENERAL:

YES NO

( ) ( ) FEVER
( ) ( ) WEIGHT LOSS OF MORE THAN 10 lbs.
( ) ( ) DECREASED APPETITE
( ) ( ) WEIGHT GAIN OF MORE THAN 10 lbs

EYES:

( ) ( ) VISION CHANGES
( ) ( ) CATARACTS
( ) ( ) GLAUCOMA

EARS/NOSE/MOUTH/THROAT

( ) ( ) EAR ACHES
( ) ( ) DECREASED HEARING
( ) ( ) FREQUENT NOSE BLEEDS
( ) ( ) COLD SYMPTOMS
( ) ( ) SORE THROAT
( ) ( ) SWOLLEN GLANDS
( ) ( ) NECK STIFFNESS

RESPIRATORY

( ) ( ) COUGH
( ) ( ) PHLEGM PRODUCTION
( ) ( ) WHEEZING
( ) ( ) SHORTNESS OF BREATH
( ) ( ) PAIN WITH BREATHING

GASTROINTESTINAL

( ) ( ) NAUSEA
( ) ( ) VOMITING
( ) ( ) DIARRHEA
( ) ( ) CONSTIPATION
( ) ( ) ABDOMINAL PAIN
( ) ( ) VOMITTING BLOOD
( ) ( ) BLOOD IN STOOLS
( ) ( ) BLACK STOOLS
( ) ( ) HEARTBURN/ULCER SYMPTOMS
( ) ( ) LIVER PROBLEMS
( ) ( ) PANCREAS PROBLEMS

GENITOURINARY

( ) ( ) PAINFUL URINATION
( ) ( ) FREQUENT URINATION
( ) ( ) BLOOD IN URINE
( ) ( ) FREGUENT INFECTIONS

GYNECOLOGIC/OBSTECTRIC

( ) ( ) IRREGULAR/HEAVY PERIODS
( ) ( ) UNUSUAL DISCHARGE
( ) ( ) BREAST LUMP/PAIN/DISCHARGE
( ) ( ) INFECTIONS OF UTERUS
( ) ( ) OVARIAN CYSTS
( ) ( ) # OF PREGNANCIES _____
( ) ( ) # OF LIVE BIRTHS _____
( ) ( ) # OF MISSCARRIAGES/ABORTIONS ___

MUSCULOSKELETAL

( ) ( ) FRACTURES/DISLOCATIONS
( ) ( ) JOINT PAINS OR SWELLING
( ) ( ) ARM/LEG WEAKNESS
( ) ( ) ARM/LEG NUMBNESS

SKIN

( ) ( ) RASH/HIVES
( ) ( ) ITCHING
( ) ( ) SKIN ULCERS

NEUROLOGICAL:

( ) ( ) SIGNIFICANT HEADACHES
( ) ( ) CONFUSION
( ) ( ) DIZZINESS/ BALANCE PROBLEMS

PSYCHIATRIC

( ) ( ) MENTAL HEALTH PROBLEMS
( ) ( ) SUICIDAL TENDENCIES
( ) ( ) MAJOR DEPRESSION

ENDOCRINE

( ) ( ) THYROID PROBLEMS
( ) ( ) VOICE CHANGE
( ) ( ) STEROID USE

HEMATOLOGIC

( ) ( ) ANEMIA
( ) ( ) ABNORMAL BLEEDING
( ) ( ) BLOOD TRANSFUSION

ALLERGIC

( ) ( ) SEASONAL ALLERGIES
( ) ( ) SERIOUS FOOD ALLERGIES

PAST MEDICAL HISTORY

HAVE YOU BEEN HOSPITALIZED RECENTLY:
( ) YES ( ) NO IF SO, REASON: _____

DIABETES..... ( ) YES ( ) NO
RHEUMATIC FEVER ..... ( ) YES ( ) NO
ARTHRITIS ..... ( ) YES ( ) NO
CANCER ..... ( ) YES ( ) NO
EPILEPSY ..... ( ) YES ( ) NO
STROKE ..... ( ) YES ( ) NO
ASTHMA ..... ( ) YES ( ) NO
EMPHYSEMA ..... ( ) YES ( ) NO
AIDS/HIV ..... ( ) YES ( ) NO
HEPATITIS ..... ( ) YES ( ) NO
VALLEY FEVER ..... ( ) YES ( ) NO
KIDNEY STONES .....( ) YES ( ) NO
TUBERCULOSIS .....( ) YES ( ) NO
VENEREAL DISEASE .....( ) YES ( ) NO
PNEUMONIA .....( ) YES ( ) NO

PAST OPERATIONS

_____

MEDICATION ALLERGIES: _____

_____

FAMILY HISTORY

DO ANY OF THE ABOVE PROBLEMS RUN IN YOU FAMILY? ( ) YES ( ) NO

_____

FATHER'S HEALTH _____ AGE AT DEATH _____ CAUSE: _____
MOTHER'S HEALTH _____ AGE AT DEATH _____ CAUSE: _____
SIBLINGS HEALTH: _____ AGE AT DEATH _____ CAUSE: _____

HEART TROBLE IN FAMILY ( ) YES ( ) NO WHOM: _____

CARDIOVASCULAR

HEART MURMUR .....( ) YES ( ) NO
PALPITATIONS/IRREGULAR HEART.....( ) YES ( ) NO
ANGINA/CHEST PAIN.....( ) YES ( ) NO
CHEST PAIN WITH ACTIVITY.....( ) YES ( ) NO
CONGESTIVE HEART FAILURE.....( ) YES ( ) NO
MITRAL VALVE PROLAPSE.....( ) YES ( ) NO
HAVE YOU HAD A HEART ATTACK? .....( ) YES ( ) NO
HEART SURGERY/PACEMAKER.....( ) YES ( ) NO
OTHER VASCULAR SURGERY.....( ) YES ( ) NO
HIGH BLOOD PRESSURE.....( ) YES ( ) NO
HIGH CHOLESTEROL.....( ) YES ( ) NO

SOCIAL HISTORY

WHOM DO YOU LIVE WITH

_____

OCCUPATION

_____

RETIRED: ( ) YES ( ) NO
SMOKE: ( ) NEVER
( ) NO, QUIT IN _____ YRS
( ) YES _____ PACKS/DAY
ALCOHOL: ( ) NONE
( ) 1 – 3 PER _____
( ) 4 – 10 PER _____
( ) MORE THAN 10 _____
OTHER DRUGS: _____

I HAVE REVIEWED THE ABOVE RECORDED INFORMATION. _____ _____

PHYSICIAN SIGNATURE DATE

COURNTEY MEDICAL GROUP, 1671 WEST INA ROAD, #101, TUCSON, AZ 85704-1928 P:520-797-8555 F: 877-409-3138

TO ALL PATIENTS:

Please be aware that while referrals for tests such as labs, x-rays, specialty scans, i.e. MRI, CT, mammograms are coming from this office, it is your responsibility to make sure that the facility you are sent to is the proper one for your specific insurance carrier. It is therefore very important for you to verify coverage by your insurance carrier at the time you are receiving services from outside facilities. If you receive a bill from an outside provider/facility for services provided to you, you will be responsible to pay for those services. You must understand there may be co-pays or other amounts due for these services as outlined by your insurance carrier and it will be your responsibility to pay any and all charges that may occur. COURTNEY MEDICAL GROUP WILL NOT PAY FOR SERVICES BILLED TO YOU. This will be enforced as long as you are a patient of Courtney Medical Group.

We at Courtney Medical Group strive to provide the best medical care possible. We order tests that we feel are appropriate and in the best interest of your health and care. Unfortunately, sometime the requested tests will not be covered by your insurance carrier. These are recommendations only and all charges should be investigated prior to services being rendered and any questions directed to the practitioner prior to services being done. You are, therefore, responsible for the charges that accrue. We also do our best to insure our patients are sent to the correct facility, but due to constant changes in insurance plans, it is impossible to always keep abreast of all changes. It is also your responsibility to follow up for all test results by scheduling an appointment in the office so we may appropriately discuss any issues or concerns.

When outside persons, i.e. relative, friends, significant others, outside health professionals, etc. are permitted in the exam room during your scheduled appointment, you are giving consent for those person to hear you private health information. If you do not wish to share your private health information, do not allow them to accompany you into the examination room.

By signing below, I am certifying that I have read this form in its entirety and completely understand the contents of the form. Any and all questions have been answered completely at the time of signing the document.

_____ _____

Patient's Signature Date

_____ _____

Witness's Signature Date

Courtney
Medical Group
Occupational & General Medicine

FINANCIAL POLICY

It is the patient's responsibility to notify our office of any changes in insurance carriers to insure appropriate billing. Courtney Medical Group will bill the insurance carrier provided by the patient. If you cannot provide your insurance card or proof of insurance, you will be billed as a self-pay at the time of service and it will be your responsibility to obtain reimbursement from your insurance carrier. Co-pay amounts will be due at the time of service. If you are unable to pay your co-pay at the time office, your appointment may be rescheduled to another date. Charges incurred that are not covered by your insurance carrier will become the responsibility of the patient. Should your physician NOT BE CONTRACTED with one or more of your insurance carriers, you will be responsible for any charges that your insurance denies, such as deductibles, co-insurances, co-pays, etc.

We will send you a maximum of 3 (three) statements showing any payments due after your insurance has processed your claim and advised us of any charges that you are financially responsible for, this will also include any fees due for late cancellations and no-shows. If after those statements no payment arrangements or payments have been received, your account will then be turned over to our outside Collection Agency. Once your account is turned over to collections you will then be required to contact them to make payments and will be responsible for the 25% collection fees in addition to the balance owed to Courtney Medical Group. (Balance due to CMG +25% collection fees will be the total due at that time.)

By signing below you acknowledge that you accept financial responsible for any of these charges that are accrued.

_____ _____

Patient's Signature **Date**

_____ _____

Witness Signature **Date**

1671 WEST INA RD, #101, Tucson, AZ 85704-1928

Phone # 520-797-8555 Fax # 877-409-3138

PRIVACY PRACTICES ACKNOWLEDGMENT

ACKNOWLEDGEMENT:

I have received the Notice of Privacy Practices and I have been provided an opportunity to review them.

I also understand that by signing this form I am allowing Courtney Medical Group to review all of my medication history from all physicians under my insurance plan with any physician or encounter.

Name: _____ DOB: _____

Signature: _____

Date: _____

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is requested that if you must cancel your appointment you **provide more than 24 hours notice**. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations **made less than 24 hrs** we are unable to offer that time to another patient.

Any scheduled appointments which are cancelled with less than 24 hours notification will be billed a $50.00 Cancellation Fee.

Patients who **do not** show up for their scheduled appointment without a call to cancel that appointment will be considered a **NO SHOW**. Patients who **No-Show or Cancel two (2) or more times within a twelve (12) month period will be dismissed from the practice** thus they will be denied future appointments and we will no longer be their physician.

Any patient who misses their scheduled appointment will also be billed a

$50.00 No Show Fee.

The cancellation and no show fee are the sole responsibility of the patient as insurance companies do not pay for these charges. We understand that special unavoidable circumstances may cause you to cancel with less than a 24 hour notice therefore fees in this instance may be waived only with physician/management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

_____ _____

Patient/Parent Signature Date

Authorization to Release Medical Records
(IF MORE THAN 10 PGS, PLEASE MAIL)

Note: There is a fee for records released to patients for personal use.

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize: _____

Address: _____

City: _____ State: _____ Zip: _____

To release photocopies of **ALL MEDICAL RECORDS** concerning the above names patient

TO: **COURTNEY MEDICAL GROUP**

1671 W INA ROAD, #101

TUCSON, AZ 85704-1928

PHONE: 520-797-8555 FAX: 877-409-3138

I authorize the release of photocopies of the following medical records in the possession of _____

For the purposes hereof, "MEDICAL RECORDS" shall include all confidential HIV-related information (as defined in A.R.S. section 36-661), confidential communicable disease related information (as defined in A.R.S. section 36-661), confidential alcohol or drug related information (as defined in 42 CFR section 2.1 ET SEQ.), and confidential mental health diagnosis/treatment information.

_____ All medical records as specified above

OR

_____ The following described records only (specify types and dates):

_____

This consent will expire one-hundred twenty (120) days after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify Courtney Medical Group in writing to that effect. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights confidentiality. I understand authorization is considered acceptable in lieu of the original.

_____ _____

Patient's Signature Date

If patient is a minor or information is to be released regarding treatment for psychiatric, alcohol or drug abuse, both the patient and parent/legal guardian must sign.

_____ _____

Parent/Legal Guardian Signature Date