

Arizona Community Physicians

Patient Information

FIRST NAME MIDDLE LAST NAME ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE EMERGENCY PHONE# EMERGENCY CONTACT NAME / RELATION

/ /

DOB SEX MARITAL STATUS EMAIL RACE (optional)

PRIMARY CARE PHYSICIAN STUDENT? FT OR PT PREVIOUS NAME

EMPLOYER NAME EMPLOYER ADDRESS EMPLOYER PHONE

**Billing Information
(If different than patient)**

FIRST NAME MI LAST NAME ADDRESS CITY STATE/ZIP PHONE

Primary Insurance Information

INSURANCE NAME EFFECTIVE DATE MEDICAL CLAIMS ADDRESS

SELF SPOUSE CHILD OTHER

GROUP ID# POLICY ID# RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) SUBSCRIBER ADDRESS (if different than patient) SUBSCRIBER PHONE (if different than patient)

/ /

SUBSCRIBER DATE OF BIRTH SUBSCRIBER SEX SUBSCRIBER SSN# CO-PAY AMOUNT

SUBSCRIBER EMPLOYER EMPLOYER ADDRESS EMPLOYER PHONE#

Secondary Insurance Information

INSURANCE NAME EFFECTIVE DATE MEDICAL CLAIMS ADDRESS

SELF SPOUSE CHILD OTHER

GROUP ID# POLICY ID# RELATIONSHIP OF PATIENT TO SUBSCRIBER

SUBSCRIBER NAME (POLICY HOLDER) SUBSCRIBER ADDRESS (if different than patient) SUBSCRIBER PHONE (if different than patient)

/ /

SUBSCRIBER DATE OF BIRTH SUBSCRIBER SEX SUBSCRIBER SSN# CO-PAY AMOUNT

SUBSCRIBER EMPLOYER EMPLOYER ADDRESS EMPLOYER PHONE#

By signing this form, I am consenting to Arizona Community Physicians' use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Arizona Community Physicians' Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Arizona Community Physicians for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

PERSON GIVING CONSENT RELATIONSHIP IF NOT THE PATIENT DATE



Patient name: _____

MRN: _____

The government mandates that all healthcare is provided fairly, without regard to race or ethnicity. These registration questions are to insure we are meeting these guidelines. This information will be kept confidentially.

Race

- American Indian/Alaskan Native
- Asian Indian
- Black, African American
- Caucasian (White)
- Chinese
- Filipino
- Guamanian/Chamorro
- Japanese
- Korean
- Native Hawaiian
- Other Asian
- Other Pacific Islander
- Samoan
- Vietnamese
- Unknown
- Decline

Preferred Language

- English
- Spanish
- Arabic
- Chinese (all types)
- French
- German
- Greek
- Italian
- Japanese
- Korean
- Navajo
- Polish
- Russian
- Tagalog
- Ukrainian
- Vietnamese
- Other(Specify) _____

Ethnicity

- Cuban
- Mexican/ Mexican American
- Other Hispanic/Lantino/a or Spanish Origin
- Puerto Rican
- Non Hispanic/Latino/a or Spanish Origin
- Unknown
- Decline

Interpreter Services Needed: YES NO

Veteran Status

- No, Currently Serving branch _____
- No, Never Serviced
- Yes
- Yes Combat veteran
- If YES, Branch of Service _____

Marital Status:

- Married
- Divorced
- Legally Seperated
- Single
- Widowed
- Significant Other
- Other

Emergency Contact

Name _____

Phone _____

Relationship: _____

Currently employed Yes No

If YES, Employer _____

Patient Email: _____

Do you want to sign up for MY CHART -online access to your Medical Records? YES NO

Patient(or Guardian) Signature: _____ **Date:** _____

Patient Name:		Birth Date	Age	M	F
Mother's Name:	Father's Name:	Forms Completed By:		Date	

Household Information

Name	Relation to Child	Birth Date	Health Problems	Occupation

Social History

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

Does the child have access to a pool? Is it fenced or covered? ()yes ()no
Explain. _____

What languages are spoken in home? () English
() Spanish () Other _____

Childcare? () Parents () Relatives () Daycare
() Babysitter/Nanny

Days per week at daycare (not with parents). ___

Do any household members smoke? ()yes ()no

Birth History

Did mother have any illness or problems with pregnancy? ()yes ()no Explain _____

During the pregnancy did mother use medications, drugs, smoke or drink alcohol?
()yes ()no Explain _____

Was the delivery () Vaginal? () C-section?

Was the baby () Term? () Early?

Gestational Age? ___ weeks

What was the baby's birth weight ___ lbs ___ oz

Did your baby have any problems right after birth?
()yes ()no Explain _____

Did your baby pass the hearing screen?
()yes ()no Explain _____

Did your baby get the Hepatitis B vaccine?
()yes ()no Explain _____

Did your baby go home with mother from the hospital? ()yes ()no Explain _____

General Information

Does your child see any specialists?
()yes ()no Explain _____

Does your child have any serious illness or medical condition?
()yes ()no Explain _____

Has your child had any serious injuries or accidents?
()yes ()no Explain _____

Has your child had any surgeries?
()yes ()no Explain _____



Cancellation and No-Show Policy

Patient Name _____ DOB _____ MRN _____

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide at least 24 hour notice. This will allow for another patient who is waiting for an appointment to be scheduled in that appointment time.

All appointments without a call to cancel prior to the appointment time, will be considered a no-show appointment. No-show appointments are subject to a \$50.00 no-show fee.

If you have three or more no-showed appointments in a 12 month period of time you may be dismissed from the practice and denied any future appointments with any of our physician(s).

Same day scheduled appointments cancellations may also result in a \$50.00 fee depending on the time frame of your notice.

Cancellation and no-show fees are the sole responsibility of the patient (parent). They are not covered by your insurance and must be paid in full prior to your next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in these instances may be waived but only with managerial approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding the good communication. We are happy to discuss any questions you may have about our cancellation and no-show policy and fees.

Parent/Guardian _____

Signature _____ Date _____



Patient Name

Patient DOB

MRN

Dear Patient:

You are scheduled today for your Annual Preventative Medicine visit, commonly referred to as an Annual Physical.

Please know that your insurance may limit the reimbursement for this service to once every 365 days. If you have received this service from another provider within the past 365 days, you may be charged for the visit.

The Annual Preventative Medicine visit includes the following:

- An age-appropriate history and exam that is not part of disease management.
- Counseling, guidance and risk factor reduction.
- Ordering of routine tests such as screening colonoscopy, screening labs and radiology services to identify potential problems.

The Annual Preventative Medicine visit does not include the services below. If you require these additional services today, please be aware your insurance has a separate billing category for which your provider may charge your insurance. Alternatively, please let your provider know if you do not want these services.

- Evaluation and Management of new or ongoing problems requiring further workup or discussion. This may include a more extensive problem focused physical exam, ordering of diagnostic tests for known problems, prescription drug management, coordinating care with another specialist, or simply providing further counseling related to a chronic diagnosis.

If you have any questions regarding this information, please see the front office staff.

By signing below, you have received and read this information.

Patient Signature

Date

05/03/2019



Arizona Community Physicians Minor Release of Information Form

Account # _____

Patient Name: _____ DOB: _____ Date: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your child's health information.

Please list the names and phone numbers of anyone who has your permission to have access to your child's medical records. This information is not limited to but may include appointments, billing information and test results.

Parent/Guardian Name: _____ Contact Number: _____

Parent/Guardian Name: _____ Contact Number: _____

Other Adult: _____ Contact Number: _____

Other Adult: _____ Contact Number: _____

I give permission for my child to be taken to their medical appointments by:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Permission is granted to leave detailed messages regarding appointments, test results or other imperative information at the following phone numbers:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

DO NOT RELEASE Information to the following people (Legal directive must be provided if parent or guardian):

Name: _____ Name: _____

Please initial if your child is 16 years old or older and you give permission for them to be seen without an adult:

_____ I give permission for my child to be seen without the presence of an adult.

_____ I give permission for my child to have minor procedures or immunizations without the presence of an adult.

I acknowledge that the information above is accurate and that I may withdraw the terms of this agreement upon written notice.

Parent Name: _____ Date: _____

Parent Signature: _____

Note: This is a general consent form and is not a substitute for separate written informed consent discussing risks, benefits, and possible side effects of treatment when required (e.g., invasive procedures and immunizations). Offices treating minors will need to ensure the parent/legal guardian has separately signed and authorized the procedural or VIS vaccine forms, prior to the appointment, when permitting their child to come to the visit unaccompanied.

ARIZONA COMMUNITY PHYSICIANS, P.C.
AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name _____ Account # _____
Former Name (If any) _____
Daytime Telephone _____ Birth Date _____

INFORMATION TO BE RELEASED FROM

I hereby authorize (name of organization) _____
To release the following medical information contained in patient's medical record.

INFORMATION TO BE RELEASED TO

Name of Physician/Organization _____
Street Address _____
City/State/Zip _____
Phone # 520-202-3488 FAX: 520-202-3486

Dyson Pediatrics
2222 N. Craycroft Rd.
Ste. 150
Tucson, AZ 85712

PURPOSE FOR THE REQUEST

(Please check a box)

- Moving Treatment or consultation Dissatisfaction Change of Insurance Plans At patient's request
 Other (specify) _____

TYPE OF INFORMATION TO BE RELEASED (No information will be released unless a box is checked)

General Release

DATES OF TREATMENT

- Medical Records/Excluding Protected Records
(This will be limited to 1 year of information including Lab, x-ray reports unless otherwise stated)

From _____ To _____

- Other Records (specify) _____

From _____ To _____

Information Protected by State/Federal Law

- All of my records including:
AIDS/HIV and Other Communicable Disease Information,
Behavioral Health Care/Psychiatric Care, Alcohol and/or Drug Abuse Treatment

From _____ To _____

THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE AFTER ONE YEAR (or 60 days for drug and alcohol abuse records) from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation.

With respect to drug and alcohol abuse treatment, information or records regarding communicable disease-related information, the recipient of this information understands that it is prohibited from making any disclosure of this information unless further disclosure is expressly permitted by written consent of the undersigned or otherwise permitted by applicable law.

Signature of Patient or Personal Representative Who May request Disclosure

I understand that Arizona Community Physicians may not condition my treatment on whether I sign this authorization form unless specified above under Purpose for Request. I can inspect or receive a copy of the protected health information to be used or disclosed. I authorize Duane Dyson MD to use and disclose the protected health information specified above.

Signature of Patient OR Legal Representative

Date

Please Print Name of signing party

Patient Requesting Medical Record Copies
The charge for copying medical records from a paper chart will be \$0.10 a page.
For offices using our Electronic Health Record system, patients may request a copy of their chart on a "CD" for \$10.00.

MyChart Minor Proxy Authorization

Minor/Child Information	
Patient Name: _____	[] Male [] Female
DOB: _____ Age: _____ Address: _____ _____	
Relationship to minor/child: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other: _____	
<i>**Legal documentation of guardianship is required, if applicable (e.g. court order, adoption decree, etc.)</i>	
Parent/Guardian Information	
Parent/Guardian Name: _____	
DOB: _____	Contact phone: _____ Email Address: _____
Address: [] Same as minor <i>If different:</i> _____ _____	

MyChart Terms and Conditions:

- A minor who is a teen (age 14 – 17) may activate his/her own MyChart account. Parents or legal guardians may have full access to what is available in MyChart.
- MyChart may not contain full and complete medical records. AZ Minor Consent Laws allow some medical information to be kept confidential.

By signing below, I agree to the following:

- I am entitled to access the patient's protected health information as his/her parent or legally appointed guardian.
- My rights to access the patient's protected health information have not been modified in any manner by any court of law.
- The documents I have provided in support of my right to access the patient's protected health information, if any, are true and correct copies and are the most recent documents related to this matter.

Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Patient MRN:	Proxy Activation Date:
Proxy Verified by:	Verification Documentation:



Patient Name: _____

Patient DOB: _____

Patient MRN: _____

CONSENT TO THE USE OF AI SOFTWARE DURING MEDICAL VISITS

We are committed to providing the best possible care for you, and as a part of this commitment, we are continually looking for ways to enhance our services. One of those enhancements is an artificial intelligence (AI) tool that helps summarize what is said during patient visits.

Purpose of AI

Ambient listening AI technology is utilized to convert spoken words into text format for the purpose of documenting medical information in an efficient and accurate manner. The AI software may be employed in the creation of medical notes, reports, and other relevant documents.

How Ambient Listening AI Works

During medical appointments, any verbal information provided by the patient, my healthcare provider, or caregiver may be captured using ambient listening AI. The AI software processes spoken words and generates text, contributing to the creation of medical records. The AI summary will then be reviewed, edited, and signed by your provider before becoming part of your medical record. The AI software works in the background and will not interact with the provider or the patient directly.

Data Privacy and Confidentiality

We want to assure you that your privacy is our utmost priority. The AI software tool adheres strictly to the Health Insurance and Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secure and protected.

Patient Rights

Amendment of Information: Patients have the right to request corrections or amendments to any inaccuracies in their medical records.

Withdrawal of Consent: Patients have the right to withdraw consent for the use of Ambient Listening AI at any time.

I agree to the use of ambient listening AI software during my medical visits.

I do not agree to the use of ambient listening AI software during my medical visits.

Printed Name of Patient or Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Date: _____