PrimaCare
Internal Medicine
Competent • Compassionate • Care

Zaheer Shah, M.D.
Kayla Shelley, PA-C

New Patient Information

Patient Information:

Patient Name: _____ Date of Birth: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ SSN: _____ - _____ - _____

Primary Language: _____ Race: _____ Ethnicity: _____

Pharmacy Name: _____

Pharmacy Address: _____

Emergency Contact:

Name: _____

Relationship to Patient: _____

Phone Number: _____

Primary Insurance:

Insurance Carrier: _____

Guarantor: _____

Guarantor relationship: _____ Date of Birth: _____

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Patient Medical History

Patient Name: _____

Date of Birth: _____ How You Heard About Us: _____

Previous Primary Care Physician: _____

Medical Conditions	Medications
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____

Surgeries: _____

Hospitalizations: _____

Social History

Tobacco Use: ◯ Yes ◯ No ◯ Previously Quit Date: _____

Alcohol Use: ◯ Occasional / Social ◯ Never ◯ Daily

Drug Use: ◯ Yes ◯ No ◯ Previously

Family History

Mother: _____ Father: _____

Siblings: _____ Other: _____

Concerns for today's visit: _____

_____

2163 East Baseline Road, Suite 101 | Tempe, Arizona 85283 | Phone: (480) 646-8123 | Fax: (480) 646-8125

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Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse: _____

Child (ren): _____

Other: _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ◯ my home ◯ my work ◯ my cell Number: _____

If unable to reach me:

◯ you may leave a detailed message ◯ please leave a message asking me to return your call

Signed: _____ Date: _____

Witness: _____ Date: _____

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Consent to Email

Patient Email: _____

Patient Signature: _____

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Medical Record Release

Patient Name: _____ Date of Birth: _____

Obtain From:

Name: _____

Address: _____

Fax: _____

Furnish To:

Name: _____

Address: _____

Fax: _____

Information pertaining to my identity, prognosis, diagnosis, or treatment. Information to be released includes:

☐ Discharge Summary ☐ Operate/Pathology reports ☐ Complete Records

Other: _____

Do not release:

☐ HIV ☐ Psych records ☐ Alcohol/drug treatment records

Other: _____

The information is needed for the following purpose: ☐ Patient Care ☐ Other: _____

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws. I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. The Health Insurance portability and Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information. As required by "HIPPA" we have prepared this explanation of how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be teeth cleaning services. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review, An example of this would be sending a bill for your visit to your insurance company for payment. Health operations include the business aspects of running our practice, such as conducting quality assessment and improving activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. 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. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

PRIMACARE INC. Zaheer A. Shah, MD Patient "Signature on file" Authorization

I certify that, to the best of my knowledge, the information I have supplied in relation to my claim is accurate. I also understand that if I request service benefits from Zaheer A. Shah, MD that I am responsible for all charges incurred if my insurance should not be in effect, or I have not designated the Doctor as my Primary Care Physician (PCP). I permit a copy of this authorization to be used in place of the original, and requests payment of medical insurance benefits to the provider above who accepts assignment.

Patient name (Please print): _____

Signature: _____ Date: _____

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CONSENT TO TREAT

I hereby acknowledge that I presented myself for medical treatment. I authorize the physician or physicians who are about to treat me to order and/or administer any treatment of my injury or illness. I understand that the physician who will treat me may not be an employee of this office but an independent physician, and that all treatment rendered by the physician is given under his/her own knowledge and discretion. I also understand that this office does not control, supervise, or direct, nor does it have the right to control, supervise or direct any physician in his/her treatment and diagnosis of any patient.

I acknowledge that it is my obligation to make this facility's office aware of any changes to my insurance coverage information. If I am issued a new insurance card, which indicates a new insurance policy number, I need to report this to the secretary and to the billing office. Should I fail to provide the information necessary to have any claim properly adjudicated within the filing limits of my insurance carrier, I agree to assume financial responsibility for services rendered by my physician.

I acknowledge that a $20.00 fee will be assessed for any returned checks. I also understand that I will be responsible for paying this whole amount in cash at this facility or I will be held subject to collection procedures.

I acknowledge that if I am seeking the services of PrimaCare without a referral from my personal physician (PCP), I understand that the terms of my health plan coverage may require that I obtain a referral. If I fail to obtain a referral, I will be responsible for either application co-pays and deductibles or the total cost of the services I receive, in accordance with the terms of my health plan coverage.

I acknowledge that my insurance carrier may not cover certain services provided by PrimaCare. If for any reason my insurance carrier denies payment of these services, I will be responsible for the charges submitted to my carrier. PrimaCare will submit all services to Medicare. Any service that Medicare does not cover will be the responsibility of the patient, including any amount applied to yearly deductible, co-insurance, or non-covered services Medicare covers only one visit per week, per condition.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to PrimaCare for services rendered in person or under their supervision.

I understand that I am financially responsible for any balance not covered by my insurance.

I hereby authorize PrimaCare to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

A photocopy of the assignments shall be valid as the original.

Patient name (Please print): _____

Signature: _____ Date: _____