Dr. Jeff Carls, Family Medicine & Aesthetics

1720 Mesquite Ave, Suite 202

Lake Havasu City, AZ 86403-5644

Patient Information Forms

Name: ______________________________ Nickname: ______________

Social Security #: ______________________ Date of Birth: ________________

Sex: M/F Marital Status: ___________ Preferred Language: __________________

Primary Phone#: _______________ Cell #: ___________ Work #: ____________

Billing/Mailing Address: ____

City: __________________ State: __________________ Zip: ______________

Email: __________________________ Pharmacy Name: ___________________

Occupation: _____________________ Employer: _________________________

Driver's License #: _______________________________ State: ____________

Emergency Contact: _______________________ Phone #: _________________

Race: (Check ALL that apply)

[] Native Hawaiian [] Hispanic [] Alaskan Native

[] American Indian [] Asian [] Pacific Islander

[] African American [] White [] Other

Ethnicity: (Check One)

[] Hispanic

[] Non- Hispanic

[] Refuse to Report

RESPONSIBLE PARTY ON INSURANCE

Subscriber on Insurance (Name): _______________________ DOB: ___________

Subscriber's Social Security #: __________________ Relationship to Patient: ______

INSURANCE INFORMATION

Commercial Insurance: ___________ Policy/ID #: ______________ Group #: ______

Medicare/ Advantage Plan: _______________ Medicare/Advantage #: ____________

I understand that payment for services rendered is due at the time of service, unless previous arrangements have been made. I authorize the provider to release any information needed for the payment. I further permit copies of the authorization to be used in place of its original. I give consent for the communication of care and/or medications with my pharmacy. **IT IS THE PATIENT'S** RESPONSIBILITY **TO KNOW THE PROVISIONS OF THEIR INSURANCE POLICY**

Patient /or Guardian Signature: _______________________________ Date: ________

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Patient Questionnaire

Patient Name: ______________________________ Date of Birth: _______________ Age: ____

Emergency Contact: ______________ Relationship: ___________ Phone #: __________________

Reason for your visit: ____

Medical History (Circle ALL that Apply)

Diabetes	High Blood Pressure	High Cholesterol	Thyroid Disease
COPD (Emphysema)	Asthma	Heart Disease	Atrial Fibrillation
Strokes	Peripheral Arterial Disease	Headaches	Rheumatoid Arthritis
Enlarged Prostate (BPH)	Kidney Cancer	Kidney Stones	Bladder Cancer
Breast Cancer	Colon Cancer	Diverticulitis	Pancreatitis
Intestinal Obstruction	Acid Reflux	Glaucoma	Hepatitis
HIV (AIDS)	Melanoma	Blood Clots	

Other ....

Prior Surgeries

[] please check box if you have no previous surgeries

Previous Surgical Procedures:	When:
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________
______________________________	________________

Have you had a **COLONOSCOPY** in the past? Y/N When: _ _ _ _ _ _ _ _ _ _

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Medications & Allergies

List **ALL** Current Medications (including Aspirin and Over the counter medications)

Medication	Dosage (How much and How Often)
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Allergies

Are you Allergic to **ANY** medications? Y/N

Name of Medication Allergic to	Type of Reaction
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Allergic to other things (e.g.; Bees, Peanuts, Latex etc...)

______________________	______________________
______________________	______________________
______________________	______________________

Name Of Patient: ______________________ DOB: ______________

Patient /or Guardian signature: ______________________________

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Are You Currently Experiencing or Have You Had ANY Of the Following

Question	Yes	No
Have you had recent weight loss (>10 lbs.)?	[] Yes	[] No
Have you had recent weight gain (<10 lbs.)?	[] Yes	[] No
Have you had recent fevers?	[] Yes	[] No
Are you fatigue/extremely tired?	[] Yes	[] No
Do you have night sweats?	[] Yes	[] No
Do you have sleep apnea?	[] Yes	[] No
Do you have hay fever/seasonal allergies?	[] Yes	[] No
Has there been any changes in your voice?	[] Yes	[] No
Do you have a history of heart murmurs	[] Yes	[] No
Any unusual chest pain w exertion?	[] Yes	[] No
Do you have any leg or foot swelling?	[] Yes	[] No
Do you have a history of heart disease/heart attack?	[] Yes	[] No
Do you suffer from pain in legs when you walk?	[] Yes	[] No
Do you have palpitations or abnormal heart rhythm?	[] Yes	[] No
Do you have a pacemaker?	[] Yes	[] No
Do you have artificial heart valves?	[] Yes	[] No
Do you have a persistent cough?	[] Yes	[] No
Do you have any shortness of breath?	[] Yes	[] No
Do you have asthma?	[] Yes	[] No
Do you have a history of tuberculosis?	[] Yes	[] No
Have you recently coughed up blood?	[] Yes	[] No
Do you have a history of valley fever?	[] Yes	[] No

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Do you have any blood disease or bleeding disorders?	[] Yes	[] No
Do you have unusual bleeding (bruise easily)?	[] Yes	[] No
Do you have blood clots (legs or lungs)?	[] Yes	[] No
Could you have AIDS or HIV?	[] Yes	[] No
Do you take blood thinners (coumadin/aspirin/Plavix)?	[] Yes	[] No
Do you have blood in stool?	[] Yes	[] No
Have you had any recent diarrhea?	[] Yes	[] No
Have you had any recent constipation?	[] Yes	[] No
Have any stool incontinence (stool leaking)	{] Yes	[] No
Have you had any nausea or vomiting?	[] Yes	[] No
Do you have difficulty swallowing?	[] Yes	[] No
Do you have severe frequent heartburn?	[] Yes	[] No
Have you had recent loss of appetite?	[] Yes	[] No
History of liver disease (cirrhosis or hepatitis)?	[] Yes	[] No
History of diverticulitis?	[] Yes	[] No
History of jaundice?	[] Yes	[] No
History of stomach ulcers?	[] Yes	[] No
Have you ever had an upper endoscopy (stomach)?	[] Yes	[] No
Have you ever had a colonoscopy?	[] Yes	[] No

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Question	Yes	No
Do you have unusual headaches?	[] Yes	[] No
Do you have seizures?	[] Yes	[] No
History of stroke or stroke symptoms (TIA)?	[] Yes	[] No
Do you suffer from fainting spells?	[] Yes	[] No
Do you have joint problems?	[] Yes	[] No
History of gout?	[] Yes	[] No
History of back problems?	[] Yes	[] No
Do you suffer from depression?	[] Yes	[] No
Do you suffer from anxiety?	[] Yes	[] No
Any history of eating disorders?	[] Yes	[] No
Psychiatric problems?	[] Yes	[] No
Any history of kidney stones?	[] Yes	[] No
Any history of kidney disease?	[] Yes	[] No
Do you suffer from frequent kidney infections?	[] Yes	[] No
Have you had any recent blood in urine?	[] Yes	[] No
Do you have any urine incontinence (leaking)?	[] Yes	[] No
Do you have painful urination (peeing)?	[] Yes	[] No

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For Females Only

Do you have any nipple discharge?	[] Yes	[] No
Have you gone through menopause?	[] Yes	[] No
Are you pregnant?	[] Yes	[] No
Have you had a pap smear within the last year?	[] Yes	[] No
Have you had a mammogram in the last two years?	[] Yes	[] No

For Males Only

Do you have difficulty urinating (peeing)?	[] Yes	[] No
Do you suffer from impotence?	[] Yes	[] No
Do you awake at night to urinate (pee) more than twice?	[] Yes	[] No
Have you had a prostate exam in the last year?	[] Yes	[] No
Have you had a PSA screening in the last year?	[] Yes	[] No

SOCIAL HISTORY:

Occupation: [] Employed [] Retired [] Unemployed [] Disabled [] Student

Marital Status: [] Single [] Married [] Divorced [] Widow [] Life Partner

Do you Smoke? [] Yes [] No [] Quit- (when:___________)

Do you Drink Alcohol? [] Daily [] Never [] Occasionally (how many____)

(Beer____) (Wine____) (Other______)

Do you use recreational drugs? [] Yes-Occasionally [] Yes- Frequently [] No

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FAMILY HISTORY: (Check ALL that apply)

Mother:

[] Diabetes [] Heart Disease [] High Blood Pressure [] Blood Disease

[] Kidney Disease [] Thyroid Disease [] Cancer (type of cancer)____________________

Father:

[] Diabetes [] Heart Disease [] High Blood Pressure [] Blood Disease

[] Kidney Disease [] Thyroid Disease [] Cancer (type of cancer)____________________

Brother:

[] Diabetes [] Heart Disease [] High Blood Pressure [] Blood Disease

[] Kidney Disease [] Thyroid Disease [] Cancer (type of cancer)____________________

Sister:

[] Diabetes [] Heart Disease [] High Blood Pressure [] Blood Disease

[] Kidney Disease [] Thyroid Disease [] Cancer (type of cancer)____________________

Maternal Grandfather:

[] Diabetes [] Heart Disease [] High Blood Pressure [] Blood Disease

[] Kidney Disease [] Thyroid Disease [] Cancer (type of cancer)____________________

Maternal Grandmother:

[] Diabetes [] Heart Disease [] High Blood Pressure [] Blood Disease

[] Kidney Disease [] Thyroid Disease [] Cancer (type of cancer).____________________

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Acknowledgement of Notice of Privacy Practices

I acknowledge that there is always a readily available copy of the office privacy policy at the front desk supplied by Dr. Jeff Carls, Family Medicine & Aesthetics.

Please Print Patient Name:_________________________________ Date:__________

Please Sign Patient/Guardian: ____

Release of Information

I AUTHERIZE THE RELEASE OF MEDICAL INFORMATION TO THE FOLLOWING PERSONS:

Print Name: ______________________________________ Relationship: _____________

Print Name: ______________________________________ Relationship: _____________

Print Name: ______________________________________ Relationship: _____________

Print Name: ______________________________________ Relationship: _____________

Print Name: ______________________________________ Relationship: _____________

Please Print Patient Name: ___________________________________ Date: ____________

Please Sign Patient/Guardian: ____

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PATIENT RESPONIBILITIES

We frequently experience delays in completing necessary testing ordered by physician due to the complexity of the administrative process of your insurance policy. We will assist you in the process of obtaining authorization for the test ordered, but ultimately it is YOUR responsibility to communicate with your insurance company.

It is your responsibility to:

+ Follow through with all test ordered
+ Follow up with your doctor as recommended
+ Allow 72 hours for all prescription refill requests
+ Inform us immediately if your symptoms worsen, change, or if you are experiencing difficulties with your treatment plan
+ Pay your co-payments and deductibles at time of service

You are fully aware that your doctor can not be responsible or held liable if you Do Not follow through with the test ordered of fail to follow up on the test results that are necessary to diagnose and treat your disease process.

You, the Patient, MUST actively participate in your care. Open communication is vital to any Doctor-Patient relationship. Please sign below to acknowledge that you have read AND understand your responsibility as a patient.

Please Print Patient Name:_________________________________ Date:_______________

Please Sign Patient/Guardian: ____

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IMPORTANT OFFICE POLICIES

p·1ease read the following important office policies. You are responsible for understanding these policies. If you are a minor, your parent or legal guarding MUST agree to these terms and sign.

Insurance and/or payment protection forms:

You may be charged a fee of $25.00 per form. For filling out additional forms from various companies that are above and beyond the usual and customary disability form.

Financial Responsibility:

I understand and agree that I am financially responsible for ALL services rendered by this office and its employees. If my account is not paid in full within 90 days, my account may be sent to collections.

Insurance Coverage:

This office works with several different insurance companies that carry several different types of coverage which change constantly for a variety of reasons. As a result, I understand and agree that I am solely responsible for knowing which types of services are covered under my policy or not covered by my policy.

Proof of Insurance:

All Patients must complete out patient information PRIOR TO BEING SEEN. We must obtain current and valid proof of insurance. If you fail to provide these you may be responsible for the balance of a claim

Coverage Changes:

If your insurance changes, please notify us prior to your next visit.

Insurance Billing:

We will bill all primary and secondary insurance companies as a courtesy. We DO NOT bill third party insurances. Your insurance plan is a contract between YOU and your insurance. Ultimately, the patient is responsible for ANY account balances past 90 days.

Copayments/ Deductibles:

I understand that I am responsible for knowing if my insurance plan has a copay or deductible, and if applicable, how much it is. The copayment/ deductible is **DUE AT THE TIME OF SERVICES RENDERED.** If for some reason the copayment/deducible is not paid at the time of service, I am still responsible for the copay/ deductible and will be billed for it in addition to any other charges that may be due.

Cash Pay Patients:

Full payment is due at the time of treatment. We accept cash, checks, master card, visa, and discover.

Non-Sufficient Funds:

In the event that I pay for services by check and that is returned because of non-sufficient funds, I understand that I will be billed for the charges again in addition to a $25.00 non-sufficient funds fee to compensate to office for expenses it incurs as a result.

Appointment order & rescheduling of late Arrivals:

I understand that it is possible that someone who arrives after me may be seen first because of my late arrival. If I arrive late for my appointment, I also accept that *my* appointment may have to be rescheduled at Dr Carls discretion.

By my signature below, I hereby agree to the preceding important office policies

Name of Patient: ______________________________ Date: ______________

Signature of Patient/Guardian: ______________________________

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CANCELLATION AND NO-SHOW POLICY

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 more then 24-hour notice, so we are able to offer that slot to other people.

Office appointments which are canceled with LESS then 24-hour notice may be subjected to a $25.00 cancellation fee.

Patients who do NOT show up for their appointment without a call to cancel an office appointment OR procedure appointment will be considered as a NO SHOW. Patients who No Show 3x or more times in a 12-month period may be dismissed from the practice and thus they will be denied ANY future appointments. Patients may also be subjected to a $25.00 fee for office appointment No Show fee.

This Cancellation and No-Show fee are the sole responsibility of the patient and must be paid in full before the patients nest appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

We believed that a good Physician/Patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the billing department (928-855-1550 ext.: 1020)

Please sign that you have read understand and agree to this cancellation and no-show policy.

Name Of Patient: ____ Date: ________________

Patient/Guardian signature: ____

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New Patient and Annual Wellness Visit

PLEASE KEEP THIS COPY FOR YOUR RECORDS

Please be aware that Dr. Carls does not generally perform Annual Wellness exams on the first initial visit. This is meant to be a "get acquainted" visit between you (the patient) and the provider. We will obtain your medical history and try to answer any questions or concerns you may have. Tests cannot be ordered for you for you without knowing your medical history and/or concerns.

It is common for a provider to address new or chronic health issues at the same time that they are performing a wellness exam. If a problem is discovered and treated during a wellness exam or if a chronic issue is discussed at this time, a separate office visit will be charged. You may choose to schedule a separate visit to address these issues if you'd like. Your insurance may have separate benefits for preventative/wellness visits vs a regular office visit.

The purpose of a preventative/ wellness visit is to review the patient's health history, preform a physical examination, review risk factors, instruct the patient on how to reduce their risk factors and to order labs or other test for screening reasons. Most insurance policies that cover annual wellness visits will pay for ONE wellness exam per year and then ONE office visit at which time the provider performs the examination and gives the test results. Most insurance companies WILL NOT pay for the first visit (the ordering of test) as an annual wellness. Generally, we bill the first visit as an office visit using whatever diagnoses you have discussed with your provider at the time of your new patient visit.

We know how confusing insurance can be and it is our intention to help clarify any concerns or issues prior to you receiving treatment. If you have any questions regarding this policy, please do not hesitate to contact the billing department.

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PLEASE KEEP THIS COPY FOR YOUR RECORDS

A REMINDER OF OUT OFFICE POLICY IF YOU NEED A

MEDICATION REFILL:

Please call your pharmacy AT LEAST 3 days prior to your LAST refill dosage even if your prescription bottle states NO REFILLS.

We ask that you give us AT LEAST 72 hours' notice for medication refills. Not because it will take 72 hours to process your refill, but simply because we cannot control other factors that are involved in the processing of your prescription.

Ex: insurance approval, the pharmacy, or technical issues.

NO MEDICATION WILL BE FILLED ON THE WEEKEND.

You Must Call **BEFORE.12PM** ON Friday OR **AFTER** 10AM on Monday

Thank you

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To Our MEDICARE Patients,

Your Medicare Part B benefits include TWO preventative visits, the IPPE (Welcome to Medicare) and the Annual Wellness Visit (AVW). You pay nothing for these visits if the provider accepts Medicare assignment; Dr Carls accepts Medicare assignment.

The IPPE (Welcome to Medicare) is NOT a head-to-toe physical examination. It is a preventative visit where you and your physician may discuss your health status and maximize the preventative services that are available to Medicare beneficiaries. The "Welcome to Medicare" preventative visit can only be done during the first 12 months of starting Medicare Part B.

The Annual Wellness Visit (AMV) is not a head-to-toe physical examination. It is a preventative visit where you and your physician may discuss your health status and maximize the preventative services that are available to Medicare beneficiaries. *A Health Risk Assessment (HRA) must be completed before the visit. The HRA form will be given to you at the check-in.* The Annual Wellness visit can be done if you have had Medicare Part B for longer than 12 months. It can only be done ONE time per year.

Please come prepared with the following information:

+ Medicare records
+ immunization records
+ detailed family health history
+ ALL medications in there ORIGNAL bottles
+ Supplements & vitamins
+ list of ALL providers involved in your medical care.

Please refer to your Medicare handbook (Medicare & you) for a list of preventive services that may be covered.

If you have a non-Wellness issue that you wish to discuss with the provider at this visit, a separate office visit charge will be billed to Medicare. You will be responsible for the deductible and/or coinsurance for this office visit charge.

Please don't hesitate to call if you have any questions,

Thank You

Dr. Carls and Staff