Good Years
FAMILY MEDICINE

NEW PATIENT HEALTH HISTORY FORM

Name: _____ Preferred Name: _____ Date of Birth: ____/___ /____

Chronic Medical Problems: Include year of diagnosis

1) _____

2) _____

3) _____

4) _____

Current Medications: Include strength & directions

Pharmacy: _____ Cross Streets _____

1) _____

2) _____

3) _____

4) _____

5) _____

(If more than five please list on the back page)

Allergies to Medications: Include reaction

1) _____

2) _____

3) _____

Health Maintenance: Please write date & results

Last Physical Exam: _____

Last Colonoscopy: _____

Last Bone Density (DEXA): _____

Last Pneumonia vaccine: _____

Shingles vaccine: _____ Flu vaccine: _____

Last pap smear? (Females only) _____

Have all pap smears been normal? _____

Last mammogram? _____ Normal? _____

List past surgeries: Include year done.

1) _____

2) _____

3) _____

4) _____

Family History: Include only blood relatives & relationship

Heart Disease: _____

Any type of cancer: _____

Depression: _____

Diabetes: _____

High Cholesterol or Triglycerides: _____

Thyroid Disease: _____

Other: _____

Social History:

Occupation: _____

Marital Status: _____

Number of children: Sons: _____ Daughters: _____

Who do you live with? _____

Do you currently smoke cigarettes? _____

How much? _____ What year did you quit? _____

Any history of drug use? _____

How much alcohol do you drink? _____

Type of alcohol? _____

How much caffeine do you drink? _____

Do you exercise? _____ How often? _____

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10240 W Indian School Rd., Suite 155
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T: 623-594-3171 F: 623-594-3161

14960 W Indian School Rd., Suite 340
Goodyear, AZ 85395
T: 623-594-3171 F: 623-594-3161

Advance Beneficiary Notice on Non-Coverage (ABN)

Please read and sign below

- Your provider may order test during your visit **DONE HERE OR AT AN OUTSIDE FACILITY that MAY OR MAY NOT** be covered by your insurance policy. We do not know the limitations of your policy.
- If you decide to have these tests performed and your insurance does not cover all or a portion of the costs associated with these tests. **IT WILL BECOME YOUR FINANCIAL RESPONSIBILITY TO PAY FOR ANY NON-CONVERED SERVICES ORDERED BY THIS OFFICE**.
- We will only use appropriate diagnosis codes relevant to your healthcare on your order for your testing or insurance claim. Codes cannot be added or removed after your testing to try to get "non-covered" services covered. **THIS IS FRAUD**.
- Any bills you receive are your financial responsibility.
- Our office will NOT call insurance companies, laboratories or diagnostic imaging facilities on your behalf regarding your bills. Any appeals regarding non-covered services must be done by the patient or guarantor.
- Certain insurance require time limits for certain services such as early physicals, mammograms, pap smears or other kinds of testing. If you choose to have these services BEFORE the date your insurance states you can each year, you may be billed and will be responsible for charges if your insurance does not cover the service. It is your responsibility to know when you are due for yearly physical.
- **It is your responsibility to know the limitations and terms of your insurance plan.**

By signing below, I acknowledge that nay services or testing ordered or done by this office will become my financial responsibility if my insurance plan does not cover these services/tests.

Patient Name: _____

Patient D.O.B: _____/_____/_____

Patient/Guarantor or Guardian Signature: _____

Date: _____/_____/_____

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HIPAA NOTICE OF PRIVACY PRACTICES

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health Information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and discloser of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosers to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Practice Administrator or owners. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. You have the right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosers that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policy please contact the Practice Administrator or owners.

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HIPAA Privacy Practices Acknowledgment and Communications Authorization

ACKNOWLEDGMENT: I have received or have been offered a copy of our office's Notice of Privacy Practices policy and have been provided an opportunity to review it.

Printed Name: _____ D.O.B _____/_____/_____

Signature: _____ Date: _____/_____/_____

COMMUNICATIONS AUTHORIZATION: I authorize Good Years Family Medicine to contact me and leave voice messages, text messages or emails at the following:

Home: _____-_____-_____ Cell Phone: _____-_____-_____

Work: _____-_____-_____ Email: _____

I authorize the following person(s) to discuss my medical or financial responsibility with Good Years Family Medicine:

_____

Name Relationship Phone Number

_____

Name Relationship Phone Number

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Consent for Release of Medical Information/Records

Patient Name: _____ DOB _____ Date _____

Address: _____ City _____ Zip _____

**Release Records from: _____

Phone _____ Fax _____

Address: _____ City _____ Zip _____

**Release Records to: _____

Phone _____ Fax _____

Address: _____ City _____ Zip _____

RECORDS REQUESTED:

- ○ X-ray Report(s)
- ○ Laboratory Report
- ○ Consultation Reports
- ○ Eye Exam
- ○ Copy of Diagnostic Imaging study/studies
- ○ Progress Notes
- ○ Colonoscopy/Pathology Report
- ○ All Records

Dates of Records Requested: From _____ To _____ All ○

Records are for: Continuation of Care ○ Personal Use ○ Second Opinion ○

Records can be delivered by: Check all that apply- Fax ○ Us. Mail ○ Will pick up in office ○

I hereby authorize the above entities to handle the release/transfer of my medial information or records as specified. I, being the patient or patient representative have the legal right to inspect, copy and request delivery as specified of this protected health information within the next 30 days in accordance with public law. I accept responsibility for any fees that may be associated with this request. I can revoke this authorization in writing to the above entities with a 30 day notice.

Patient Signature: _____ Date: _____

Patient's Legal Representative: _____ Date: _____

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FINANCIAL POLICY

Patient/ Guarantor Name: _____

D.O.B _____ / _____ / _____ Social Security Number: _____ - _____ - _____

The providers and staff at Good Years Family Medicine are committed to you with quality care in a way that is financially responsible for your and our practice. It is important that you read, sign, and clearly understand the contents of our financial policy.

If you HAVE an insurance policy that our office accepts, we expect you to:

- Pay your copay, deductible or co-insurance amounts at the time of service.
- Know and UNDERSTAND the details of your insurance policy. Although we verify your coverage, it is your responsibility to know your benefits, requirements for prior authorizations, copay/co-insurance amounts and deductibles.
- Update your insurance with us immediately if there are any changes including new cards, ID numbers, benefit changes, guarantor information, etc.
- If you do not have current information at the time of your visit, or if we are unable for any reason to verify your policy and its conditions, we will expect you to be a self-pay patient for that visit, until we receive current, updated information or we will have to reschedule your appointment.

If you DO NOT have current insurance, we will expect you to:

- Pay in full, at the time of service, or we will have to reschedule your visit.

Methods of payment: We accept cash, credit or debit cards. Personal checks will ONLY be accepted for balances on established accounts. If your check is returned, a $30 fee will be added to your account.

INITIAL: _____

Cancellation/No show Policy: A fee of $25 will be added to your account for cancellations without a 24 hour notice, or a no show to your scheduled appointment. Insurance companies do not pay these fees, and they will be your responsibility. ***If there are 3 or more no shows or cancellations within a calendar year,*** you will be discharged as a patient from our practice.

INITIAL: _____

Past Due Accounts: Accounts will be considered due if they are not paid within 60 days of the time of service. If your account is not paid, we reserve the right to assign your account to a private collection agency. If you are turned to collections, we will not have authority over your account. ALL payments, arrangements etc., will be made directly with the collection agency. Your account will go back to a "Bad Debt" status with our office, and you will be discharged as a patient from our practice. I understand that if my account is assigned to collections, I agree to pay an additional 10% of the outstanding balance assigned. I also agree to pay any interest on the principle balance court costs, and attorney fees associated with the collection efforts of my account.

INITIAL: _____

Medical Record Fees: One complete, complimentary copy of your medical records will be furnished to you at your request, free of charge. If you request another copy or if a legal firm or other non-medical facility requests your records, a charge of $75 will be billed to retrieve these records. Records will not be released until payment is received. If another doctor's office or hospital requests your records, no fees will be charged as this is for continuity of your medical care. **Please allow 7-10 business days for processing of ALL records requests.**

INITIAL: _____

FMLA Forms Fee: As of February 1st, 2024 our office charges $40 if paying in cash or $45 if paid by card for all FMLA forms or other paperwork that has to be filled out by a provider. Sports Physicals are $50, this is in addition to any copays or coinsurance amounts that are deemed patient responsibility. Fees are due once paperwork is turned in to be filled out.

INITIAL: _____

Statement of Responsibility

** I have read and understand in its entirety the contents of Good Years Family Medicine's above financial policy and its requirements for me, as their patient**

Printed Name of Patient/Guarantor: _____

Signature: _____

Relationship to patient: Self [ ] Parent/Guarantor [ ] Responsible Party [ ]

Authorize to Release Information: I hereby authorize my provider's billing agent to release such information as may be necessary for the completion of my insurance claims, of for continuity of care to other medical provider's facilities or treatment assessment and planning for my medical care.

Signature: _____ Date: _____