Ponderosa Family Care
Rural Health Clinic

* Internal Medicine
* Pediatrics
* Family Practice
* Behavioral Health
* Wellness Center
* Nephrology
* Neurology

Alan P. Michels, MD
Medical Director and CEO

127 E. Main St, Ste D
and 600 E. Hwy 260, Ste 9
Payson, Arizona 85541
ph. (928) 468-8603
fax. (928) 468-8625
Behavioral Health
ph. (928) 363-1469
fax (928) 363-4423

New Patient Packet

Dear Patients,

These forms that we require you to fill out are an integral part of creating an extensive, accurate and informative electronic health record. The information you provide on these forms is very important to the physician who will be treating you. The more we know about your current health and well-being the better the outcome of your visit will be.

These forms are very extensive and that is why we require you to pick them up and fill them out at home. This practice is (whole person internal medicine) which means that the physician covers your entire medical from head to toe. It is imperative to have as much information as possible to assist the physician in diagnosing and preparing a medical plan for you.

If certain sections of these forms do not apply to you, you may mark NIA. All sections of these forms must be filled out or marked NIA only if they do not apply or they will be returned to you. The immunization section needs to be filled into the BEST of your ability, if you have immunization health records, bring them with you to your scheduled appointment.

Ponderosa Family Care Opioid Analgesics and Controlled Substance Policy:

Because controlled medications are dangerous, can be addictive, and carry legal risks, the Ponderosa Family Care provider team has the following policy regarding controlled substances of any type:

We will not prescribe controlled substances of any type at a new patient visit. It is our goal to build a relationship with each patient and carefully assess the needs and issues of each patient before prescribing controlled medications.

We will review the records of new patients prior to making a decision regarding prescribing controlled medication of any type. We will obtain these records directly from your prior provider. Patient copies are not accepted.

We do not guarantee that we will continue the medications prescribed by the prior treating provider.

Once you have completed these forms, return them to the office, they will then be reviewed, keep in mind that this is not a chronic pain management clinic. Once your forms are reviewed then you will receive a call from us to schedule your appointment or to assist you in finding a facility that would be more suitable for your medical needs.

Respectfully,
Ponderosa Family Medicine
Management

PATIENT REGISTRATION FORM

Patient Name: _____

Last First MI

Address: _____City_____State_____Zip_____

Home Phone (_____)_____Cell Phone (_____)_____ SSN _____-_____-_____ Male or Female

DOB _____/_____/_____ Marital Status S M W D Preferred Pronouns_____

E-mail address_____Driver's License_____

I would like to receive text messages for reminders, medications, test results, etc. Yes No

Employer Name: _____Phone (_____) _____

Primary Insurance Information

Policy Holder Name_____DOB____/____/____Relationship to holder_____

Address_____City_____State_____Zip_____

Insurance Name_____Policy#_____Group#_____

Secondary Insurance Information

Policy Holder Name_____DOB____/____/____Relationship to holder_____

Address_____City_____State_____Zip_____

Insurance Name_____Policy#_____Group#_____

Emergency Contact

Name_____Relationship_____Phone (_____)_____

If patient is a child, who may authorize treatment? _____Phone (_____)_____

I assign all medical and/or surgical benefits to which I am entitled, under any and all insurance, or any other health plan to Ponderosa Family Care. I authorize the release of my medical information necessary to process claims and direct payment of benefits from my insurance company. I accept financial responsibility for all charges, including but not limited to, co-payments and annual deductibles. I have received my Medical Treatment Agreement. This includes my email and phone communication preferences as well as the Consent to Treat Agreement.

_____ _____

Signature of patient, parent, or legal guardian Date

PATIENT NAME_____**DATE**_____**DOB**_____

Medications:

1) Drug_____ Dosage_____Frequency_____For_____
2) Drug_____ Dosage_____Frequency_____For_____
3) Drug_____ Dosage_____Frequency_____For_____
4) Drug_____ Dosage_____Frequency_____For_____
5) Drug_____ Dosage_____Frequency_____For_____
6) Drug_____ Dosage_____Frequency_____For_____
7) Drug_____ Dosage_____Frequency_____For_____
8) Drug_____ Dosage_____Frequency_____For_____
9) Drug_____ Dosage_____Frequency_____For_____
10) Drug_____ Dosage_____Frequency_____For_____

Vitamins, supplements, and over the counter medicine:

_____

_____

Preferred Pharmacy: _____

Allergies (Please list the allergy and the reaction) ____No known allergies

Drug allergies_____

_____

Food allergies_____

_____

Past surgical history:

Surgery_____ Month/Year_____

Surgery_____ Month/Year_____

Surgery_____ Month/Year_____

Surgery_____ Month/Year_____

PATIENT NAME_____**DATE**_____**DOB**_____

Physical Medical History

Please list any significant medical history such as diabetes, heart disease, etc., and any hospitalizations including the date of hospitalization

____No significant medical history

_____

_____

_____

_____

Mental Health History

Please list any mental health diagnosis and psychiatric hospitalizations including the date of hospitalization

____ No mental health history

_____

_____

_____

_____

Family history

Please put initials of family member next to each diagnosis and indicate the age at onset of diagnosis or age at death. M=mother, F=father, S=sister, B=brother, GM=maternal grandmother, GF=maternal grandfather

Diagnosis	*Age at onset or death*	*Relationship*	*Diagnosis*	*Age at onset or death*	*Relationship*
ADD/ADHD			Hearing deficiency		
Alcoholism			Hyperlipidemia		
Allergies			Hypertension		
Alzheimer's disease			Irritable bowel disease		
Asthma			Learning disability		
Blood disease			Mental illness		
CAD (chronic heart)			Migraines		
CAD-Premature			Obesity		
Cancer			Osteoarthritis		
CVA (stroke)			Osteoporosis		
Depression			PVD (vascular)		
Developmental Delay			Renal disease		
Diabetes			Seizure disorder		
Eczema			Other		

PATIENT NAME_____**DATE**_____**DOB**_____

Review of Systems

Please circle if you have any of the following symptoms

Constitutional: Fatigue Fever Night sweats

HEENT: Ear drainage Hearing loss Nasal drainage

Respiratory: Cough Dyspnea (respiratory abnormalities) Wheezing

Cardiovascular: Chest pain Irregular heartbeat/palpitations

Vascular: Claudication (stricture and reduced elasticity of an artery)

Gastrointestinal: Abdominal pain Constipation Diarrhea Vomiting

Genitourinary: Dysuria (painful urination) Hematuria (blood in urine) Polyuria (excessive urination)

Reproductive: Penile discharge

Metabolic/Endocrine: Cold intolerant Heath intolerant Polydipsia (excessive thirst)

Neuro/Psychiatric: Gait disturbance Psychiatric symptoms

Dermatologic: Pruritus Rash

Musculoskeletal: Bones/Joint symptoms Muscle weakness

Hematologic: Bleeding Easily bruising

Gynecologic History

Are you? ___Premenopausal ___Perimenopausal ___Postmenopausal

Do you take HRT (hormone replacement therapy): _____ Have you had a hysterectomy? _____

Last menstrual period date:_____ Do you have children?_____ How many? Boys___ Girls___

How many pregnancies have you had?_____ Are you currently pregnant?____

Circle all that apply

Breast augmentation Tubal ligation Breast biopsy (benign? _____) D and C

Breast reduction Mastectomy Cesarean section Removal of Fibroid Removal of ovaries

PATIENT NAME_____**DATE**_____**DOB**_____

Adolescent History (only fill out if patient is birth to 17 years of age)

Mother/Guardian:_____ Occupation:_____

Cell number_____ Work_____ Other_____

Father/Guardian:_____ Occupation:_____

Cell number_____ Work_____ Other_____

Child resides with/custody arrangement: _____

_____

Childcare:_____ Hours/day _____

Primary language:_____ Language spoken at home:_____

School:_____ Grade:_____ Do you like school?_____

Overall performance in school (circle one) Below grade level At grade level Above grade level

Any concerns with education or ability to learn? _____

_____

Does the child use/consume: ___ Tobacco Type:_____ Amount_____ Frequency_____

___ Alcohol Type:_____ Amount_____ Frequency_____

___ Caffeine Type:_____ Amount_____ Frequency_____

Are there smokers in the home? _____

Circle all that apply

Takes nap Sleeps with parents Sleeps through the night Minimum 8 hours of sleep Nightmares

Uses bike/skating helmet Car restraints (car seat, booster, seat belt)

Exercise/sports: _____ hours/day TV/computer games:_____ hours/day

Anything else you would like us to know about your child?

_____

_____

_____

_____

PATIENT NAME_____**DATE**_____**DOB**_____

Social History and Needs Assessment

Ponderosa Family Care is credentialed as a **Patient-Centered Medical Home**. This is an approach to primary care that is built around YOU! You are the most important member of your healthcare team. We want to meet your goals and needs. We know that health is not achieved in a clinic; but rather in our homes, schools workplaces and communities. Help us get to know you and your healthcare needs by completing this section entirely. If there is anything that is not applicable or you do not wish to answer, please mark N/A. Thank you!

Social History

Primary language spoken? _____ Country of birth: _____

Hand dominance:_____ Highest level of education:_____

Military experience:_____ Occupation:_____

Occupational hazards:_____Restrictions:_____

Do you drink alcohol?_____If so, what kind_____Frequency_____

Do you drink caffeine?_____If so, what kind_____Frequency_____

Do you exercise?_____If so, please list what type of exercise, how many hours a week, and the activity level (moderate, vigorous, or sedentary):_____

_____

Hobbies/Activities: _____

Animals in the home:_____

Religious affiliation or spiritual beliefs:_____

Home Environment/Safety

Smoke detectors in home?_____ Carbon monoxide detector in home?_____ Radon in home?_____

Firearms at home?_____ Pool/spa at home?_____ Seatbelt use?_____ Home heating_____

Tobacco Use

___ Current ___ Former ___ Never ___ Unknown

Type:_____ Units/day:_____ Years used:_____

Ever tried to quit?_____ Year quit:_____ Longest period tobacco free:_____

Please list anything that triggers the need to smoke _____

List previous methods of cessation attempts_____

Advanced Directives

Please provide a copy of your advanced directives to PFC if you have one. Check what applies below.

___ None ___ Do not resuscitate ___ Living will ___ Do not place on life support

___ Durable Power of Attorney ___ Healthcare proxy

Effective date of directive _____ Does the patient agree to a blood transfusion? _____

Needs Assessment

What matters most to you? _____

_____

_____

Do you have any health concerns today? _____

Have you been to the ER or hospitalized in the last 12 months? _____ If yes, please explain:_____

_____

My Concerns

Circle any problems or concerns that you are currently facing as you manage your health:

Thinking/memory problems Emotional issues Spiritual support Family Issues Financial stress

Inadequate housing Access to nutritious foods Transportation to appointments End of life stress

Mobility challenges My ability to manage my chronic conditions Social support-friends Drug Use

Lack of motivation Thoughts of harming yourself Thoughts of harming others Exhaustion Panic Attacks

Alcohol consumption Prescription medication use Other:_____

Goals

Circle any of the following health goals that would improve your quality of life:

Consistent control of blood sugars Weight loss Normal blood pressure Lower cholesterol

Heart health Increased energy Able to manage stress well Minimal symptoms of depression

Eliminate anxiety/panic attacks Achieve/maintain sobriety Other:_____

Identify a life goal or reason that motivates you to work towards better health.

_____

_____

_____

_____

*Community Resources are available upon request or at FindHelp.org

Medical Treatment Agreement

Patient Name_____DOB_____

Patient or the patient's legal representative agrees to the follow terms of clinic encounters:

1. **MEDICAL TREATMENT**
   The patient consents to the treatment, services, and procedures which may include but are not limited to laboratory procedures, X-ray examinations, medical and surgical treatments, procedures, or anesthesia.
2. **TELEMEDICINE**
   The patient consents to medical visits via electronic platforms including but not limited to video and/or verbal communication using smart phones, tablets, laptops, computers, Teams, Google Meets, and all/any other types of electronic formats to communicate the patient's healthcare services.
3. **LEGAL RELATIONSHIP BETWEEN CLINIC AND HEALTHCARE PROVIDERS**
   The patient will be treated by his/her attending physician or health care provider and be under their supervision. Physicians and other healthcare providers providing services to the patient may include but are not limited to radiologists and pathologists who are generally not employees of the clinic. These providers may bill separately for their services. Questions about whether a healthcare provider is an agent or employee of the clinic should be directed to administration during normal business hours.
4. **TEACHING PROGRAM**
   The clinic participates in training programs for physicians and healthcare personnel. Some patient services may be provided by persons in training under the supervision and instruction of physicians or clinic employees.
5. **RELEASE OF INFORMATION**
   The patient acknowledges and agrees that medical and/or financial records (INCLUDING INFORMATION REGARDING ALCOHOL OR DRUG ABUSE, HIV RELATED OR OTHER COMMUNICABLE DISEASE RELATED HEALTH INFORMATION) may be released to the following:
   a. Healthcare providers or their agents who are providing or have provided healthcare to the patient, any individual accrediting the facility or conducting utilization review quality assurance, or peer review and to the clinics and providers legal representatives and professional liability carriers.
   b. Individuals and organizations engaged in medical education and research, provided that information may only be released for the use in medical studies and research without patient identifying information.
   c. Individuals and entities as specified by federal and state laws and/or in the clinic's notice of privacy practices.
   d. Patient records of services provided at any time may be exchanged among these facilities where necessary to provide appropriate patient care. This release shall continue for so long as the medical and/or financial records are needed for any of the above stated purposes.
   e. This is an assignment of benefits and rights under my insurance. I authorize the release of any medical information necessary to process claims and direct payment of benefits from my insurance company.
   f. Individual visit summary available upon request.
   g. Staff will return patient phone calls within 24 hours, Mon-Fri 8am-5pm. After hours and weekends contact the on-call provider.
   h. Refill requests take 3 business days. Please contact your pharmacy to request refills.

6. **CONTRABAND**
   Drugs, alcohol, weapons and other articles specified as contraband by the Clinic may not be brought onto clinic premises. Any illegal substances will be confiscated and turned over to Law Enforcement authorities.
7. **COMMUNICATION**
   _____OK to call my home and leave a message
   _____ call my home phone but DO NOT leave a message
   _____ DO NOT CALL MY PHONE, call only this number: _____
   _____ DO NOT speak to a family member
   _____ OK to send me my health information by encrypted email.
   I authorize the following individuals to inquire and receive verbal information regarding my care:

   1. _____Relationship_____Phone_____
   2. _____Relationship_____Phone_____
   3. _____Relationship_____Phone_____

I have received the notice of Privacy Practices. I am the patient, the parent of a minor child, or the legal representative of the patient and am authorized to act on the patient's behalf to sign the agreement.

_____

Signature of Patient/Representative/Parent of a minor child **Date**

NOTICE OF HEALTH INFORMATION PRACTICES

You are receiving this notice because your yealthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current, a Contexture company. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

Hospital records	Radiology reports
Medical history	Clinic and doctor visit information
Medications	Health plan enrollment and eligibility
Allergies	Other information helpful for your treatment
Lab test results	

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and other participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and other may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the

rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statues title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers-even in an emergency
2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

ACKNOWLEDGEMENT RECEIPT: HIPPA NOTICE OF PRIVACY PRACTICES

By reviewing and signing this form, you acknowledge that Ponderosa Family Care has given you the right to review and obtain a copy of the HIPPA privacy policies, which explain how your health information will be handled in various situations, if you would like to review the detailed form or obtain a copy, please see the receptionist.

"I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I choose to Opt Out."

Signature of Patient/Representative/Parent of a minor child **Date**

Printed name

Every is automatically opted into the HIE program.

I opt out of PFC sharing my information with AZ HIE. Only initial if you **do NOT want** to participate in the Health Information Exchange Program, _____. The front desk will give you the **opt out form** to fill out and give back to them.
