

Patient Information

How did you hear about us?		Today's Date	
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PATIENT INFORMATION

Last Name		First Name		M.I.	
Date of Birth		Social Security #			
Age		Gender			
Main Phone		Other			
Email			Married		
Address			City		
State			Zip		
Employer			City		
Occupation					

EMERGENCY CONTACT/ PARENT / GUARDIAN/ SPOUSE

Last Name		First Name			
Home Phone		Cell			
Relationship		Other			
Other		Ok to Discuss Labs or Reports	Yes	No	

PRIMARY INSURANCE

Policy Company		ID #			
Policy Address		Group #			
Policy City		Policy Holder			
Policy Zip		Relationship			

SECONDARY INSURANCE

Policy Company		ID #			
Policy Address		Group #			
Policy City		Policy Holder			
Policy Zip		Relationship			



Medical History

PATIENT NAME: _____ **AGE** _____

WHY ARE YOU HERE TODAY?

HAVE YOU OR ANY BLOOD RELATIVE SUFFERED ANY OF THE FOLLOWING? PLEASE CIRCLE AND INDICATE SELF OR WHAT RELATIVE.

THYROID _____	ASTHMA _____	HYPERTENSION _____
OSTEOPOROSIS _____	HEART DISEASE _____	EPILEPSY _____
ALCOHOLISM _____	ANEMIA _____	MIGRAINE _____
HAYFEVER _____	STROKE _____	MENTAL ILL _____
ARTHRITIS _____	DIABETES _____	GLAUCOMA _____
CANCER _____	BLEEDS EASILY _____	

ALLERGIES:

LIST ALL MEDICATIONS YOU ARE NOW TAKING (with Dosage)

HOSPITAL ADMISSIONS

YEAR	ILLNESS OR OPERATION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

VACCINES

- _____ TETANUS/Td
- _____ FLU
- _____ PNEUMONIA
- _____ HEPATITIS
- _____ TUBERCULOS

Please Check all that apply:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Indigestion or Heartburn | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Measles Rheumatic Fever |
| <input type="checkbox"/> Ringing in Ear | <input type="checkbox"/> Persistent Nausea / Vomiting | <input type="checkbox"/> Convulsions / Seizures | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Ear Infections - frequent | <input type="checkbox"/> Peptic Ulcers | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Abdominal Pain- chronic | <input type="checkbox"/> Tremor / Hands Shaking | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Failing Vision D Eye Pain | <input type="checkbox"/> Gall Bladder Trouble | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Contact with Blood or Body Fluids |
| <input type="checkbox"/> Double or Blurred Vision | <input type="checkbox"/> Jaundice / Hepatitis | <input type="checkbox"/> Numbness / Tingling | Alcohol _____oz. per week |
| <input type="checkbox"/> Eye Infections - frequent | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Sensations | Smoking _____cig. per day |
| <input type="checkbox"/> Nose Bleeds - recurrent | <input type="checkbox"/> Diarrhea D Constipation | <input type="checkbox"/> Headaches - frequent | _____ #yrs. |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Diverticulosis D Crohn's / Colitis | <input type="checkbox"/> Arthritis / Rheumatism | Coffee / Tea _____cups per day |
| <input type="checkbox"/> Sore Throats - frequent | <input type="checkbox"/> Bloody or Tarry Stools | <input type="checkbox"/> Back Pain - recurrent | |
| <input type="checkbox"/> Hayfever / Allergies | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bone Fracture / Joint Injury | FEMALES - Please complete |
| <input type="checkbox"/> Hoarseness - prolonged | <input type="checkbox"/> Hernia | <input type="checkbox"/> Gout | Menstral Flow: |
| <input type="checkbox"/> Pneumonia / Pleurisy | <input type="checkbox"/> Urine Infections - frequent | <input type="checkbox"/> Osteoporosis | Reg. ___ Irreg. ___ Pain / Cramps |
| <input type="checkbox"/> Bronchitis / Chronic Cough | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Foot Pain | Days of Flow ___ Length of Cycle |
| <input type="checkbox"/> Asthma / Wheezing | <input type="checkbox"/> Urination | <input type="checkbox"/> Cold Numb Feet | Date -1 st day of last period |
| <input type="checkbox"/> Shortness of Breath: | <input type="checkbox"/> Overnight, >2X | <input type="checkbox"/> Rashes | _____ Pain / Bleeding during or after sex |
| <input type="checkbox"/> on Exertion | <input type="checkbox"/> Painful | <input type="checkbox"/> Hives | Number of: |
| <input type="checkbox"/> Lying Flat | <input type="checkbox"/> Loss of Control | <input type="checkbox"/> Psoriasis | Pregnancies ___ Abortions ___ |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Decrease in Force / Flow | <input type="checkbox"/> Eczema | Miscarriages ___ Live Births ___ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleeping - difficulty | Birth Control Method _____ |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Nervousness | B.C. Pill (name) _____ |
| <input type="checkbox"/> Irregular Pulse | <input type="checkbox"/> Urethral Discharge | <input type="checkbox"/> Depression | _____ Flushing / Menopause |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Memory Loss | Date of last PAP Test _____ |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Weight Loss - recent | <input type="checkbox"/> Moodiness - excessive | _____ Normal ___ Abnormal |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Anemia ___ Bruise Easily | <input type="checkbox"/> Phobias | Date of last Mammo- |
| <input type="checkbox"/> Leg Pain - walking | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Illness | gram _____ |
| <input type="checkbox"/> Varicose Veins / Phelbitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chicken Pox ___ Polio | _____ Normal ___ Abnormal |
| <input type="checkbox"/> Loss of Appetite-Recent | | <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> Difficulty Swallowing | | <input type="checkbox"/> Measles ___ German | |

Signed Documents

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with which this office has a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. I further understand that if I do not show for an appointment or do not give 24 hours notice to Agave Family Health, PLLC when canceling an appointment I may be responsible for charges up to the potential cost of the visit.

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the hereby authorize Agave Family Health, PLLC and its employees to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my or my child's medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to Agave Family Health, PLLC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

FINANCIAL POLICIES

The patient or their guarantor is responsible for all co-pay, coinsurance, balances and deductibles on the day of service. You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If we do not receive payment within 30 days, the patient will be billed.

**** IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS. ****

If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. However, the agreement of the insurance company to pay for medical care is between you and your carrier. Please present your insurance card at each visit.

If you are unclear of your insurance benefits, you will need to contact your insurance carrier for clarification of coverage. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen.

Delinquent accounts over 60 days will be sent to collections for processing. At which point all collection fees, contingent or not, shall be added to the patients responsibility. In the event legal action is required, the patient shall be responsible for all reasonable attorney's fees and costs.

****All Delinquent accounts shall be assessed a 15% late fee per month until paid**

If your check is returned due to non-sufficient funds you will be charged an additional \$35.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I HAVE READ AND I UNDERSTAND THE ABOVE POLICIES AND I AGREE TO ABIDE BY ALL TERMS.

Patient Signature		Date	
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Authorization to Receive Medical Records

I authorize the release of my medical records by the organization or physician listed below:

PREVIOUS PHYSICIAN INFORMATION

Physician Name		Practice	
Phone #		Fax #	

PATIENT INFORMATION

Patient Name		Date of Birth	
Phone #		SS#	

**PLEASE FAX ENTIRE
MEDICAL RECORDS TO:**

(PLEASE DO NOT MAIL)

**Agave Family Health
3420 S. Mercy Road #113
Gilbert, AZ 85297
FAX - 480-219-3652**

Disclaimer:

I understand this authorization will expire, without my revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to the state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company.

I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for any copying fees. Shipping and applicable sales tax may also be charged.

Patient Signature		Date	
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Office Policies

Thank you for choosing Agave Family Health, PLLC as your primary care specialist. We welcome you! We hope the following information will help you answer some of your questions.

OFFICE HOURS

Monday through Thursday 8:00 am to 5:00 pm

Fridays 8:00 am to 2:00 pm (We are closed for lunch from 12 pm to 1 pm.)

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YOUR APPOINTMENT

Please arrive for your appointments 20 minutes prior or you may be required to re-schedule. Be prepared to show your insurance card and to pay your portion of the visit.

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CANCELLATION POLICY

We require a 24-hour notification of cancellation for appointments. If you fail to cancel, you may be billed for the scheduled time.

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AFTER HOURS

All patient matters will be handled during office hours. If you have an urgent matter, call 911 or go immediately to the nearest emergency room.

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PAYMENT

Payment will be due at the time of service for all co-payments, co-insurance and deductibles. (This is the policy of your insurance company) We will reschedule your appointment if you do not have your co-payment. Methods of payment accepted include cash, debit, Mastercard and Visa. No Checks.

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INSURANCE CLAIMS/BILLING

Any amount not covered by your insurance company is your financial responsibility. This includes co-payment, co-insurance and deductibles. This is your agreement with you and your insurance company. Any questions should be directed toward them.

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MEDICATION REFILLS

Contact your pharmacy to submit medication refill request.

** We do not manage chronic pain and will not fill pain medication under any circumstance.

REFERRALS

Most referrals require insurance pre-authorization and cannot be processed immediately.
We require 7-10 business days for the processing of routine referrals.

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TEST RESULTS

We require 5-7 business days for the processing of test results.
You will receive a call from a staff member when your results have been reviewed.

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MEDICAL FORMS

There will be a fee charged for filing out a variety of health related forms.
The fee will be \$25.00. Forms cannot be filled out while you wait.
We need 48 hours to fill out most forms.

CONTACTING US

By Phone: Call 480-219-3346 Please follow the prompts for the best service.
Leave ONE message with date of birth, full name, and message and we will return your call.
**Multiple messages will only be pushed to the end of the wait list.

By Email: You can reach us by email at info@agavefamilyhealth.com

By Website: **New Appointment** requests can be made at www.agavefamilyhealth.com

By Fax: **Medication Refill, Records, or Document** requests should be made by fax

**Dr. Finley may not be available by phone during business hours.
You may leave a message with a staff member and someone will get back to you.**

Many routine questions can be answered by visiting our website at www.agavefamilyhealth.com.