IMS
Integrated Medical Services

Patient Registration Sheet

Personal Information **Today's Date:** _____

Patient First Name: _____ Initial: _____Last Name: _____

DOB: _____ Age: _____Social Security #: _____ Email: _____

Address: _____
Street Apt # City/State/Zip

Home Phone: _____ Work Phone: _____Cell phone: _____

Assigned Sex at Birth: ☐ M ☐ F Gender Identity: _____ Pronouns: _____
Language: ☐ English ☒ Spanish OTHER: _____ Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ O
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined ☐ Unknown
Race: ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Declined ☐ Unknown
☐ Native Hawaiian/Other Pacific Islander

Occupation: _____Retired: ☐ Yes ☒ No From: _____

Employer Name: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Financial Responsible Party Information

Responsible Party Name: _____ Relationship to patient: _____

DOB: _____ Age: _____Social Security #: _____

Emergency Contact Name: _____ DOB: _____

Phone Number: _____ Relationship to patient: _____

Insurance Information

Primary Insurance: _____ Address: _____

Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

Secondary Insurance: _____ Address: _____

Policy #: _____ Group #: _____
Policy Holder Name: _____ DOB: _____ Relationship to patient: _____

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Acknowledgement and Consent for Treatment

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that the consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) you consent to treatment at this office or any other location under common ownership; and (3) the information you have provided is true and accurate. This consent will remain in effect until revoked in writing by you.

Signature of Patient/Representative: _____Date: _____

Printed Name of Patient/Representative: _____Relation: _____

Disclosure to Others

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM IMS OR THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION WITH? IF YES, PLEASE LIST BELOW:

I give permission for my Protected Health Information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the following below:

First Name	Last Name	Relationship	Contact Number

Patient Signature: _____Date: _____

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Patient Financial Responsibility Agreement

Patient Name: **Date of Birth**: **Account No.:**

We at Integrated Medical Services, Inc. ("IMS") are committed to providing quality care and service to all our patients. Your understanding of our financial policies is important to our professional relationship. Please take a moment to read through this document to fully understand yourresponsibility as a patient and sign and date the bottom.

Insurance Information: You are responsible for making sure we have all up-to-date insurance information on file, including current insurance cards. Failure to provide this information in a timely manner may result in the charges being billed to you. We ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments and Coinsurance: If you have not met your health plan's deductible on the date of service, we will collect an estimated amount before you are seen towards your deductible. Please note you may receive a bill for additional charges for services rendered. You are responsible for any co-payments and co-insurance required by your insurance carrier at the time of service. Payments received in excess of charges may be applied to subsequent services. We recommend you contact your carrier directly with any questions pertaining to your coverage.

Non-Covered Services: IMS verification of benefits team will verify coverage before you are seen, but it is ultimately your responsibility to ensure payment of your bill. Any service performed by our providers that is not covered by your insurance is your responsibility. It is your responsibility to know your benefits prior to being seen. Verification of benefits and insurance coverage is not a guarantee of payment.

Referrals: It is your responsibility to ensure we have a valid referral for services on file. Any non-covered services are the financial responsibility of the patient.

Self-Pay: If you do not have health insurance, are on a plan we are not contracted with, or if we are unable to verify your coverage at the time of service, we will collect an estimated payment before you are seen by a provider. There may be additional charges depending on the services provided for which you may receive a bill.

Forms Completion: You will be required to pay a $50 administrative fee or to make an appointment with the provider, when requested by the provider, for the completion of forms such as FMLA, Disability and other forms requiring manual completion. Payment is required in advance and is not billable to your insurance carrier.

Medical Records Request: An administrative fee will be charged for a paper copy of your medical records. An electronic copy of your records is available through your patient portal free of charge.

Returned Checks: For any returned checks, we add a $25 NSF fee to your unpaid charge balance.

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Minors: For all services rendered to minor patients, the parent, guardian or responsible party who brings the patient to the appointment is responsible for all payments due at the time of service.

Delinquent Accounts: Additional fees, including collection fees and finance charges may be added to unpaid delinquent accounts. Your account may be sent to a collection agency if the balance is 90 days old, or partial or no payment has been made towards the balance. If your account has been sent to collections, you could be subject to additional finance fees and collection fees of up to 25%.

It is IMS' responsibility: To file insurance claims on the patient's behalf. IMS will file a claim with primary carriers. As a courtesy to our patients, secondary and tertiary claims will also be filed one time. A 60-day period will be extended for pending insurance payments, after which the patient may be held responsible for the balance.

Contact: If you have any questions regarding your bill, please contact the IMS billing office at (602) 633-3838.

I have read the above financial policies of IMS and agree to be bound by its terms. I also understand that IMS has the right to amend these policies at any time.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient: _____

Printed Name of Responsible Party: _____ Relation to Patient: _____

Contact Phone Number of Responsible Party: _____

No Show Policy

IMS does enforce a no-show policy; we understand circumstances may arise which make it impossible for you to keep a scheduled appointment. Should this happen, please call us as soon as you know the appointment will be missed, with a minimum 24-hour notice.

Multiple no shows interfere with patient care and as a result we may no longer be able to provide care for you and you may be discharged from the practice. However, we do have resources to assist you as needed. Please reach out to the clinic and ask for assistance from the Care Management Team.

Patient Signature: _____Date: _____

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Assignment of Benefits

I do, hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans or other payers, for service rendered by **Integrated Medical Services, and the medical professionals caring for me during my treatment in this office to be paid directly to Integrated Medical Services,** or other associated providers as appropriate. I understand that I am responsible for all charges not paid by insurance. This assignment will remain in effect until revoked in writing by me.

Patient Signature: _____ Date: _____

Telemedicine Patient Consent

I agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. [Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to be heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all my medical information may be used for teaching or educational purposes.

Patient Signature: _____ Date: _____

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Text, Email, and Phone Consent

I agree that IMS and the provider or agent of the provider may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

I hereby permit IMS, and the provider or other healthcare professionals involved in my care to release healthcare information for the purposes of treatment, payment or healthcare operations.

I hereby consent to the use of my email, cellular telephone or other electronic communication methods for appointment reminders and other important healthcare communications. I understand that I may opt out of these communications at any time.

I understand that IMS uses an electronic health record that will update to the information and consents I provide here and that for my convenience this information will be updated at all our affiliated clinics that share an electronic health record in which I have a relationship.

I authorize IMS to contact me on the telephone numbers I have provided, and that IMS may leave an electronic message if indicated to do so.

Patient Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

I acknowledge that I can request a copy of the IMS Notice of Privacy Practices, which describes the ways in which IMS may use and disclose my healthcare information of its treatment, payment, healthcare operations and other described and permitted uses. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I also understand that this information may be disclosed electronically by IMS or its agent. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the IMS Notice of Privacy Practices.

Patient Signature: _____ Date: _____

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Advanced Directives

An Advanced Directive is a way to document your preferences for end-of-life care by assigning a person you trust to make decisions on your behalf. An Advanced Directive can be in the form of a Living Will, Healthcare Power of Attorney, Mental Health Care Power of Attorney, Prehospital Medical Care Directive.

Do you have an Advanced Directive in place? _____Yes ____No

If yes, have you provided a copy to IMS? _____Yes ____No

Date Provided _____

If no, are you interested in receiving information regarding Advanced Directives? ____ Yes ____ No

Your Clinic can provide you with a packet with additional information or you can visit the following website

Healthcare Directives Registry Arizona https://azhdr.org/

Patient Signature: _____Date: _____

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Notice of Health Information Practices

You are receiving this notice because your healthcare 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
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

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, care coordination, care or case management, transition of care planning, payment for your 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 others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others 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.

<u>Your Rights Regarding Secure Electronic Information Sharing</u>
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 Statutes 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 INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT