Mark Webb, M.D. Susan Madsen, M.D. Abigail Gerken, FNP-C

Patient Registration Form: Valley Internal Medicine and Pediatrics

Ph: (480) 991-5088 Fx: (480) 367-1361

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)

Mailing Address: Apt #

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Preferred Method of Contact for reminder calls and other electronically generated messages: ☐ Voice

If Voice, Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work

Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician or Pediatrician:

Marital Status: Social Security #:

Employer Name: Emergency Contact Name:

Emergency Contact Phone #: Relationship to Patient:

Additional Information and Responsible Party

Last Name: First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip: Relationship to Patient:

Email Address: Can we leave a message regarding your medical care & test results? ☐ Yes ☐ No

Race (please select):
☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one):
☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil)
☐ Sign Language ☐ Spanish ☐ Russian ☐ Other

Preferred Pharmacy Name & Location:

Insurance Information

Ins. Co. Name	Policy I.D.#
Policy Holder Name:	Group #
Policy Holder's Date of Birth:	Claims Address:
Policy Holder's Social Security #:	
Patient Relationship to Policy Holder:	Claims Phone#

I hereby authorize payment directly to VALLEY INTERNAL MEDICINE & PEDIACTRICE, P.C. for medical benefits, if any, otherwise paid to me for unpaid services rendered and the release of any information necessary to process claims for paid services and authorization to release records pertaining to my treatmentto my insurance compay or other 3rd parties responsible for payment of my medical charges, including reviewactivities related to my physician's participation with my health plan, via voice, electronic, mail, or fax transmission. I also agree to pay all charges and/or co-payments at the time of service. In the event of default, I promise to pay all legal fees, collection costs and/or interest as may be required to effect collection of this note. This will also serve as an authorization for release of emergency department, urgent care, and/or medical records which may be necessary.

I have reviewed a copy of VIMP's privacy notice. ☐ (Initials)

Signature of Responsible Party: X _____ Date: _____

Printed Name of Responsible Party: X _____ Date: _____

PATIENT INFORMATION SHEET

NAME:_____ DOB:_____ DATE:_____

ALLERGIES:_____

SOCIAL HISTORY:

Recreational Drug Use: Current / Past / Never

Smoking: Currently Past Never Packs/day:_____

Alcohol: Currently Past Never Drinks/day:_____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

Medications	OTC and vitamins

PERSONAL MEDICAL HISTORY: (Please circle/fill in all that apply)

ADHD	COPD	High Cholesterol	Peptic Ulcer
Alcoholism	Dementia	HIV	Psoriasis
Allergies, Seasonal	Depression	Hepatitis	Pulmonary Embolism (PE)
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Rheumatoid Arthritis
Anxiety	Diverticulitis	Kidney Stones	Sciatica
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Kidney Disease	Seizure Disorder
Arthritis	Eczema	Lupus	Sleep Apnea
Asthma	Emphysema	Liver Disease	Stroke
Bipolar	Gallstones	Macular Degeneration	Thyroid Disorder
Bladder problems/Incontinence	GERD (Acid Reflux)	Migraines	Ulcerative Colitis
Bleeding problems	Glaucoma	Nosebleeds	
Cancer:_____	Heart Disease	Neuropathy	
Carpal Tunnel	Heart Attack (MI)	Osteopenia/Osteoporosis	
Headaches	Hiatal Hernia	Parkinson's Disease	
Crohn's Disease	High Blood Pressure	Peripheral Vascular Disease	

Last Menstrual Period	Yes/No Date:____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dxa (Bone Density)	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____

_____ _____

_____ _____

FAMILY HISTORY:

FATHER: Living: Age_____ Deceased: Age_____

Alcoholism	Blood Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Skin Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Lymph Cancer	Thyroid disorder	
Anemia	Asthma	Breast Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Prostate Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:_____

MOTHER: Living: Age_____ Deceased: Age:_____

Alcoholism	Breast Cancer	Migraines	Bipolar	Osteoporosis
COPD/Emphysema	Blood Cancer	Colon Cancer	High Cholesterol	
Stroke	Heart Disease	Skin Cancer	Thyroid disorder	
Anemia	Asthma	Lymph Cancer	Dementia	
Blood Clot/DVT	Depression	Kidney Disease	Ovarian Cancer	
Arthritis	High Blood Pressure	Diabetes 1 or 2	Thyroid Cancer	

Other:_____

Siblings:_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, etc.)

_____

_____

Patient signature:_____ Date:_____

Provider reviewed:_____ Date:_____

Valley Internal Medicine and Pediatrics, P.C.

Susan J. Madsen, M.D.
Mark G. Webb, M.D., FAAP
Board Certified Pediatrics
Internal Medicine

10900 N. Scottsdale Rd., Suite 206
Scottsdale, AZ 85254

Phone: (480) 991-5088
Fax: (480) 367-1361

Please list all family/friend members whom you would like information released to:

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Do you have any of the following?:

1) Do Not Resuscitate form filled out? Yes:____ No:____

2) Living Will (End of Life Care)? Yes:____ No:____

3) Power of Attorney? Yes:____ No:____

If yes, please provide the office with a copy.

If no, please notify the office if you would like paperwork pertaining to any of the above.

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason:

VALLEY INTERNAL MEDICINE AND PEDIATRICS, P.C.
FINANCIAL POLICY

We strive to provide the highest quailty of medical care to all of our patients while taking into consideration administrative costs. To help us achieve this goal, payment is expected at the time of service. We accept cash, checks, American Express, Discover, MasterCard, and Visa credit cards. Outstanding balances 45 days beyond the date of service are subject to interest charges of 1.5% per month. Please speak with our office manager if you want to set up a payment plan.

MISSED APPOINTMENTS

We have reserved time specifically for your appointment. If you need to change or cancel an appointment, we require a minimum of one business day's notice. We understand that emergencies occur, however, **if you miss or cancel an appointment without adequate notice more than once during a 12 month period, you will be billed $50 for appointments. Physical examinations "no-shows" have an automatic fee of $150 even if it is the first missed appointment.** These fees are your responsibility and are not billable to your insurance company.

INSURANCE PROCESSING

We bill insurance companies with whom we have a signed contract. You are responsible for any co-payment, deductible, and non-covered expenses.

FEES

Returned checks from the bank will be subject to a **$25 fee** that will be applied to your account and your account will be placed on a "cash-only" basis.

There is an administrative fee of **$25-$40** (depending of the length of form) for completing forms such as DMV, physical forms, FMLA, leave of absence, disability etc. Most forms require 5-7 working days to research your information and complete the form.

There is an additional fee of **$25** if we are asked to copy medical records per patients request.

There is an additional charge if the physician is asked to participate in a deposition or phone consultation on your behalf. The fee will be based on the amount of time spent.

COLLECTIONS

Balances unpaid more than 60 days from the date of service will be sent to collections if you have not contacted our office to set up a payment plan. You will be responsible for all legal fees, collection costs, and/or interest charges that may be required to effect collection of this note.

PRE-AUTHORIZATIONS OR REFERRAL

If your insurance plan requires a referral to see a specialist, we will process your request in a timely manner. Some insurance companies require at least 7 business days to process a request. We notify you by phone when the referral has been approved.

MEDICATION REFILL POLICY

Please allow 24-48hrs for prescription refills.

*********By signing below, I acknowledge that I have read and understand the above policy.*********

_____ _____

Signature (Patient or Guardian) **Date**