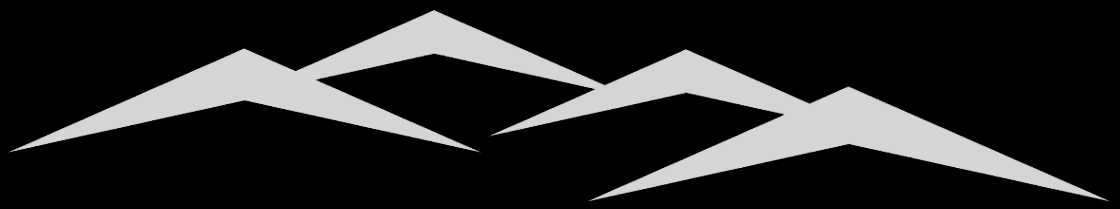

FOUR PEAKS PRIMARY CARE & INTERNAL MEDICINE

Patient Welcome Packet

DR. FAYZ YAR KHAN, MD

FOUR PEAKS PRIMARY CARE & INTERNAL MEDICINE
10214 N TATUM BLVD, SUITE B300 | PHOENIX, AZ 85028
(623) 256-4160

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PATIENT INFORMATION FORM

Name (Nombre): _____

Date of Birth (Fecha de Nacimiento): _____ **Age (Edad):** _____

Height (Altura): _____ **Weight (Peso):** _____ **Male (Hombre):** ☐ **Female (Mujer):** ☐

Home Address (Domicilio): _____

City (Ciudad): _____ **State (Estado):** _____ **Zip (Código Postal):** _____

Married (Casado) ☐ **Single (Soltero)** ☐ **Widowed (Viudo)** ☐ **Divorced (Divorciado)** ☐

Social Security # (Numero de seguro social): _____

Driver's License # (Numero de license): _____

Home Phone (Teléfono de casa): _____ **Cell (Celular):** _____

Email (Correo Electronico): _____ **Occupation (Ocupación):** _____

Emergency Contact Name (Contacto de Emergencia): _____

Phone Number (Numero de telefono): _____ **Relationship (Relacion):** _____

Primary Care Doctor (Doctor Primario): _____ **Phone # (Telefono):** _____

Fax #: _____ **Referring Doctor:** _____ **Phone:** _____

Pharmacy Name (Pharmacia): _____ **Address (Direccion):** _____

Language Spoken (Idioma): _____

Race (Choose One):

Other

Ethnicity (Circle one):

Insurance Coverage

Policy Number	Group Number	Type of Plan	Additional Info
_____	_____	_____	_____

FOUR PEAKS PRIMARY CARE & INTERNAL MEDICINE

PATIENT MEDICAL HISTORY

Name (Nombre): _____

Date of Birth (Fecha de Nacimiento): _____

HAVE YOU EVER HAD THE FOLLOWING?

⊙ YES	○ NO	ALCOHOL/SUBSTANCE ABUSE	○ YES	○ NO	HIGH BLOOD PRESSURE
○ YES	○ NO	ANEMIA	○ YES	○ NO	GALL BLADDER DISEASE
○ YES	○ NO	HEART PROBLEMS	○ YES	○ NO	STROKE/ HEART ATTACK
○ YES	○ NO	KIDNEY PROBLEMS	○ YES	○ NO	TUBERCULOSIS
○ YES	○ NO	EPILEPSY/ SEIZURES	○ YES	○ NO	HIV
○ YES	○ NO	THYROID PROBLEMS	○ YES	○ NO	LEUKEMIA
○ YES	○ NO	PNEUMONIA	○ YES	○ NO	PROSTATE DISEASE
○ YES	○ NO	DEPRESSION	○ YES	○ NO	ARTHRITIS
○ YES	○ NO	OBESITY	○ YES	○ NO	CANCER
○ YES	○ NO	GLAUCOMA	○ YES	○ NO	LIVER DISEASE
○ YES	○ NO	HERNIA	○ YES	○ NO	RHEUMATIC/ SCARLET FEVER
○ YES	○ NO	ASTHMA	○ YES	○ NO	DIABETES TYPE 1 OR 2
○ YES	○ NO	MIGRAINES	○ YES	○ NO	HIGH CHOLESTEROL

SOCIAL HISTORY:

○ YES ○ NO CIGARETTE SMOKER? DAILY CONSUMPTION (# OF CIGARETTES): _____
○ YES ○ NO DO YOU HAVE TATTOOS? _____
○ YES ○ NO DRINK ALCOHOL? DAILY CONSUMPTION: _____
○ YES ○ NO HAVE YOU HAD ANY BLOOD TRANSFUSIONS? YEAR: _____
○ YES ○ NO HAVE YOU TRAVELED OUTSIDE THE U.S. IN THE LAST 6 MONTHS? WHERE: _____

SURGERIES/ HOSPITALIZATIONS:

_____ _____ _____
_____ _____ _____

CURRENT MEDICATIONS & STRENGTH:

_____ _____ _____
_____ _____ _____

ALLERGIES

_____ _____ _____
_____ _____ _____

FAMILY HISTORY:

MOTHER: Living ILLNESSES: _____ CAUSE OF DEATH: _____

FATHER: Living ILLNESSES: _____ CAUSE OF DEATH: _____

Four Peaks Primary Care & Internal Medicine

Payment Authorization

Per office policy, we will bill your insurance, but since the contract is between you (the patient) and them (your insurance company), the patient or responsible party is responsible for all deductibles, copays, co-insurance and non-covered services. Charges are determined by services rendered to each patient. It is the patients' responsibility to be knowledgeable of the coverages that their insurance provides. I hearby authorize Dr. Yar Khan to release to my insurance company any info acquired in the course of my examination and treatment. I also authorize payment directly to Dr. Yar Khan for services rendered.

Patient Signature: _____ DATE: _____

APPOINTMENT CANCELLATION POLICY

I understand that I must confirm my appointment with the office of Dr. Yar Khan within 24 hours of booking. I understand that failure confirm my appointment within 24 hours of booking or failing to call to cancel my appointment will be considered a no-show and a $35.00 fee will be charged to me as a No-Show Fee (Per ARS 36-2930.01).

Medical Records

I understand that when I request medical records for myself or other documents needed to be filled out by a provider, there may be a $25.00 fee charged to me.

Signature: _____ Date: _____

Release of Medical Information

Release of Information Contact: Designated person(s) we may speak to on your behalf

_____ _____

Name Date of birth

_____ _____

Name Date of birth

Patient Rights & Responsibilities

To our patients: This describes how your health information, as a patient of this clinic, can be used and disclosed, and how you can get access to this information. This is a requirement of the Privacy Regulations established as a result of the Health Insurance Mobilization and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy: Our clinic is dedicated to safeguarding the privacy of your health information. Under the law, we are required to keep your health information confidential.

Use and disclosure of your health information under special circumstances

The following circumstances may require the use or disclosure of information relating to your health:

1. Disclosure of personal information to public health authorities and health oversight agencies authorized by law to collect such information.
2. Disclosure of personal information during similar lawsuits or proceedings, by administrative or court order.
3. Disclosure of personal information when required by a law enforcement official.
4. Disclosure of personal information when necessary to reduce or prevent hazards to your health and safety, or the health and safety of others. We will only disclose this information to persons or organizations capable of preventing such danger.
5. If you are a member of the United States Army or any other country (including veterans), we will disclose personal information only to the appropriate authorities.
6. Disclosure of personal information to federal officials for reasons of intelligence or national security authorized by law.
7. Disclosure of personal information to law enforcement officials or correctional institutions if you are an inmate or in the custody of a law enforcement official.
8. Disclosure of personal information to Workers Compensation Program or similar programs.

Your Rights Regarding Your Health Information:

1. You can decide how and where our clinic communicates information related to your health. We will try to honor your requests as long as they are reasonable.
2. You may request a restriction on the use or disclosure of your health information during the payment of your treatment or procedures. In addition, you have the right to request that disclosure of your health information be limited to those individuals involved in your care or payment for your treatment, such as family or friends. We are not required by law to accept your request. If we do accept it, we are required to honor your request, except when required by law, in emergency situations, or when this information is necessary for your medical treatment.
3. You have the right to obtain a copy of your health information used to make decisions about you, including medical or pay records, but not including psychotherapeutic notes. To obtain these records, you must request them in writing.
4. You can request that your health information be corrected, if you consider it incorrect or incomplete, as long as the info comes from or is used by our clinic. You must request it in writing.
5. You have the right to receive a copy of this Notice of Private Practices and can request it at any time.
6. Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint in writing to our clinic or the Department of Health and Human Services Secretary. You will not be penalized for filing a complaint.
7. Our clinic will obtain your written authorization before using or disclosing your health information in ways not identified in this notice or permitted.

For more Info or if you have questions regarding this announcement or our privacy practices, please contact our office at 623-256-4160

I hereby declare that I have been presented with a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

Print Name: _____