NORTH PHOENIX INTERNAL MEDICINE, P.C.

W. KENT BRUBAKER, M.D. • PHUC H. PHAM, M.D.

WELCOME TO OUR PRACTICE

ENCLOSED YOU WILL FIND A PACKET OF INFORMATION THAT NEEDS TO BE COMPLETED BEFORE YOU HAVE YOUR VISIT WITH US.

THE INFORMATION PACKET HAS BEEN DIVIDED INTO WHAT YOU NEED TO BRING WITH AN WHAT YOU WILL KEEP FOR YOUR RECORDS.

PLEASE MAKE SURE THAT YOU :

1. **CHANGE YOUR PROVIDER TO DR. WILLIAM K BRUBAKER**
2. **MAKE SURE YOU BRING ALL MEDICAL INS CARDS INCLUDING YOUR MEDICARE CAI D IF IT APPLIES TO YOUR MEDICAL CARE.**
3. **DON'T FORGET TO BRING YOUR COPAYS IF YOU HAVE ONE THRU YOUR INSURANCE COMPANY. CO-PAYS ARE DUE AT TIME OF SERVICE.**
4. **PLEASE MAKE SURE YOU BRING YOUR DRIVERS LICENCE WITH YOU WE DO MAKE PHOTO COPIES OF INSURANCE CARDS AND YOUR AZ DRIVERS LICENCE**
5. **PLEASE REMEMBER THAT IF YOU DO NOT CHANGE YOUR PRIMARY CARE PROVIDE : THAT YOU WILL BE RESPONSIBLE FOR THE BILL AT THE TIME OF SERVICE.**
6. **PLEASE ARRIVE AT LEAST 20 MINUTES EARLY FOR YOUR APPOINTMENT SO IF YOU HAVE ANY QUESTIONS ABOUT YOUR PAPERWORK WE CAN ANSWER ANY OF YOUR QUESTIONS YOU MAY HAVE.**
7. **IF YOUR ARE MEDICARE PATIENT. PLEASE BE ADVISED THAT NOT ALL SERVICES A :E COVERED UNDER MEDICARE GUIDELINES.**
8. **IF YOU REQUIRE A REFERRAL FROM THIS OFFICE AND YOU DO NOT HEAR FROM U WITHIN TEN(10) DAYS PLEASE CALL OUR OFFICE TO FOLLOW UP ON YOUR REFERR AL.**
9. **IF YOU HAVE ANY QUESTIONS REGUARDING SERVICES COVERED BY MEDICARE OR YOUR INSURANCE COMPANY YOU MAY CALL YOUR INSURANCE COMPANY THRU TI E CUSTOMER SERVICE NUMBER ON YOUR INSURANCE CARD.**
10. **IF YOU ARE COVERED BY MORE THAN (2) TWO INSURANCES WE WILL GLADLY BILI THE PRIMARY AND SECONDARY INSURANCE FOR YOU. IF YOU HAVE A THIRD INSURANCE CARRIER YOU WILL BE RESPONSIBLE FOR SUBMITTING FOR PAYMENT FROM THAT CARRIER.**

THIS SMALL CHECK LIST WILL MAKE YOUR CHECK IN AND CHECK OUT AS SMOOTH AS POSSIBLE. WE KNOW HOW IMPORTANT YOUR TIME IS AND THIS WILL MAKE YOUR VISIT T OUR OFFICE A PLEASANT ONE.

YOUR APPOINTMENT DATE IS:_____@_____

SINCERELY YOURS,

GAYLIA YOUNG
BILLING DEPARTMENT

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INTEROFFICE MEMORANDUM

TO: OUR PATIENTS

FROM: NORTH PHOENIX INTERNAL MEDICIN E.

SUBJECT: INCORRECT INSURANE INFORMATION

DATE: EFFECTIVE IMMEDIATELY.

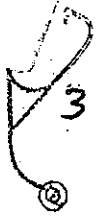
CC:

ALL CURRENT INSURANCE INFORMATION MUST BE GIVEN TO US AT THE TIME OF YOUR VISIT.

IF THE INSURANCE INFORMATION GIVEN IS NOT CORRECT AND THE INFORMATION CAUSES A CLAIM TO BE RETURNED- YOU WILL BE RESPONSIBLE FOR ALL UNPAID AMOUNTS UP TO AND INCLUDING - COPAY'S-COINSURANCE AND DEDUCTBLES.

IF YOU ARE UNSURE ABOUT YOUR INSURANCE PLEASE CALL YOUR HUMAN RESOURCE DEPARTMENT AND GET CLARIFICATION ABOUT YOUR PLAN.

THE MANAGEMENT



NORTH PHOENIX INTERNAL MEDICINE, P.C.

W. KENT BRUBAKER, M.D. • PRESTON MILLER, P.A.-C.

PATIENT and/or INSURANCE INFORMATION FORM

PATIENT DATA

PATIENT LAST NAME	FIRST	MI	SEX	MARITAL STATUS	BIRTHDATE	AGE

CURRENT MAILING ADDRESS	CITY	STATE	ZIP	PHONE

PERMANENT MAILING ADDRESS	CITY	STATE	ZIP	PHONE

PATIENTS EMPLOYER, IF SELF- COMPANY	OCCUPATION	SOCIAL SECURITY NUMBER

EMPLOYER ADDRESS, IF SELF –COMPANY	CITY	STATE	ZIP	PHONE

SPOUSE and/or RESPONSIBLE PARTY

SPOUSE'S NAME OR RESPONSIBLE PARTY	DRIVERS LICENSE	BIRTHDATE	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP	PHONE

EMPLOYER NAME	OCCUPATION	SOCIAL SECURITY NUMBER

EMPLOYER ADDRESS	CITY	STATE	ZIP	PHONE

IN CASE OF EMERGENCY NOTIFY

NAME OF NEAREST RELATIVE NOT LIVING WITH PATIENT	WORK PHONE	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP	PHONE

INSURANCE COVERAGE

PATIENTS PRIMARY INSURANCE COMPANY NAME	GROUP NUMBER	ID OR POLICY NUMBER

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP	PHONE

INSURED'S NAME	INSURED'S SOCIAL SECURITY	INSURANCE EFFECTIVE DATE

PATIENT'S SECONDARY INSURANCE COMPANY NAME	GROUP NUMBER	ID OR POLICY NUMBER

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP	PHONE

INSURED'S NAME	INSURED'S SOCIAL SECURITY	INSURANCE EFFECTIVE DATE

"I request that payment of authorized Medicare(or any other insurance company's) benefit be made either to me or on my behalf to North Phoenix Internal Medicine P.C. for services furnished me by North Phoenix Internal Medicine P.C.. I authorize any holder of medical information about me to release to the health care financing administration, its agents, or any other insurance company and information needed to determine these benefits payable for related services."

PATIENT OR AUTHORIZED PERSON'S SIGNATURE	DATE SIGNED

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RTH PHOENIX INTERNAL MEDICIN
DR. UC PHAM,MD / DR. W. KENT BRUBAK ,MD
1747 E MORTEN
SUITE 303
PHOENIX,ARIZONA 85020
PHONE NUMBER-602-589-0370
FAX NUMBER-602-589-0650

I AUTHORIZE_____TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)FROM THE HEALTH RECORDS OF:

PATIENT'S NAME_____

ADDRESS_____

PHONE NUMBER_____

SOCIAL SECURITY NUMBER_____

DATE OF BIRTH_____

DATES OF TREATMENTS TO BE RELEASED_____

SEND RECORDS TO:

NAME OF PERSON OR FACILITY_____

ADDRESS_____CITY_____STATE_____ZIP_____

PHONE NUMBER_____FAX NUMBER_____

SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED:

ALL RECORDS_____

OTHER: SPECIFY_____

SPECIFIC DESCRIPTION OF THE PURPOSE OF THE DISCLOSURE:

CONTINUED PATIENT CARE_____

DISCLOSURE AT PATIENTS REQUEST_____

OTHER:_____

I AUTHORIZE THE PROVIDER TO USE OR DISCLOSE INFORMATION RELATED TO:

I CONSENT TO THE RELEASE OF NFORMATION CREATED WITHIN 12 MONTHS AFTER THE DATE THIS AUTHORIZATION WAS SIGNED

I UNDERSTAND THAT THE HOSPITAL\CLINIC OR DOCTORS OFFICE WILL NOT CONDITION TREATMENT ON MY SIGNING THIS AUTHORIZATION. THE HOSPITAL\CLINIC OR DOCTORS OFFICE WILL NOT DENY ME TREATMENT IF I DO NOT WISH TO SIGN THIS FORM. I MAY REFUSE TO SIGN THIS AUTHORIZATIONFORM. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATIONAT ANY TIME. I MUST SUBMITT ANWRITTEN REGUEST TO MEDICAL RECORDS. UNLESS I REVOKE THIS AUTHORIZATION EARLER, IT WILL EXPIRE SIX MONTHS FROM THE DATE OF SIGNATURE. I UNDERSTAND THAT IF THIS INFORMATIONIS DISCLOSED TO A THIRS PARTY,THE INFORMATION MAY NO LONGER BE PROTECTED BY THE FEDERSL PRIVACY REGULATION AND MAY BE REDISCLOSED BY THE PERSON/ORGANIZATION THAT RECEIVES THE INFORMATION.
I UNDERSTAND THAT THE MATTERS DISCUSSED ON THIS FORM. I RELEASE THE PROVIDER,IT'S EMPLOYEES,OFFICERS AND DIRECTORS,MEDICAL STAFF MEMBERS AND BUSINESS ASSOCIATES FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR THE DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND THE AUTHORIZATION HEREIN

_____ _____ _____

I

SIGNATURE OF PATIENT DATE WITNESS

IF SOMEONE OTHER THAN PATIENT HAS AUTHORITY TO SIGN FOR THE PATIENT,ALSO COMPLETE THE REVERSE

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NAME _____ DOB _____ DATE _____

Please circle yes or no to all of the following:

PAST ILLNESS

Regular Measles - 10 day ..... Y N
German Measles - 3 day ..... Y N
Mumps ..... Y N
Chicken Pox ..... Y N
Diphtheria ..... Y N
Whooping Cough ..... Y N
Scarlet Fever ..... Y N
Venereal disease ..... Y N
Pneumonia ..... Y N
Rheumatic Fever ..... Y N
Arthritis or Rheumatism ..... Y N
Any bone or joint disease ..... Y N
Bursitis ..... Y N
Polio ..... Y N
Meningitis ..... Y N
Anemia ..... Y N
Jaundice ..... Y N
Epilepsy ..... Y N
Valley Fever ..... Y N
Hepatitis ..... Y N
TB ..... Y N

CURRENT ILLNESSES:

_____

_____

FAMILY HISTORY:

Name those having any of the following:

Cancer _____

Tuberculosis _____

Diabetes _____

High Blood Pressure _____

Heart Disease _____

Epilepsy _____

SYSTEMS REVIEW:
E.E.N.T.

Migraine headaches ..... Y N
Frequent headaches ..... Y N
Dizziness ..... Y N
Double vision ..... Y N
Glasses ..... Y N
Ear infections ..... Y N
Hearing Loss ..... Y N
Nose bleeds ..... Y N
Gums bleed easily ..... Y N
Nasal Discharge ..... Y N
Hard to Swallow ..... Y N

CARDIOVASCULAR

Pain over heart ..... Y N
Climb stairs easily ..... Y N
Swelling of ankles ..... Y N
Heart Attack ..... Y N
Stroke ..... Y N
Pain in legs ..... Y N

High Blood Pressure ..... Y N
Nervous Breakdown ..... Y N
Hay Fever ..... Y N
Asthma ..... Y N
Hives or Eczema ..... Y N

ALLERGIES:

List medications you are allergic to:

_____

_____

_____

_____

OTHER ALLERGIES:

_____

_____

PREGNANCIES:

How many live pregnancies _____

How many live children _____

Any complications _____

Age of children _____

_____

MENSTRUAL:

Periods regular ..... Y N

Usual interval from first day of cycle to first day of next cycle.

Flow ..... heavy mod. light

Pain ..... severe mod. light

Date of last Pap _____

VAGINA:

Excessive discharge ..... Y N
Vaginal itching ..... Y N
Contact Bleeding ..... Y N
Bleeding between menses ..... Y N

LUNGS:

Chronic cough ..... Y N
Cough with blood ..... Y N
Pain on breathing ..... Y N

GASTROINTESTINAL:

Nausea ..... Y N
Sour stomach ..... Y N
Bloating ..... Y N
Rectal Bleeding ..... Y N
Color of Stool _____

HABITS:

Alcohol: ..... never occ. freq. daily
Cigarettes: ..... never occ. freq. daily
_____ packs per day

DRUG USE:

Chemical Abuse never occ. freq. daily

TRANSFUSIONS: Have you had,

Blood or Plasma ..... Y N
Any Reactions ..... Y N

DRUGS:

Sedative ..... never occ. freq. daily
Tranquilizers ..... never occ. freq. daily
Sleeping Pills ..... never occ. freq. daily
Aspirin ..... never occ. freq. daily
Insulin ..... never occ. freq. daily
Hormones ..... never occ. freq. daily
Cortisone ..... never occ. freq. daily
Thyroid ..... never occ. freq. daily

IMMUNIZATION: Have you had,

Small pox ..... Y N When _____
Tetanus Toxoid ... Y N When _____
Polio ..... Y N When _____
MMR ..... Y N When _____
DPT ..... Y N When _____
Pneumonia ..... Y N When _____
Influenza ..... Y N When _____

KIDNEY AND BLADDER:

Attacks of kidney paid ..... Y N
Burning on urination ..... Y N
Frequency of urination ..... Y N
Poor control of urine ..... Y N
Kidney / bladder infection ..... Y N

OTHER:

Phlebitis ..... Y N
Varicose veins ..... Y N
Leg/foot cramps ..... Y N
Muscle weakness ..... Y N
Paralysis ..... Y N

BLOOD AND GLANDS:

Any anemia ..... Y N
Are you a bleeder ..... Y N
Any enlarged glands in neck or groin ..... Y N
Any enlarged glands under arms .. Y N
Any HIV history ..... Y N

Weight _____ One year ago _____

SURGERIES / OPERATIONS / HOSPITALIZATIONS:

_____

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Live alone? ..... Y N
Pets? ..... Y N
Family living close by? ..... Y N

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North Phoenix Internal Medicine

Patient Name: _____

Date of Birth: _____

Home Phone: _____

Work Phone: _____

Cell / Other: _____

___I give permission to call my place of business.

___I give permission to leave only normal results on my home answering machine.

___ I give permission to leave all test results on my home answering machine.

___I give permission to speak to _____ regarding my test results.

___I give permission to have my normal results mailed to me at:

_____

_____

Patient Signature: _____

Date: _____

Witness: _____

* This will be in effect for twelve (12) months unless revoked sooner by the patient.

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ACKNOWLEDGEMENT OF RECEIPT OR NORTH PHOENIX INTERNAL MEDICINE P.C.'S NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the opportunity to review a current copy of North Phoenix Internal Medicine's "Notice of Privacy Practices". My signature means that I agree to the terms of this notice. Please return this acknowledgement of receipt of notice to North Phoenix Internal Medicine P.C.. I understand that I may refuse to sign this acknowledgement.

_____ _____

Printed name of patient or legally authorized individual Date & Time

_____ _____

Signature of the patient or legally authorized individual Date & Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

_____

For Office Use Only

_____

North Phoenix Internal Medicine P.C. could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited it
- ☐ An emergency situation prevented us
- ☐ Other (please specify)

_____

_____

_____

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North Phoenix Internal Medicine P.C.
(Effective December 1, 2002)

Thank you for choosing North Phoenix Internal Medicine P.C. as your Primary Physician. We welcome you! We are committed to providing the finest in personalized and professional health care possible for our patients. Please carefully read and sign the following statement policy prior to treatment. Feel free to speak to our office personnel if you have any questions.

The patient of their guarantor is responsible for payment of services that are rendered. 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. Please present you insurance card at each visit. You will be responsible for all co-pay, coinsurance, and deductibles on the day of service. Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request.

IT IS YOUR RESPONSIBILTY TO BE AWARE OF YOUR INSURANCE BENEFITS.

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 60 days, the patient will be billed. 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 if you do not have insurance, payment in full will be expected the day you are seen. For your convience, we accept VISA, MasterCard, cash, or checks.

Delinquent accounts over 90 days will be subject to the following action. Your outstanding balance will be turned over to J.R. Brothers Financial Inc. for further processing.

There will be a $25 service fee for all returned checks. NSF checks must be redeemed with certificed funds. (Cashier's check, money order, certified check or cash)

If you need to cancel a scheduled appointment, please contact our office at least **24 hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A $50 FEE WILL BE ASSESED FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 24-HOUR ADVANCE NOTICE.**

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 Financial Policy and I agree to abide by its terms.

PRINTED NAME OF PATIENT _____ SIGNATURE OF PATIENT/RESPONSIBLE PERSON _____

DATE: _____

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NORTH PHOENIX INTERNAL MEDICINE

DR.W.KENT BRUBAKER, M.D.

PRESTON MILLER P.A.-C

ADVANCE DIRECTIVES

To comply with Medicare, managed health care plans, and hospital admission requirements, we are required to provide to you information about Federal and State laws that allow you to accept or refuse treatment to formulate Advance Directives. Advance Directives are documents that enable you to give directions about your future medical care. This form is not intended to provide you legal advice but merely to provide information only.

Before making any decision about Advance Directives, please talk with your family, physicians, and/or attorney, if you need assistance. If you already have an Advance Directive or have decided to develop one, please give copies to your family, close friends, and your physician, so that they will be aware of your wishes.

We would like to assure you that this is not required and that you may elect to not have Advance Directives. In the event of a medical emergency, all measures, including life support will be given to those who do not sign Advance Directives.

Please review the enclosed information and sign at the bottom. Your signature does not signify any decision but merely shows that you have been given the information, and offered the opportunity for Advance Directives. Thank you.

_____

Patient Signature

_____

Date