Golden Years Primary Care, LLC

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

PATIENT INFORMATION

Fields with * are required

Last name*: _____First name*: _____ Middle initial: _____ ☐ Male ☐ Female ☐ No response

Name you would like to appear on your health records: _____ DOB*:_____ Veteran?: ☐ Yes ☐ No

Social Security#*: _____ Drivers license #*: _____ Email address*_____

Home address*: _____ APT #: _____ City*: State*: ZIP*:_____

☐ Home #*: _____ ☐ Mobile #*: _____ (Please check the best number to use)

Most recent PCP*: _____ Phone #: _____ Fax # _____

IF THE PATIENT IS LIVING IN AN ASSISTED LIVING FACILITY OR GROUP HOME*

Name of Facility*: _____ Room #: _____

Address*: _____ City*: State*: ZIP*: _____ Date of Move in? _____

POA CONTACT INFORMATION

Last name*: _____ First name*: _____ Middle initial: _____

Home address*: _____ APT #: _____ City*: State*: ZIP*: _____

☐ Home #*: _____ ☐ Mobile #*: _____ (Please check the best number to use)

Email address*: _____ Relationship to patient*: _____

POA legal paperwork is required for us to speak to your POA about anything related to you or your treatment.

Please fax this information to 480.393.4290 PRIOR to your first appointment.

INSURANCE

Primary Insurance Name: _____ Policy #:_____ Group #: _____

Secondary Insurance Name: _____ Policy #:_____ Group #: _____

Tertiary Insurance Name: _____ Policy #:_____ Group #: _____

Medicare Policy #: _____ **Please provide the front & back of insurance cards**

PAST MEDICAL HISTORY (check all that apply)

☐ Anemia ☐ Anxiety ☐ Arthritis or Gout ☐ Asthma ☐ Alcoholism
☐ Arrhythmia (irregular heartbeat) ☐ Allergies ☐ Bleeding Problems ☐ Bladder Problems (Incontinence)
☐ Bipolar Disorder ☐ COPD ☐ Chron's Disease ☐ Cancer: _____
☐ Dementia ☐ Depression ☐ DVT (blood clots) ☐ Diabetes ☐ Diverticulitis
☐ GERD ☐ Glaucoma ☐ High Cholesterol ☐ High Blood Pressure ☐ Heart Disease
☐ HIV ☐ Hiatal Hernia ☐ Heart Attack (MI) ☐ Headaches ☐ Irritable Bowel Syndrome
☐ Hepatitis ☐ Kidney Stones ☐ Kidney Disease ☐ Lupus ☐ Liver Disease
☐ Neuropathy ☐ Parkinson's ☐ Peptic Ulcer ☐ Psoriasis ☐ Macular Degeneration
☐ Pulmonary Embolism ☐ Peripheral Vas Disease ☐ Osteopenia/Osteoporosis
☐ Rheumatoid Arthritis ☐ Sleep Apnea ☐ Stroke ☐ Seizure Disorder
☐ Thyroid Disorder ☐ Ulcerative Colitis ☐ Other:_____

Family Medical History (check all that apply)

Mother: ☐ Living, Age ____ ☐ Deceased, Age ____
☐ Asthma ☐ COPD ☐ Dementia ☐ Diabetes
☐ Heart Disease ☐ High BP ☐ Kidney Disease
☐ Migraines ☐ Stroke ☐ Cancer (type): _____

Father: ☐ Living, Age ____ ☐ Deceased, Age ____
☐ Asthma ☐ COPD ☐ Dementia ☐ Diabetes
☐ Heart Disease ☐ High BP ☐ Kidney Disease
☐ Migraines ☐ Stroke ☐ Cancer (type): _____

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Surgical History:

Previous Surgery: _____

Date of Surgery: _____ Complications? ☐ Yes ☐ No

Previous Surgery: _____

Date of Surgery: _____ Complications? ☐ Yes ☐ No

OTHER MEDICAL PROVIDERS/SPECIALISTS:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Recent Hospitalization or Skilled Nursing Facility admission & discharge: ☐ Yes ☐ No

Hospital Name_____

Date of Illness or Admission & Discharge: _____/_____

Skilled Nursing Facility Name_____

Date of Illness or Admission & Discharge: _____/_____

Pharmacy Name/address/phone/fax: _____

Allergies/ Reaction to medication

1. _____
2. _____
3. _____

☐ Check here if you plan to send a separate medication list document

Medications: List ALL medications you are CURRENTLY taking. (Please include all herbals, vitamins, & supplements.)

Name	Dose	Frequency

IF MEDICATION LIST DOES NOT FIT IN THE BOXES ABOVE, PLEASE ATTACH A SEPARATE SHEET.

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HOW WE OPERATE AND HOW IT EFFECTS THE PATIENT:

OPIOID PATIENT PRESCRIPTION SEARCH & CONSENT: On October 24, 2016, Governor Dough Ducey issued an executive order limiting all initial prescriptions of opioids to no more than a seven-day dose. Link to the Executive Order: http://azgovernor.gov/sites/default/files/prescription_opioid_initial_fill_limitation_e.o_0.pdf
As noted above, there is a law for prescribing opioids for treatment of acute and chronic pain. This law applies to all physicians, dentists, optometrists, podiatrists, physician assistants, certified nurse midwives, or advanced practice nurses authorized to prescribe controlled substances. I agree to allow Golden Years Primary Care, LLC to run an AZPMP pharmacy search of all my prescribed medications."

CHRONIC CARE MANAGEMENT SERVICES: Chronic care management services involve non-face-to-face coordination provided to patients with two or more chronic conditions expected to last at least 12 months. These conditions significantly increase the risk of death, acute exacerbations, or functional decline. CCM plays a crucial role in primary care by fostering ongoing relationships with patients' care teams. It can be initiated during an Annual Wellness Visit, Preventive Physical Exam, or a scheduled appointment. Examples of chronic conditions include Alzheimer's disease, arthritis (osteoarthritis and rheumatoid), asthma, atrial fibrillation, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), depression, diabetes, hypertension, and infectious diseases like HIV/AIDS. We bill your insurance for CCM. If your insurance does not cover the service, you may receive a bill. However, most insurances cover CCM. You may have a small co-pay if you lack secondary or supplemental insurance and Tricare 4 Life does not pay for CCM ultimately perhaps resulting in a $10 copay. We develop a comprehensive care plan for you, including a list of your conditions, expected outcomes, treatment goals, symptom management, planned interventions, medication management, ordered community and social services, coordination with external agencies and specialists, and a schedule for periodic review and revision of the care plan. We collaborate closely with home health and hospice teams to ensure optimal care coordination. You can opt out of this service by notifying us in writing that you do not want this service, but it is the best way to manage several chronic conditions because it enables all your providers to communicate effectively about your care.

FINANCIAL RESPONSIBILITY: The patient (or patient's guardian/POA) is ultimately responsible for the payment for treatment and care provided by Golden Years Primary Care, LLC (GYPC).
Please check one box below:

☐ Check here if you agree to the self-pay rate for services rendered, at time of service. If you wish to be a self-pay / Cash pay patient, you agree to pay $200 for an initial visit and $100 for subsequent visits thereafter.

☐ Check here if you elect to use available medical insurance for visit coverage. Self-pay rates will not apply after the date of service.

We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance. In the event, insurance denies payment, or a balance remains beyond 90 days, the patient will be financially responsible for the debt. Payment programs will be made available to help the patient and Golden Years Primary Care, LLC mitigate balances. Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Patients may incur and are responsible for the payment of additional charges, if applicable. I understand I am financially responsible for charges not covered by my insurance company. Consent is considered a general liability waiver absolving Golden Years Primary Care LLC of all liability for procedures ordered that are not covered by the patient's insurance. I also agree to pay any outstanding balance as well as attorney fees and costs to **Golden Years Primary Care, LLC** if this matter is referred to collection.

TRANSFER OF CARE: I understand that I am receiving in-home care from Golden Years Primary Care LLC (GYPC) and that they may or may not remain as my Primary Care Provider should I move from my current address. GYPC reserves the legal right to terminate services at any time, without cause, upon thirty (30) days prior notice. I further understand that GYPC may change my provider to any other GYPC providers at any time without prior notice.

HOSPICE CARE: I understand that if I am admitted to hospice, Golden Years Primary Care LLC will remain as my Primary Care Provider (PCP) and as my attending Physician (GV), unless otherwise notified in writing.

AUTHORIZATION: By signing below, you or your assigns authorize Golden Years Primary Care LLC (GYPC) to disclose results of the patient's complete health records including lab results, X-ray reports, medical exam consultation reports, immunization records, and any other findings necessary for treatment. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

PRIVACY PRACTICES: Golden Years Primary Care LLC (GYPC) participates in the Government Health Information Exchange (HIE) program which I can opt out of at any time. Medical information is considered private and confidential. However, I am aware, that in accordance with HIPAA Law, my information may be shared or disclosed verbally, electronically or on paper as needed to others who are involved in my care and as needed for medical billing and care coordination. To improve care coordination, I give my permission to GYPC to leave phone messages regarding medical care and account information via (check box that applies).

☐ Voicemail: _____ ☐ Text Message: _____ ☐ Email: _____

_____ _____ _____

Patient's or POA's printed name **Patient's or POA's Signature*** **Date***

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO

GOLDEN YEARS PRIMARY CARE, LLC

Last name*: _____First name*: _____ DOB*:_____

Address*:_____

DO NOT FILL OUT BELOW
EXCEPT FOR YOUR SIGNATURE AT THE BOTTOM OF THE PAGE

I authorize Golden Years Primary Care, LLC to obtain from:

_____ **Fax #: _____**

Doctor or hospital name

Address: _____ City: _____ Zip: _____

Any information about my health and health care, including diagnosis, treatment, or examination rendered to me during the time period from: _____ to _____

CONFIDENTIALITY POLICY (Please read before signing)

Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

I understand this authorization is voluntary and may refuse to sign it. I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient or authorized representative signature*: _____ Date*: _____

Patient or authorized representative name*: _____ Relationship to patient*: _____

Fax records back to 480-393-4290 (preferred)
Mail to: 20235 N Cave Creek Rd, Ste. 104, #306, Phoenix, AZ 85024-4455
Call 480-999-4704 if you have questions related to fulfilling this request.