WELCOME

ACTIVE LIFESTYLE MEDICAL

Date: ____________________

Patient Information

Name: (Last, First, Middle Initial) ____

Email address: _______________________________________

Mailing Address (City, State, Zipcode): ____

Phone # (Home) _______________ (Work) ___________________(Mobile) ______________________

Can we call you at work? ☐ Yes ☐ No Can we text your mobile? ☐ Yes ☐ No

Can we leave messages on your phone? ☐ Yes ☐ No Phone Preference? ___________________

Date of Birth: _______________ Sex: ☐ Male ☐ Female SSN#: _______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other

Ethnicity: ☐ Hispanic ☐ Latino ☐ Non-Hispanic / Non-Latino

Occupation: _____________________________ Employer: ____________________________________

Employer Address: ____ Phone: __________________

How did you hear about our practice? ____

Emergency Contact: Name: _____________________________ Relation: _______________________

Phone #: _____________________________

Pharmacy: ____

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other _______________________________

Has it been reported? ☐ Yes ☐ No If yes, to whom? _________________________

Insurance Information

Policy Holder Name: ________________________________ D.O.B.: _____________________________

Relationship to patient (if other than self): _____________________ Phone # _______________________

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: __________________________

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: __________________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S) AND DRIVER'S LICENSE.

Active Lifestyle Medical
9449 N. 90th St. Ste. 114 – Scottsdale, AZ 85258 – Phone: (480) 860-0300 – Fax: (480) 422-4321

Health History

Who is your primary care physician? (Doctor and/or practice) ____

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Neck Pain/Stiffness ☐ Pins/Needles in Arms ☐ Light Bothers Eyes
☐ Sudden Weight Loss ☐ Nausea ☐ Cold Feet
☐ Back Pain/Stiffness ☐ Pins/Needles in Legs ☐ Bowel/Bladder Changes
☐ Stomach Problems ☐ Loss of Taste ☐ Depression ☐ Shortness of Breath
☐ Arm/Hand Pain ☐ Fatigue ☐ Nervousness ☐ Loss of Memory ☐ Chest Pain
☐ Leg/Knee Pain ☐ Sleeping Difficulties ☐ Tension ☐ Jaw Problems ☐ Fever
☐ Headaches ☐ Loss of Smell ☐ Cold Sweats ☐ Constipation ☐ Fainting
☐ Dizziness ☐ Allergies ☐ Asthma ☐ Blurred Vision ☐ Night Pain

Please check to indicate if you have ever had any of the following:

☐ Allergy Shots ☐ Chemical Dependency ☐ Herniated Disc ☐ Parkinson's Disease
☐ Aids/HIV ☐ Cancer ☐ Hepatitis ☐ Osteoporosis ☐ Stroke
☐ Alcoholism ☐ Cataracts ☐ Hernia ☐ Pacemaker ☐ Suicide Attempt
☐ Anemia ☐ Chicken Pox ☐ Herpes ☐ Pinched Nerve ☐ Tonsillitis
☐ Anorexia ☐ Diabetes ☐ High Cholesterol ☐ Pneumonia ☐ Tuberculosis
☐ Appendicitis ☐ Emphysema ☐ Kidney Disease ☐ Polio ☐ Tumors/Growths
☐ Arthritis ☐ Epilepsy ☐ Liver Disease ☐ Prostate Problems ☐ Typhoid Fever
☐ Asthma ☐ Fractures ☐ Measles ☐ Prosthesis ☐ Ulcers
☐ Glaucoma ☐ Migraines ☐ Psychiatric Care ☐ Thyroid Problems ☐ Mumps
☐ Vaginal Infections ☐ Venereal Disease ☐ Bleeding Disorders ☐ Heart Disease
☐ Breast Lump ☐ Goiter ☐ Miscarriage ☐ Rheumatoid Arthritis
☐ Bronchitis ☐ Gonorrhea ☐ Mononucleosis ☐ Rheumatic Fever ☐ Whooping Cough
☐ Bulimia ☐ Gout ☐ Multiple Sclerosis ☐ Scarlet Fever
☐ Other ___________________________________

Are you currently under drug and/or medical care? ☐ Yes ☐ No If yes, explain ______________________________

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)

____

Please list any surgeries and/or hospitalizations you have had (**type & date**): ______________________________

Please list any allergies: ______________________________

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________________

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

☐ Heart Disease______________________________ ☐ Diabetes ______________________________

☐ Cancer ___________________________________ ☐ Arthritis ______________________________

☐ Other ____________________________________

Do you exercise: ☐Never ☐Daily ☐ Weekly ☐Walks ☐Runs ☐Swims

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine __________ cups/day Alcohol ___________ drinks/week Cigarettes ___________ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

PATIENT SIGNATURE _______________________________________ **DATE** ____________________________

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NEUROLOGICAL/ MRI/ VASCULAR PATIENT QUESTIONNAIRE

NAME ____ **DATE** _____________________

For any YES answer, please include details.

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? ☐NO ☐YES
   Comment: ______________________________
2. Do you have weakness, numbness or burning in your shoulder, arms or hands? ☐NO ☐YES
   Comment: ______________________________
3. Do your hands or arms fall asleep regularly? ☐NO ☐YES
   Comment: ______________________________
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? ☐NO ☐YES
   Comment: ______________________________
5. Do you suffer from a loss of handgrip strength? ☐NO ☐YES
   Comment: ______________________________
6. Do you suffer from back pain with pain in your buttocks, legs or feet? ☐NO ☐YES
   Comment: ______________________________
7. Do you have weakness, numbness or burning in your buttocks, legs or feet? ☐NO ☐YES
   Comment: ______________________________
8. Do our legs or feet fall asleep regularly? ☐NO ☐YES
   Comment: ______________________________
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? ☐NO ☐YES
   Comment: ______________________________
10. Do you suffer from cold hands or feet? ☐NO ☐YES
    Comment: ______________________________
11. Do have frequent falls or find that you trip over your feet while walking? ☐NO ☐YES
    Comment: ______________________________
12. Have you tried any medications such as anti-inflammatory? ☐NO ☐YES
    If yes, what kind of medication? ______________________________
13. Have you tried any Physical Therapy or Chiropractic treatments before? ☐NO ☐YES
    If yes: When? For how long? What kind?
    ____
14. Have you had an MRI? ☐NO ☐YES
    If yes: When? Who ordered it? What was it ordered for?
    ____
15. Have you used any splint or braces or other prescribed treatment by an MD? ☐NO ☐YES
    If yes: When? What kind? Who ordered it?
    ____
16. If you have tried any treatment or medications, did this make your problem better? ☐NO ☐YES
    Comment: ______________________________

For any yes answer, rule in/out the diagnosis with these two tests:

A) NCU/EMG tests ☐Upper ☐Lower ☐Indicated ☐Not Indicated
B) Vascular Test ☐Indicated ☐Not Indicated

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ACTIVE LIFESTYLE MEDICAL, P.C.

FINANCIAL POLICY / RECEIPT OF PRIVACY PRACTICES / LEGAL ASSIGNMENT ARBITRATION AGREEMENT

All patients / legal representatives /guarantors are responsible for payment at the time of service. We accept cash, checks and most major credit cards.

If your insurance deductible is not met, we will collect a portion of it at the time of service until met. Thereafter, we will collect your co-payment only. Insurance co-payments are due at the time of service. We will bill for co-insurance payments. If you have no insurance, full payment is due at the time of service.

Supplements or medications prescribed, dispensed or suggested by our doctors must be paid for on receipt unless prior arrangements have been made. Nutritional Counseling, Home Exercise Programs, Durable Medical Equipment, and Orthotics must be paid for in full upon ordering. As a service to you we will bill your insurance for you, or print out a claim form for you to turn into your insurance for reimbursement.

If your account is placed in collection status, all future services must be paid in full at the time of service.

LEGAL ASSIGNMENT: I, the undersigned, have health insurance and/or employee healthcare benefits coverage and hereby assign and convey directly to Active Lifestyle Medical, PC all medical benefits and/or insurance reimbursement otherwise payable to me for services rendered to me by Active Lifestyle Medical, PC, its officers, directors and/or employees (“ALM”). Notwithstanding the above, I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize ALM to release any and all of my medical information as necessary to process my medical claims. Further, I agree to fully cooperate with ALM in its attempts to pursue my medical claims against my insurers and/or health care benefit plan as necessary, including bringing suit against any such insurer and/or health care benefit plan. This assignment will remain in effect until revoked by me (or by patient’s legal representative or guardian) in writing.

PATIENT NAME ________________________________ **DATE** ________________________________

If you have any questions regarding this notice, please contact us at 480-860-0300 or 9449 N 90th Street, Suite 114, Scottsdale, AZ 8525

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ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence, giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the health care provider to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the health care provider, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must by communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non- economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: **General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. ________ Effective as of the date of first professional services.

I have read and agree to abide by the above Financial Policy, Missed Appointment Policy, Legal Assignment and Arbitration Agreement. I have also received a copy of the Notice of Privacy Practices:

Patient Signature: Date:

If a minor or incapacitated, name and signature of legal representative or guardian:

Signature: ____ Date: _________________________________

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your Privacy…

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and Disclosure of Your Health Information

We may be required to use or disclose your health information:

1. if public health authorities and/or health oversight agencies authorized by law to collect information make a request for information;
2. with respect to lawsuits or similar proceedings in response to a court or administrative order;
3. when docketing a medical provider lien;
4. when your or a third party's insurance company and/or attorney submits a request for information;
5. if required to do so by a law enforcement official;
6. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to reduce or prevent the threat;
7. if you are a member of U.S. or foreign military forces (including veterans) and we are required to disclose by the appropriate authorities;
8. to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official;
9. to Workers' Compensation or similar programs; and
10. to companies performing diagnostic testing services on your behalf.

Your Rights Regarding Your Health Information

1. You may request that our practice communicate with you about your health and related issues in a particular manner or location. We will accommodate reasonable requests (i.e. home vs. work);
2. You have the right to request we do not leave information regarding your care and treatment, including but not limited to appointments, insurance and billing matters, with a particular individual or on a telephone answering or voice-mail system. However, **please note that we may leave messages for you with alternative sources regarding the above unless and until specifically directed by you in writing not to do so;**
3. You have the right to obtain a copy of your health information, including your medical and billing records, but not including psychotherapy notes. You must submit your request in writing to us at 9449 N 90th Street, Suite 114, Scottsdale, AZ 85258;
4. If you believe your privacy rights have been violated, you may file a written complaint that clearly outlines the nature of the violation with our office or with the Secretary of the Department of Health and Human Services; and
5. Our office will obtain your written authorization for uses and disclosures not identified by this notice.

If you have any questions regarding this notice, please contact us at 480-860-0300 or 9449 N 90th Street, Suite 114, Scottsdale, AZ 85258