

Rebecca Weiss, D.O. & Kristine Sarna, M.D.

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2060 W. Whispering Wind Drive, #173

Phoenix, AZ 85085

NorterraFamilyMedicine.com

NORTERRA

FAMILY MEDICINE

Patient Intake and Medical Information

Patient Name: _____ **Today's Date** _____

DOB: _____ **GENDER:** M _____ F _____ **SSN:** _____

Marital Status: Divorced _____ Married _____ Separated _____ Single _____ **REQUIRED Widowed** _____

Name of Guardian, if minor _____ **Relationship** _____

Address: _____ **City** _____ **Zip** _____

Phone (H): _____ **Phone (W):** _____ **Phone (C):** _____

Email Address: _____

Emergency Contact: _____ **Relationship** _____ **Contact #:** _____

Primary Insurance Policy: _____

Primary Policy ID#: _____ **Group #:** _____

Effective Date: _____

Customer Service Contact Phone #: _____

**** Name of Insured:** _____ **Relationship:** _____ **DOB** _____
Self or other person carrying insurance

Address: _____ **SSN:** _____

Secondary Insurance Policy: _____

Secondary Policy ID #: _____ **Effective Date:** _____

Customer Service Contact Phone #: _____

Name of Insured: _____ **Relationship:** _____
Self or other person carrying insurance

Is this visit pertaining to a Workers Compensation Case or Work-Related Claim? YES NO

Date of Last Physical Exam: _____ **Recent Blood Work?** _____

Date of Last Pap (if applicable): _____ **Mammogram (If applicable):** _____

Date of Last Colonoscopy (if applicable): _____ **Tetanus Shot?** _____

Date of Last Influenza vaccine _____ **Pneumonia vaccine** _____ **Other vaccines** _____

Name & Phone Number of Prior Primary Care Physician: _____

Please provide names and Phone numbers for any medical specialists that you currently see:



Surgical History:

Procedure	Date	Procedure	Date

Social History:

Do you currently use TOBACCO? YES NO If YES, how much do you currently smoke/chew?_Packs/day

Did you use tobacco in the past? YES NO If YES, when did you quit? _____

If you used tobacco in the past, how much did you use? _____Packs/day

Do you drink ALCOHOL? YES NO If YES, how much do you drink per day? _____

Do you use any ILLICIT DRUGS? YES NO If YES, which drugs? _____How much _____/wk

How would you describe your DIET? Healthy/Balanced Average Poor

Do you currently EXERCISE? YES NO If YES, how many days per week do you exercise? _____

What activities do you do to exercise? _____

Past Medical History:

Have you had, or do you currently have, any of the following medical problems? (PLEASE CIRCLE)

Abnormal Pap Smear

Environmental Allergies

Migraines

Arthritis / Joint Disease

Fibromyalgia

Prostate Disorder

Asthma

Hearing or Vision Problems

Seizure Disorder

Bulging Disc

Heart Disease

Stroke / CVA

Cancer: (Type)

High Blood Pressure

Thyroid Dysfunction

Hypothyroid / Hyperthyroid

Chronic Fatigue Syndrome

High Cholesterol

Urinary Tract Disorders

Depression or Anxiety

Immune Disorders

Uterine or GYN problems

Diabetes / High Blood Sugar

Irregular Heart Beat

Vascular Disease

Eczema

Irritable Bowel Disorder

Please list any other medical problems:

Emphysema / COPD

Kidney Disease

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Please List All Medications and Supplements You Are Currently Taking:

(*Attach separate list if you are on more than 6 medications)

Do you have ANY ALLERGIES to medications? _____

PHARMACY (name & location): _____ **Phone Number:** _____

Do any IMMEDIATE FAMILY members suffer from the following?

Cancer? YES NO Type? _____ **Relationship?** _____

Heart Disease? YES NO Relationship? _____

Diabetes? YES NO Relationship? _____

Obesity? YES NO Relationship? _____

Psychiatric Disorder? YES NO Relationship? _____

Kidney Disease? YES NO Relationship? _____

What is your primary concern(s) for seeing the physician/provider today?

How did you hear about Norterra Family Medicine? **ADVERTISEMENT** **WEB** **REFERRAL**

• **Do you have an interest in our aesthetic services available at Paradise MedSpa & Wellness, including Laser Skin Care, Botox, and SmartLipo Laser Body Contouring?** **YES** **NO**

• **Do you have an interest in our wellness services available at Paradise MedSpa & Wellness, including Acupuncture, Weight Loss and BioIdentical Hormone Therapies?** **YES** **NO**

Name (Please print): _____ **Signature:** _____

Date: _____

Signature of Guardian (if minor): _____

*We look forward to providing you and your family with the highest quality medical care!
We welcome any feedback you may have now or in future regarding our services. Thank you!*



2010 Financial Policy

Thank you for choosing Norterra Family Medicine (NFM) for your healthcare needs. This financial policy is an important part of your healthcare. Due to increased insurance company demands we ask you to read and agree to the following policies. Please initial each policy.

_____ I request NFM to bill my insurance company on my behalf. NFM will agree to invoice my insurance company in a time manner (within 5 business days).

_____ I understand it is my responsibility to know my healthcare policy and to verify all benefits and coverage information prior to having any services rendered.

_____ I understand it is my responsibility to notify NFM of any changes to my insurance plan or policy prior to my visit.

_____ I agree to pay my copay prior to each visit. We DO NOT accept personal checks as a form of payment. We accept most major credit cards, debit cards and cash.

_____ I agree to pay what my insurance company states as “patient responsibility”. This includes deductibles, co-insurance or uncovered services.

_____ I understand that I must pay any outstanding patient balance prior to being able to schedule future appointments.

_____ **I understand I may be personally responsible for payment if:**

- I cannot verify that I have insurance at the time of my appointment
- I do not have active insurance coverage (please ask about our “Cash Pay” policy)
- My insurance is not accepted by NFM
- I receive a service that is not covered by my policy
- My insurance company denies my claim for any reason that is not resolvable

_____ **I agree to pay a fee if:**

- I “No Show” or cancel a scheduled appointment without 24 hour notice (\$25)

_____ I agree to pay in a timely manner. If NFM needs to send me more than one statement, I understand a \$10 processing fee will be assessed for each subsequently-mailed statement. If, after three statements are mailed, and I do **not** pay my balance in full or agree to a payment plan, NFM reserves the right to send me to collections.

Signature

Please print your name and date

Questions about this policy? Please contact our billing department at 623-565-5060

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Appointments

Our patient appointments are scheduled Monday and Thursday from 8:00 – 7:45 p.m. and Tuesday, Wednesday and Friday from 8:00 a.m. to 4:30 p.m. Our phones are answered from 8:00 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. All attempts are made by our office to keep your scheduled appointments on time, however, unforeseen issues may come up that may cause delays and we apologize in advance for that but each of our patients are important to us and are given the attention that is needed to address each patient's medical needs.

If you arrive more than 15 minutes late for your scheduled appointment, we may ask that you reschedule your appointment.

Due to patients with allergies, please be considerate and do **NOT** wear perfumes and/or fragrant lotions while in the office.

New Patients

We ask that our new patients arrive in the office **30 minutes** prior to their scheduled appointment time to fill out new patient paperwork and allow our staff to get you set up in our computer system. Our forms can be accessed online at www.Norterrafamilymedicine.com so you will have the ability to download and prepare your paperwork prior to your appointment.

Medications

For any medication refills requested by our patients, please provide a minimum 72 hours notice. For requests after 4:00 p.m. on Fridays, these requests will be addressed the following Monday morning.

On-Call Policies

Norterra Family Medicine does not have on-call services between the hours of 10 pm and 6 am. During this time period, if you require urgent medical services, we recommend that you proceed directly to your nearest Emergency Department or Urgent Care Center. If you need urgent, after-hours, medical advice between the hours of 5 pm and 10 pm or 6 am and 8 am, you may call our office to leave a message for our on-call provider. These messages will be checked each hour and your call promptly returned. Please note, our providers do not refill medications after-hours for ANY reason, this includes pain medications. It is your responsibility to keep track of the level of your medications and call our office during normal business hours to request medication refills.

I hereby acknowledge receipt and understanding of the above policies.

Signature _____

Date _____

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LABS / PRESCRIPTIONS

Norterra Family Medicine will send your lab tests to Sonora Quest Laboratory unless your insurance carrier prefers that they be sent to an alternate lab. If you are aware that your labs need to go to an alternate lab, please indicate the name of the lab: _____ . If you are unsure of your insurance policy requirements concerning lab testing, please ask one of our staff to verify this information for you or contact your insurance carrier prior to your appointment to ensure that your labs get sent to the correct laboratory. Please note that there may be some labs and/or prescriptions that are not a covered benefit on your insurance plan.

By signing this form, you agree to pay any laboratory costs that are not covered by your insurance carrier and consent to understanding that Norterra Family Medicine is not responsible for these charges, if and when they occur.

Thank you for your acceptance and understanding of this policy.

Norterra Family Medicine

Signature: _____

Date: _____

Print: _____

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RELEASE OF TEST INFORMATION

Patients Name: _____

Date of Birth: _____

I give my consent to the staff of Norterra Family Medicine to relay any lab, radiological testing, referral information or any other pertinent information as follows:

Please provide my medical information to individual(s) other than myself or state NONE.

(Name) _____

(Relationship) _____

(Name) _____

(Relationship) _____

Please check the following:

YES NO

_____ Leave information on my answering machine at home. Home telephone # _____

- On answering machine
- With anyone answering the phone
- With designated person listed above
- Leave message with call-back number only

_____ Leave information on my work phone # _____

- On answering machine
- With anyone answering the phone
- Leave message with call-back number only

_____ Leave information on my cell phone # _____

- On answering machine
- With anyone answering the phone
- Leave message with call-back number only

Signature _____ Date _____

MUST BE FILLED OUT COMPLETELY

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MEDICAL RECORD RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Records are being requested from the following office: _____

Phone: _____

Fax: _____

I, hereby, authorize the release of my medical records consisting of the following checked items:

_____ Lab Reports

_____ EKG Report(s)

_____ Recent Physical Exam(s)

_____ Operative Report(s)

_____ Radiologic Testing – X-Rays, Ultrasound, CT Scan, MRI Report(s)

_____ All Records from the Following Dates: _____

To be released to the physicians and staff of Norterra Family Medicine.

Fax #623.565.5061

Signature: _____ Printed Name: _____

Today's Date: _____