



Patient Intake and Medical Information

PATIENT INFORMATION

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

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

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

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

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

Email Address: _____

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

Primary Employer:	Secondary Employer:
Address:	Address:
City, State, Zip:	City, State, Zip:
Work Phone:	Work Phone:

Financially Responsible Individual (If different than above)

Name of Insured:	Relationship to Patient:
SSN:	DOB: _____ Gender: M _____ F _____
Home Phone Number:	Work Phone Number:
Address:	

Primary Insurance

Insurance Co:	Group #:	Co-pay:
Effective Date:	Policy ID:	Deductible:
Name of Insured:	Customer Service Number:	

Secondary Insurance

Insurance Co:	Group #:	Co-pay:
Effective Date:	Policy ID:	Deductible:
Name of Insured:	Customer Service Number:	

****Please note that if you have a secondary insurance and it is not identified the patient will be financially responsible for any claims not paid.**



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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:

Are you a Diabetic? _____

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

High Blood Sugar

Irregular Heart Beat

Vascular Disease

Eczema

Irritable Bowel Disorder

Please list any other medical problems:

Emphysema / COPD

Kidney Disease

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? Please note MATERNAL or PATERNAL.

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

Heart Disease? YES NO Relationship? _____

Diabetes? YES NO Relationship? _____

Obesity? YES NO Relationship? _____

Psychiatric Disorder? YES NO Relationship? _____

NORTERRA
FAMILY MEDICINE

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

2060 W. Whispering Wind Drive, #173

623.565.5060 ☐ Phone

Phoenix, AZ 85085

623.565.5061 ☐ Fax

NorterraFamilyMedicine.com

Kidney Disease? YES NO **Relationship?** _____

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 and Weight Loss?** YES NO
- **Do you experience any of these symptoms more than twice per year: Cough, cold, congestion, difficulty breathing, headaches, wheezing, runny nose, sore throat, itchy/irritated eyes, sinus pain, ear pain, unexplained fatigue, skin irritation, snoring??** YES NO
- **Have you ever been diagnosed with asthma or bronchitis??** YES NO
- **Do you experience symptoms of allergies?** 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!*

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

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

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



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 timely manner as long as the information provided is correct and accurate.

_____ 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 co-pay, coinsurance, deductible or any uncovered services that my insurance company deems "patient responsibility" **AT TIME OF SERVICE.** I understand that NFM **DOES NOT accept personal checks as a form of payment.** NFM accepts most major credit cards, debit cards and cash.

_____ 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) for weekday appointments between 8:00 a.m. and 5:00 p.m. (\$50) for 30 minute appointments, evening and Saturday appointments.

_____ I agree to pay in a timely manner. If NFM needs to send me more than one statement, I understand a \$10 processing fee may 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 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: _____



RELEASE OF TEST INFORMATION

******* MUST BE FILLED OUT COMPLETELY *******

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

_____ Leave lab information on the Televox system **(Will require your Social Security Number)**

- YES
- NO

Signature _____ Date _____

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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: _____

***** PLEASE - READ & SIGN *****

NOTICE OF PRIVACY PRACTICES

NORTERRA FAMILY MEDICINE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice, which explains our legal duties and privacy practices with respect to your protected health information. We must abide by the terms set forth in this notice. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all protected health information we maintain. We will post any revised notice in a prominent location in our office and, upon request, will provide you with a copy of the revised notice.

Accounting of Disclosures. You have the right to request a list of our disclosures of your protected health information, except for disclosures for treatment, payment, or health care operations; to you; incident to a use or disclosure set forth in this notice; to persons involved in your care; pursuant to your written authorization; for notification purposes; for national security or intelligence purposes; to correctional institutions or law enforcement officials; as part of a limited data set; that occurred before April 14, 2003 or six years from the date of your request. Your request must be writing and must state the time period for the requested information.

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such cost and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. We may condition the accommodation by asking you for your information as to how payment will be handled or specification of an alternative address or other method of contact. You must submit your request in writing to our practice administrator. The

request must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. You have the right to file a complaint with our practice administrator or with the Secretary of the Department of Health and Human Services if you believe we have violated your privacy rights. Complaints to our administrator must be in writing. We will not retaliate against you for filing a complaint.

For More Information

If you have questions or would like additional information, Please visit the HIPAA website at:

<http://www.hhs.gov/ocr/hipaa>.

We created or received your protected health information in the course of providing care to you.

Your Health Information Rights

Copy of this Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our front office staff at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making decisions about you. You may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; or protected health information that is subject to law that prohibits access to protected health information. In some circumstances, you may have a right to review our denial.

If you wish to inspect or copy your medical information, you must submit your request in writing to our office at the address set forth in this Notice. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request. You may mail your request or bring it to our office. We have 30 days to respond to your request for information that we maintain at our practice.

Request Amendment. You have the right to request that we amend protected health information. You must make this request in writing to our practice administrator. The request must state the reason for the amendment.

We may deny your request if it is not in writing or does not state the reason for the amendment. We may also deny your request if the information was not created by us, unless you provide reasonable information that the person who created it is no longer available to make the amendment; is not part of the record which

you are permitted to inspect and copy; the information is not part of your designated record; or is accurate and complete, in our opinion.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your protected health information for treatment, payment, or health care operations; to persons involved in your care; or for notification purposes as set forth in this notice. Although we are not required to agree to your requested restriction, if we do agree, we will comply with your request unless the information is needed for emergency treatment. Please contact our practice administrator as set forth in this notice to request a restriction.

Coroners, Funeral Directors and Organ Donation. We may disclose your protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his/her duties or in reasonable anticipation of death. Finally, we may use or disclose your protected health information for facilitating organ, eye or tissue donation and transplantation.

To Avert a Serious Threat to Public Health or Safety. Consistent with applicable laws, if we believe using and disclosing your protected health information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may use and disclose your protected health information. We may also disclose your protected health information if it is necessary for law enforcement to identify or apprehend an individual.

Military Activity and National Security. When the appropriate conditions apply, we may use or disclose your protected health information: (1) for activities deemed necessary by appropriate military command authorities; (2) for determining your eligibility for benefits by the Department of Veterans Affairs; or (3) to foreign military authority if you were a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation. We may use and disclose your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Department of Health and Human Services. As required by law, we may disclose your protected health information to the Department of Health and Human Services to determine our compliance with applicable laws. **Initial _____**

Written Authorization. Except as stated in this notice, we will not use or disclose your protected health information without your written authorization. You may revoke your authorization at any time, in writing, except to the extent that we have used or disclosed your information in compliance of the authorization.

Food and Drug Administration. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track replacements; or to conduct post-marketing surveillance.

Inmates. We may use and disclose your protected health information if you are an inmate of a correctional facility.

Disaster Relief. We may use and disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Research. We may use and disclose your protected health information for research projects, e.g. for a project studying the effectiveness of treatment. Generally such research projects must have been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We may use and disclose your protected health information to the extent that the use or disclosure is required by law. If required by law, you will be notified of any such uses or disclosures.

Public Health. We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. Disclosures will be made for purposes of controlling disease, injury or disability. If directed by the public health authority, we may disclose your protected health information to a foreign government agency that is collaborating with the public health authority.

Abuse or Neglect. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. If we believe you are a victim of abuse, neglect or domestic violence, we also may disclose your protected health information to the governmental agency that is authorized to receive this information. All disclosures will be consistent with the requirements of the applicable laws.

Communicable Diseases. If authorized by law, we may disclose your protected health information to a person who may have been

exposed to a communicable disease or may otherwise be at risk of contracting or spreading a communicable disease.

Legal Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceedings; in response to an order of a court or administrative tribunal; to the extent the disclosures are expressly authorized; or, if certain conditions have been satisfied, in response to a subpoena, discovery request or other lawful process.

Law Enforcement. If certain legal requirements are met, we may disclose your protected health information to a law enforcement official for law enforcement purposes, including legal processes; identification and location of suspects, fugitives, material witnesses, or missing persons; information regarding victims of a crime; suspicion that death has occurred as a result of criminal conduct; evidence of criminal conduct occurring on our premises; and, in a medical emergency, reporting criminal conduct not on our premises.

Uses and Disclosures of Your Protected Health Information

Treatment. We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We may also disclose your protected health information to other health care providers who may be treating you or involved in your health care. For example; we may disclose your protected health information to a specialist.

Payment. We may use and disclose your protected health information to obtain payment for the health care services we provide you or to determine whether we may obtain payment for services we recommend for you. We may also disclose your protected health care information to another health care provider, health care clearinghouse or health plan for their payment activities. For example; we may include with a bill to a third-party payer information that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We may use and disclose your protected health information to support our business activities. For example; we may use protected health information to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. We may disclose your protected health information to another health care provider, health care clearinghouse, health plan or "organized health care arrangement" we participate in for certain health care operations. We may also disclose your protected health information to third party business associates who perform certain activities for us (i.e., billing

services). Finally, we may disclose to certain third parties a limited data set containing your protected health information for certain business activities.

Appointment Reminders and Treatment Alternatives. We may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment, or to tell you about or to recommend possible alternative treatments or other health-related benefits or services that may be of interest to you.

Persons Involved in Your Care. We may use and disclose to a family member, a close friend, or any other person you identify, your protected health information that is directly relevant to the person's involvement in your care or payment related to your care, unless you object to such disclosure. If you are unable to agree or object to a disclosure, we may disclose the information as necessary if we determine that it is in your best interest based on our professional judgment.

Notifications. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or other person responsible for your care, of your location, general condition or death.

Printed Name

Signature

Date