



# 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

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

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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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## **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: \_\_\_\_\_

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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](http://www.Norterrafamilymedicine.com) so you will have the ability to download and prepare your paperwork prior to your appointment.

### **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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### **HIPAA POLICIES & PRIVACY PRACTICES AT 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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinated, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that our relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglects: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Sections 164.500.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing) for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. **Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization Or Opportunity To Object Unless Required By Law**

**You may revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “**designated record set**” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction on your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

**You have the right receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**Complaints**

You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may obtain the address of the OCR Regional Manager, from our privacy officer.

This notice was published and becomes effective on/or before **12/25/2008**.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient’s Name: \_\_\_\_\_