



Patient Information Sheet

Patient Information – Please Print

Prefix: _____ First Name: _____ MI: _____ Last Name: _____

Alias: _____ DOB: _____ Age: _____ Sex: _____ SSN: _____

Race: _____ Are you of Hispanic/Latino descent: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact Information – Check the box next to the best contact number

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____ Please contact me by: Phone Email Mail

Preferred Pharmacy

Pharmacy Name: _____ Phone Number: (____) _____

Approximate Location: (cross streets, city, etc.) _____

Provider Information

Referring Physician: _____ Primary Care Physician: _____

Responsible Party Insurance / Billing Information

Primary Insurance Company: _____

Policy #:	Member ID#:	Group #:
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Responsible Party: _____ DOB: _____ Relationship to Patient: _____

Address (if different than above): _____ Phone Number: (____) _____

Secondary Insurance Company: _____

Policy #:	Member ID#:	Group #:
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Responsible Party: _____ DOB: _____ Relationship to Patient: _____

Address (if different than above): _____ Phone Number: (____) _____

Women Questionnaire

Is there a possibility you may be pregnant? Yes No Date of LMP: _____

Please List ALL Current Medical Problems and the Physician Treating them:

_____	_____
_____	_____
_____	_____



Please List ALL Past Surgeries & What Year Performed:

Please List ALL Current Medications & Dosage:

Medication	Dosage	Medication	Dosage

Please List ALL Allergies:

Family Medical History:

Mother:

Sibling(s):

Father:

Other (please list):

Social History

Marital Status: Single Married Divorced Widowed

Occupation(s): *Please be specific about any occupations where you may have been exposed to hazardous materials*

Tobacco Usage: Currently, Every Day Currently, Some Days Former Never

Amount Used/Day: _____ Age Started: _____ Age Stopped: _____

Alcohol Consumption: Currently, Every Day Currently, Some Days Former Never

Amount Used: _____ per day week

Type of Alcohol: Beer Wine Liquor Multiple

Drug Use:



Payment Policy

Thank you for choosing Comprehensive Interventional Care Centers (CICC). CICC is committed to providing you with the highest quality care. Please review our Payment Policy, should you have questions we will discuss prior to your exam. **Insurance:** We participate with most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is due at the time of your exam is performed. If you are insured by a plan we are contracted with, but do not have your insurance information, payment in full is due at the time your exam is performed. Once we obtain your insurance information, we will bill the insurance company and refund your payment after the claim has been paid in full. **Co-Payments, Deductible, & Co-Insurance:** All co-payments, deductibles and co-insurance must be paid at the time your exams are performed per your contract with your insurance company. **Non-Covered Services:** In some instances, the services you receive may not be covered or not considered medically necessary by Medicare or other insurance companies. In these instances, you will be required to pay for these services in full at the time of your exam. **Proof of Insurance:** We may require that we obtain a copy of your driver's license and valid insurance care to provide proof of insurance. If we are not provided with the correct information, you will be held responsible for the balance of the claim. **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get the claim paid. **Coverage Changes:** If your insurance changes, please notify us immediately in an effort to avoid problems with your claim being paid.

Financial/Insurance Policy

I hereby assign all insurance benefits to CICC for services performed as a result of my illness or injury. **Non-insured patients:** I agree that I am responsible for payment at the time of service, unless prior arrangements have been made. **Referral & Insurance Card Responsibility:** I understand that during the check in process, if I do not have my referral and/or insurance card, I will be responsible for any payment rendered at the time of service. **Deductible/Coinsurance:** I assume and agree to pay all applicable deductibles and co-pays. If my deductible is not met, full payment will be collected at time of service. If my deductible has been met, my coinsurance amount may be collected at time of service. **Non-covered procedures:** I agree to pay for all non-covered services (preventative or routine) not covered by my insurance. **Collections:** Once an account is placed in collection status, all future services must be paid in full at the time of service. I understand that there will be a \$25.00 fee for any returned checks.

Acknowledgement – Receipt of Notice of Privacy Practices

By my signature, I acknowledge receipt of the provider's Notice of Privacy Practices (HIPAA) and have been given the opportunity to read it. I understand that this information is available to me upon my request.

Acknowledgement – Medical Record Request

I hereby authorize CICC to **obtain** and/or **disclose** my medical records for medical treatment purposes only to my physician(s), clinic, hospital, or to my insurance company without further written permission for continuation of care. As a referred patient, CICC will provide a CD copy of my exams at no charge. Copies of exams printed to film will be available to me for a flat rate of \$25.00 per exam.

General Consent and Right to Refuse Treatment

General Consent to Treatment: By signing below, I (or my authorized representative on my behalf) authorize CICC and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reason(s) for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and benefits associated with these options as well as alternative courses of treatment. **Right to Refuse Treatment:** In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment or medication recommended or deemed medically necessary as prescribed by my referring physician. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of my evaluation and/or treatment.

Advanced Directives

You have the right to information on CICC's policy regarding Advanced Directives. Advanced Directives will not be honored within the center. In the event of a life-threatening event, emergency medical procedures will be implemented. Patients will be stabilized and transferred to a hospital where the decision to continue or terminate emergency measures can be made by the physician and family. If the patient or patient's representative wants their Advance Directives to be honored, the patient will be offered care at another facility that will comply with their wishes. A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR- Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT:** Under Arizona law a Prehospital Medical Directive or DNR must be on letter sized paper or wallet sized paper of an orange background to be valid.

By signing below, I am stating that I understand and agree with the above policies and acknowledgements and all information provided by me is complete and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____