Arizona Community Physicians **J. Manuel Herrera, MD** **MRN#**_____

PATIENT INFORMATION / Información del Paciente

Nombre completo Last-Apellido First-Primer Initial Fecha de nacimiento Edad
FULL NAME _____ **DATE OF BIRTH** ___/___/____ **AGE** _____
mes día ano
mo day year
No. de seguro social
SOCIAL SECURITY NUMBER _____ Nombre de esposo si está casada
CIRCLE ONE MARITAL STATUS **S M W D** ESTADO CIVIL **S C V D** IF MARRIED, SPOUSE'S NAME _____
Dirección local
LOCAL ADDRESS _____
Ciudad Estado Código Postal Teléfono de casa Teléfono celular
CITY _____ **STATE** _____ **ZIP** _____ **HOME PHONE** _____ **CELL** _____
If different- Dirección de envió Ciudad Estado Código Postal
MAILING ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____
Correo electrónico
EMAIL ADDRESS _____
Patrón/ Lugar de Empleo Teléfono de trabajo Ocupación
EMPLOYERS NAME _____ **BUSINESS PHONE** _____ **OCCUPATION** _____
Caso de emergencia quien contactar Relación con el paciente Teléfono
EMERGENCY CONTACT NAME _____ **RELATIONSHIP TO PATIENT** _____ **PHONE** _____

PRIMARY CARE PHYSICIAN NAME / Nombre de su doctor primario

_____

Referida por
REFERRED BY _____

BILLING INFORMATION - If different than patient / Información de cobranza - si differente al paciente

Nombre completo Last-Apellido First-Primer Initial Relación con el paciente
FULL NAME _____ **RELATIONSHIP TO PATIENT** _____
Dirección
ADDRESS _____
Teléfono de Casa Teléfono de celular
HOME PHONE _____ **CELL** _____

MEDICAL INSURANCE INFORMATION / Información de seguro medico

Aseguranza principal Co-Pago
PRIMARY INSURANCE CARRIER _____ **COPAYMENT $** _____
Identificación o no. de póliza No.de grupo
ID OR POLICY # _____ **GROUP #** _____
Posesor de póliza Fecha de nacimiento
NAME OF POLICY HOLDER _____ **DATE OF BIRTH** ___/___/____
Patrón/ Lugar de Empleo mes día ano
mo day year
EMPLOYER _____
Aseguranza secundaria Co-Pago
SECONDARY INSURANCE CARRIER _____ **COPAYMENT $** _____
Identificación o no. de póliza No.de grupo
ID OR POLICY # _____ **GROUP #** _____
Posesor de póliza Fecha de nacimiento
NAME OF POLICY HOLDER _____ **DATE OF BIRTH** ___/___/____
Patrón/ Lugar de Empleo mes día ano
mo day year
EMPLOYER _____

AUTORIZACION PARA DAR INFORMACION MEDICA, DESIGNACION DE BENEFICIOS Y PAGOS DE CUENTA
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, ASSIGNMENT OF BENEFITS AND PAYMENT OF ACCOUNT

I authorize Az. Community Physicians to release medical information for insurance purposes concerning treatment of the above patient while under their care. I assign my rights to benefits of insurance plans to Az. Community Physicians and I agree to pay any amount not covered by insurance. If collection proceedings are required, I agree to pay reasonable collection fees. I will be responsible for any lab charge not covered by insurance carrier. Effective Sept. 1, 2009 personal balances over sixty (60) days will be assessed a 1% per month financing charge. Balances written off to bad debt or to a collection agency will be assessed a one-time 30% finance charge. The effective period of this authorization is from today's date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or am deceased.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Yo autorizo a la oficina de Az. Community Physicians que den información sobre mis datos médicos mientras estoy bajo el cargo de la clínica, con el objetivo de verificar el tratamiento médico para la aseguranza. Al firmar esta forma yo entiendo que todos los beneficios y derechos de mi propio plan de aseguranza se aplicaran con Az. Community Physicians y también entiendo que soy responsable de cuentas delincuentes, no pagadas por mí aseguranza. Si es necesario que una agencia de colecciones se utilice yo estoy de acuerdo en pagar gastos de colección que sean razonables. Efectivamente 1 de Septiembre del 2009 cualquier balance personal mas de (60) días se le va agregar 1% al mes de cargos financeros. Balances transferidos a Bad-debt o a una agencia de colección se le agregara solamente una vez un cargo financiero de 30%.

Yo doy conocimiento de esta noticia y he leido y entendido la Noficiación de la Salud Práctica de información con respecto a la participación de mi proveedor en la red, el Intercambio de Información en todo el stado de salud (HIE), o que yo re cibi anteriormente esta información y rechace otra copia.

_____ _____

PATIENT SIGNATURE /Firma de la paciente **DATE**/ Fecha

ARIZONA COMMUNITY PHYSICIANS
REGISTRATION ADDENDUM

Patient Name:_____

Account Number:_____

Due to a governmental mandate that all healthcare is provided fairly, without regard to race or ethnicity, we have added new fields to our patient registration form. This information will be kept confidential.

Race (check one)

☐ Black, African American (01)
☐ Asian (02)
☐ Caucasian (White) (03)
☐ American Indian, Alaskan Native (08)
☐ Native Hawaiian/Other Pacific Islander (09)
☐ Unknown (98)
☐ Declined (99)

Ethnicity (check one)

☐ Hispanic
☐ Non- Hispanic
☐ Unknown

E-mail (optional)

_____

_____
Patient Signature

_____
Parent/Guardian Signature

Preferred Language (check one)

☐ English (EN)
☐ Spanish (ES)
☐ Arabic (AR)
☐ Chinese (all types) (ZH)
☐ French (FR)
☐ German (DE)
☐ Greek (EL)
☐ Italian (IT)
☐ Japanese (JA)
☐ Korean (KO)
☐ Navajo (NV)
☐ Polish (PL)
☐ Russian (RU)
☐ Tagalog' (TL)
☐ Ukrainian (UK)
☐ Vietnamese (VI)
☐ Other_____
(Specify)

☐_____
Patient declined filing out the form. Staff signature required

Arizona Community Physicians, P.C.
Adult
Release of Information Form

Account #_____

Patient Name _____ DOB_____ Date_____

Guardian Name _____ Contact Number: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

Name/relationship _____ Contact Number_____

By providing the below phone #'(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail_____ (Phone #)

DO NOT RELEASE Information to the following people: _____

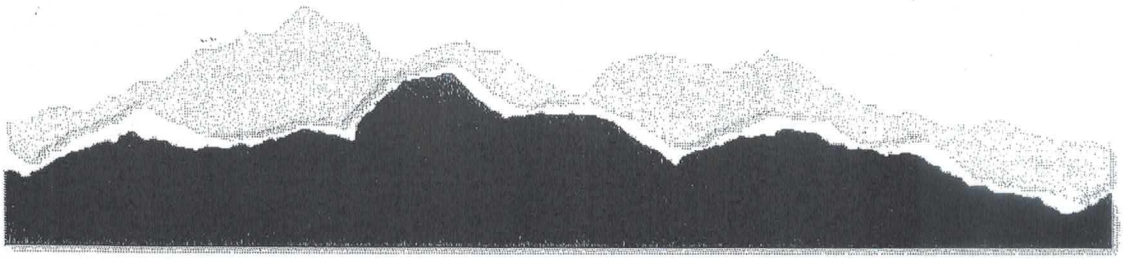
I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Name Patient/Guardian: _____ Signature _____Date_____

The information provided on this form will stay in effect until updated by the patient

J. Manuel Herrera, M.D. *Gynecology*

1261 N. Wimot Rd Tucson, AZ 85712 520-722-6858 520-722-8781 fax



Arizona Community Physicians, P.C.

Hearing Assessment Questionnaire

Date: _____

Patient Name: _____

MRN#: _____

The onset of hearing loss is usually very gradual. It may take place over 25-30 years or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Here is a simple test you can take to determine if you have a hearing problem.

1. Do you frequently have to ask others to repeat themselves? Yes or No
2. Do you have difficulty understanding speech when in noisy situations? Yes or No
3. Do you have ringing or other noises (tinnitus) in your ears or head? Yes or No
4. Do others complain that you watch the television with the volume too high? Yes or No
5. Do you often hear people, but cannot understand what they are saying? Yes or No

If you checked "Yes" to two or more of the above, it is recommended you complete a diagnostic hearing evaluation.

For Office use only: To be completed by your Physician.

Refer: Yes:_____ No:_____

Physician Name **J. Manuel Herrera, MD**

Please fax this form to the ACP TEST CENTER: 520-547-2065 to schedule the appointment.

J. MANUEL HERRERA M.D.

Patient name: _____ MRN#_____

TARDINESS, CANCELLATION AND NO SHOW POLICY

In an effort to provide better service and availability to our patients, we have developed a Tardiness, Cancellation and No show policy. As our goal is to provide quality medical care in a timely manner, this policy enables us to better utilize available appointments for our patients in need of medical care.

Please note, we do provide a courtesy reminder 2 days prior to your scheduled appointment date.

New patients who DO NOT SHOW up for their appointment or who do not provide notice at least 24 hours in advance, will not be rescheduled.

If you are more than 15 minutes late for your appointment, you will be asked to reschedule.

A patient who does NOT SHOW up for their appointment or who does not provide notice at least 24 hours in advance, will be charged a $25 administrative fee. This fee is not payable by any insurance company, and will remain the responsibility of the patient. This fee is due in full prior to you next appointment.

We ask that you please call 24 hours in advance to (520) 722-6858, if you are unable to keep your scheduled appointment, there is an option to leave a message, if line is not picked up or for after office hour calls.

PRESCRIPTIONS

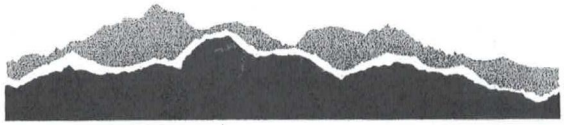
If you need a refill, please call your pharmacy first. Please allow 48 hours for a prescription to be refilled. If you have not had an appointment within the recent months, you may be required to schedule an appointment to be seen before we refill your medication.

COMPLETION OF ALL PATIENT FORMS

Please allow 48 hours for completion of any patient forms, this includes Disability, FMLA, and work related forms. There is a $25 fee charge for the completion of these forms.

_____Date_____

Patient signature



Arizona Community Physicians

J. Manuel Herrera, M.D.

NAME & DOB : _____

MEDICATION NAME	DOSE FREQUENCY	TREATMENT FOR	PHYSICIAN