PROGRESSIVE HEALTHCARE GROUP
PATIENT REGISTRATION FORM

PLEASE PRINT
PATIENT NAME:_____ GENDER: male female

Race:_____ Ethnicity_____ Language: Eng:__ Spanish:__ other_____

PATIENT ADDRESS:_____ CITY, STATE ZIP_____

PERMANENT ADDRESS:_____ MARITAL STATUS:_____

HOME PHONE:_____ BUSINESS PHONE:_____ CELL:_____

BIRTHDATE:_____ AGE:_____ SS#_____

EMPLOYMENT: 0 Fulltime 0 Unemployed 0 Retired 0 Student 0 Disabled

RESPONSIBLE PARTY:_____ RESP PARTY DOB: _____

REFERRED BY: DR:_____ ATTORNEY:_____

PATIENT EMPLOYER NAME:_____

JOB INJURY 0 YES 0 NO 0 ACCIDENT 0 AUTO 0 OTHER DATE OF INJURY_____

INDUSTRIAL CARRIER/ADDRESS:_____

NEAREST RELATIVE / PHONE #_____

INSURANCE INFORMATION:
PRIMARY INSURANCE:
INSURANCE COMPANY NAME:_____

POLICYHOLDER'S NAME:_____ BIRTHDATE:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

SECONDARY INSURANCE:
INSURANCE COMPANY NAME:_____

POLICYHOLDER'S NAME:_____ BIRTHDATE:_____

POLICY NUMBER:_____ GROUP NUMBER:_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. i AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES.

PATIENT / RESPONSIBLE PARTY SIGNATURE:_____ DATE:_____

GENERAL MEDICAL INFORMATION

Describe current medical problem/reason for today's visit:_____

Present medications:_____

Allergies to medication:_____

Other physician currently treating you:_____

Previous or other medical problems:_____

List any previous surgeries or hospitalizations include number of miscarriages and live births):_____

_____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ YES ☐ NO

Do you use Tobacco? ☐ YES ☐NO ☐Cigarettes ☐Pipe ☐Cigars ☐Chew
No.of yrs? _____ How much? _____ ☐ Interested in stopping?

Do you regularly drink alcohol? ☐ YES ☐ NO How many ounces/beers per day?_____

Do you drink coffee? ☐ YES ☐ NO How many cups per day?_____

Are you under a lot of pressure at home or work? ☐ YES ☐ NO Please describe:_____

_____

PERSONAL MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?:
(Check all that apply)

☐ Chest pain / pressure / tightening
☐ Hypertension
☐ Heart Attack
☐ Stroke
☐ Headaches
☐ Glaucoma
☐ Allergies or Eczema
☐ Depression
☐ Blood in Stool
☐ Asthma
☐ Dizzy Spells
☐ Cancer
☐ Diabetes
☐ Arthritis
☐ Difficulty Hearing
☐ Memory Loss
☐ Hemorrhoids
☐ Kidney Disease
☐ Shortness of Breath
☐ TB / Lung Disorder
☐ Ulcers
☐ Skin Disorders
☐ Hepatitis
☐ Cataracts
☐ Digestive problem
☐ Frequent urinary infections
☐ Other _____

IMMUNIZATIONS

(Year last received: If known):

Smallpox:_____
Tetanus:_____
Typhoid:_____
Polio:_____
Influenza:_____
Pneumonia:_____
Rubella:_____
Hepatitis:_____
Chicken Pox(Varicella)_____
Mumps_____
Measles_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High blood pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Eczema / Psoriasis	☐	☐	☐	☐	☐	☐
Heart attack / Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay fever	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐

PROGRESSIVE HEATLHCARE GROUP

Consent for Medical Treatment of a Minor
Consent for Emergency Treatment
(Valid for One Calendar Year)

The undersigned parent(s)/guardian(s) of _____, a minor, grant permission for any treatment that may be rendered to said minor under the general or special instructions of Dr. _____or his/her agents.

Parent Guardian _____
Home Address (Physical) _____
Work Address (Physical)_____
Telephone (Home) _____ Work _____

Other Person to Contact _____
Home Address (Physical) _____
Work Address (Physical) _____
Telephone (Home) _____ Work _____

Child's Medical History (allergies, date of last tetnus immunization, special health problems, asthma, diabetes, heart trouble)_____
_____

Insurance information (company, policy number, etc.) _____.
_____

Child's birthdate
____/____/____

Social Security Number
_____/____/_____

I am aware that the above named facility will attempt to contact me in an emergency as soon as possible but will not withhold treatment until contact is made.

____/____/____
Date

_____
Signature

_____
Print name of parent or guardian

Progressive HEALTHCARE GROUP

P.O. Box 1819
300 S. Ocotillo Street
Benson, AZ 85602
Phone: 520-586-9111
Fax: 520-586-9091

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As required by law, we have posted our practice's Notice of Privacy Practices in the reception area for our patients to read. A copy of this notice is available at our front desk area or upon request. This notice details how your health information may be used and disclosed and outlines your rights regarding your health information. You are not required to read this notice, however we would like your acknowledgement that you have been notified that our office has such a Notice of Privacy Practices.

I am aware that health information will be used for purposes of treatment, payment and other healthcare operations according to HIPPA Regulations. I also understand that my written authorization will be obtained prior to use or disclosures of my health information that are not identified by this notice or permitted by law.

I authorize Progressive Healthcare Group to release information regarding my treatment, test results and/or care to the following individuals (spouse, parent, children, friend, etc).

NAME:	PHONE:	RELATION:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
{Signature of patient or guardian}

_____
{Name/relationship of person signing form, if other than patient}

_____ _____ _____
{Name of patient} Date of Birth Date

PROGRESSIVE HEALTHCARE, INC.
NOTICE OF PRIVACY PRACTICES

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

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information within the clinic and how we may disclose it to others outside the clinic. This notice also describes the rights you have concerning your own health information. Please review it carefully and let us know if you have questions.

HOW WILL WE USE AND DISCLOSE YOUR MEDICAL INFORMATION?

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others that need that information to treat you, such as doctors, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care.

We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. If you do not want the clinic to disclose your medical information to family members or others, please tell the doctor and/or nurse so that it can be noted in your records.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or health insurance company may request to see parts of your medical record before they will pay us for your treatment.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

Other Uses and Disclosures: If the clinic wishes to make a use or disclosure of your medical information for a purpose that is not discussed in this Notice, the clinic will seek your permission. If you give your permission to the clinic, you may take back that permission any time, unless we have already relied on your permission to use or disclose the information.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, submit a written request to the Health Information Management Department. If you request a copy of your information, we will charge you for our costs to copy the information. We will tell you in advance what this copying will cost.
You can look at your record at no cost.

Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To make a request to amend your medical information, submit a written request to the Privacy Officer.

Right to Get a List of Certain Disclosures of Your Medical Information: You have the right to request a list of many of the disclosures we make of your medical information. If you would like to receive such a list, submit a written request to the Health Information Management Department. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How the Clinic Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to request us not to make uses or disclosures of your medical information to treat you, to seek payment for care, or to operate the clinic. We are not required to agree to your request, but if we do agree, we will comply with that agreement. If you want to request a restriction, submit your request in writing to the Privacy Officer and describe your request in detail.

Right to Request Confidential Communications: You have the right to request us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, submit your request in writing to the Privacy Officer.

Required by Law: Federal, state, or local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases. We also are required to give information to the Arizona Workers' Compensation Program for work-related injuries.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State of Arizona. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the clinic. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. The clinic may also disclose medical information to federal officials for intelligence and national security purposes, for presidential Protective Services, or to the Department of State for its security clearances.

Judicial Proceedings: The clinic may disclose medical information in a lawsuit if the clinic is ordered to do so by a court or if the clinic receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and court-ordered mental evaluation is treated differently than other types of medical information. For those types of information, the clinic is required to get your permission before disclosing that information to others in most circumstances.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this notice and to make the provisions in our new notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current notice of Privacy Practices at any time by coming in to Progressive Healthcare, Inc. or by writing and requesting a copy.

WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?

This Notice of Privacy Practices applies to Progressive Healthcare, Inc. and its personnel, volunteers, students, and trainees.

DO YOU HAVE CONCERNS OR COMPLAINTS

Please tell us about any problems or concerns you have with your privacy rights or how Progressive Healthcare, Inc. uses or discloses your medical information. If you have a concern, please contact the Privacy Officer.

If for some reason Progressive Healthcare, Inc. cannot resolve your concern, you may also file a complaint with the federal government. To file a complaint against the clinic, contact Ira Pollack, Regional Manager, CMS Region IX, 50 United Nations Plz., Rm. 322 San Francisco, CA 94102. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

DO YOU HAVE QUESTIONS?

The clinic is required by law to give you this notice and to follow terms of the notice that is currently in effect. If you have any questions about this notice, or have further questions about how the clinic may use and disclose your medical information, please contact the Privacy Officer.

Effective date: April 14, 2003