ARIZONA ASSOCIATES FOR WOMEN'S HEALTH

Name: _____ DOB_____
Spouse/Partner's Name: _____ DOB_____
Are you Married/Divorced/Single_____

Email Address:_____
How did you hear about us?_____

Do you have any allergies? If so, please describe: _____
How long have you and your current partner been together?_____
What is your Occupation?_____
What is your Spouse/Partner's Occupation?_____
Who is your Primary Care or Family Doctor?_____
Who is your OB/GYN?_____

WHAT IS THE REASON FOR YOUR VISIT TODAY?_____

Menstrual History

Your age_____ Age at first menstrual period?_____ Have you had a menstrual period in the past 6 months?_____
When did your last menstrual period start?_____ Previous Period?_____
Without medications: Menstrual cycles are: Always Regular Usually Regular Irregular Rare No periods
Period Are: Light Moderate Heavy Very Heavy Variable
Number of days between the start of each period: _____
Number of days each period lasts (including spotting)_____
With Medications (birth control pills) your periods are
Very Regular Usually Regular Irregular Rare No periods
Do you have cramping pain with your periods? No Yes- Mild Moderate Severe
Are you trying to become pregnant? Yes No If yes, for how long?_____

Obstetrical History

Have you ever been pregnant? Yes No How many?_____
Have you ever delivered a baby at term or in third trimester? Yes No How many?_____
Have you ever had a miscarriage? Yes No How many?_____ When?_____
Have you ever had an abortion? Yes No How many?_____ When?_____
Have you ever had a tubal or ectopic pregnancy? Yes No How many?_____ When?_____
Do you have children? Yes No How many?_____

Date of Birth	# Weeks Pregnant	Miscarriage Or Ectopic?	If Miscarriage – Any D&C?	Vaginal or C-Section	Gender	Birth Weight	Any complications during the pregnancy?

Gynecology History

Have you ever had an STD, PID, Chlamydia or Gonorrhea? Yes No When?_____ Treatment?_____
Have you ever been diagnosed with PCOS? Yes No When?_____ Treatment?_____
A history of ovarian cysts? Yes No When?_____ Treatment?_____
A diagnosis or suspicion of endometriosis? Yes No When?_____ Treatment?_____
A diagnosis of uterine fibroids? Yes No When?_____ Treatment?_____
When was your last PAP Smear? _____
Have you ever had an abnormal PAP Smear? Yes No Have you ever had a LEEP, Cone, Laser or Cryo performed?_____
Breast Disease or Breast Problems? Yes No When? _____
Have you taken birth control pills? Yes No When?_____ For how long?_____ When did you stop?_____
Are you still taking birth control? Yes No Any Side Effects?_____
Have you ever had an IUD? Yes No
Do you currently have an IUD? Yes No If so, Type: Mirena Paraguard Skyla
When was the IUD placed?_____ Any Side Effects?_____
What other types of contraception have you used?
Condoms Tubal Ligation Essure Endometrial Ablation Depo-Provera Nexplanon Other _____
What is your sexual orientation? Heterosexual Homosexual Bisexual

Pt Name_____ DOB:_____

Endocrine

What is your current Height?_____ Weight?_____
Have you had a weight change of over 10 lbs in the past year? Yes No Gain Loss How much?_____
Do you exercise the equivalent of running 20 miles or more per week? Yes No How much?_____
Any excessive hair growth on the face, chest, abdomen or back? Yes No Location:_____
Do you get acne with menses? Yes No
Have you ever been diagnosed with Thyroid Disease? Yes No When?_____ Medication?_____
If so, was it Hypothyroid (Low) or Hyperthyroid (High).
Have you ever been diagnosed with diabetes or pre-diabetes? Yes No When?_____ Medication?_____

Medical History

Do you have a history of the following (If so, circle any appropriate below):
High Blood Pressure Heart Problems Mitral Valve Prolapse Hyperthyroid (high) Hypothyroidism (low) Arthritis Trauma-Injuries Seizures Hepatitis B Hepatits C HIV Asthma Depression Bi-Polar Disorder Schizophrenia Learning Disabilities Celiac Disease
Any other chronic medical problems? Yes No If yes, please describe_____
Have you ever had mumps? Yes No What age?_____
Any bleeding or blood clotting problems (Including Factor V Leiden, Protein C or S, Von Willebrands)?_____
Have you ever had psychiatric care Yes No Treatment? _____

Social History

Do you have any Medication Allergies? Yes No Which ones?_____ Reaction:_____
Do you currently take medications? Yes No Which Ones?_____
Do you currently take any Vitamins or other Supplements? Yes No Which Ones?_____
Do you Drink Caffeine? Yes No How many cups/day?_____
Have you ever had Acupuncture? Yes No If so, whom did you see?_____ Any Herbs? _____
Do you currently smoke? (Vapor, Tobacco, Marijuana) Yes No How Much?_____
Did you smoke in the past? Yes No Quit how long ago?_____
Do you drink alcohol? Yes No How many drinks/week? _____
Do you take, or have you ever taken, recreational drugs? (Meth, Cocaine, Marijuana, Heroin) Yes No If so, which ones?_____

Surgical History

Have you ever had: **Fibroids Removed (Abdominal or Laparoscopic or Robotic or Hysteroscopic) Removal of Ovary (left/right) Removal Fallopian Tube (left/right) Removal of Ovarian cyst (left/right) Appendectomy-Ruptured or Unruptured Breast Biopsy Breasts –enlarged/ reduced Endometriosis surgery Cesarean section Gallbladder removed Mastectomy**
Laparoscopy when?_____ Reason for Surgery_____ Surgeon: _____
How Many?_____
Laparotomy when?_____ Reason for surgery_____ Surgeon: _____
Hysteroscopy when?_____ Reason for procedure_____
Any Complications with surgery or anaesthesia? _____Any other surgeries?_____

Family History

What is your ethnicity? **European African American Mediterranean Asian Hispanic Ashkenazi Jewish French Canadian Other:** _____
Any medical conditions run in the family? Yes No Unknown Are you adopted?_____
Has anyone been diagnosed with Coronary Artery Disease, Stroke, or Diabetes (if so, Type I or Type II) If so, who?_____
Cancer before 50? Yes No Who? _____ If yes, what type of cancer? _____
Bleeding or Clotting Problems (Including Factor V Leiden, Protein C / S, Von Willebrands, Blood clots in lungs or legs DVT/PE)? Who?_____
Auto-immune disease? (Multiple Sclerosis, Lupus, Rheumatoid Arthritis, Scleroderma, etc) Yes No Who?_____
Genetic disease? (Cystic Fibrosis, Spinal Muscular Atrophy, Fragile X, Sickle Cell, Beta/Alpha Thalasemia, Taysachs, hemophilia)? Who?_____
Birth Defects? (spina bifida, hydrocephaly, cleft-lip/palate, down syndrome, club feet, dislocated hip, dwarfism, kidney problems, developmental delays) Yes No Who?_____

Testing

Have you ever had a hysterosalpingogram (HSG)? Yes No When:_____ Results:_____
Have you ever used ovulation predictor kits? Yes No When:_____ Results:_____
Hormone tests (Day 3)? Yes No When:_____Results:_____ Ultrasounds Yes No Results:_____
Egg Reserve Testing FSH or AMH: Yes No When?_____Results?_____
Genetic Carrier Testing Yes No Results:_____ Have you ever been diagnosed with a Mutation? (CF, SMA, MTHFR, Frag X, other) Yes No
Have you ever had to take progesterone to support a pregnancy? Yes No If so, what medication did you take and when? _____
Previous testing with: _____(Clinic/Doctor)

Treatment

Of Prior medicated Cycles _____ (circle meds below) Did you become pregnant? Yes No Did you use insemination (IUI)? Yes No
Clomid 50mg/100mg/150mg Femara Ovidrel/Trigger shot Gonal-F/Follistim /Menopur Cycles: _____
Of IVF Cycles: _____ How many eggs were retrieved?_____ ICSI : Yes No How many embryos developed?_____
Did the embryos undergo PGD or PGS? Yes No Unsure If yes, Results:_____
Of Prior Embryo Transfers: _____ #Fresh transfers: _____ #Frozen transfers: _____ When: _____
Have you ever used Donor Eggs? Yes No Have you ever used Donor Sperm? Yes No
Previous treatment with: _____(Clinic/Doctor)

ARIZONA ASSOCIATES FOR WOMEN'S HEALTH

Name:_____DOB_____ Spouse/Partner's Name?_____DOB_____
Are you Married/Divorced/Single_____ What is your Occupation?_____
Email Address:_____ How did you hear about us?_____

Male History

What is your age?_____
Current Medications: _____
Allergies: _____

Have you ever fathered a child? Yes No If yes, was it with current partner? Yes No
How many previous pregnancies? _____
If not with current partner, how many years ago?_____
Have you ever had a semen analysis? Yes No
When was testing done? _____
What was the result?_____
Have you ever seen a Urologist? Yes No Name of Doctor:_____
When were you seen?_____ What/Any treatment prescribed?_____

Medical History: Circle all that apply:
High Blood Pressure Heart Problems Thyroid Disease Arthritis Trauma-Injuries Seizures
Hepatitis B Hepatits C HIV Asthma Depression Bi-Polar Disorder Schizophrenia
Learning Disabilities Celiac Disease Pituitary Disorder Low Testosterone
Any other chronic medical problems? Yes No
If yes, please describe_____
Any previous surgeries? _____
Have you ever had a vasectomy? Yes No Name of Doctor:_____
If so, when?_____ Did you freeze a semen sample prior? Yes No
Have you ever had a vasectomy reversal? Yes No Name of Doctor:_____
Do you have a history of the following: (circle the appropriate):
Alcohol use? Yes No Number of drinks per day: _____ Per week: _____
Nicotine Use? Yes No Type: _____(includes chewing tobacco/cigarette/ e-cig/Vapor)
If so, how often? _____For how long?_____ Quit?_____ When?_____
Marijuana use? Yes No If so, how many per week? _____ For how long?_____
Testosterone use? Yes No If so, for how long?_____ What type? _____
Anabolic Steroid Use? Yes No When?_____ What type? _____
Other illicit drug use? Yes No When? _____ What type? _____
Have you been exposed to any toxic chemicals or radiation in past? Yes No At work? _____
Have you ever had an STD? Gonorrhea Chlamydia Other _____ When? _____ Treated? _____
Have you ever had a hernia? Yes No What type?_____ Treated?_____
Have you ever had Undescended testes? Yes No When?_____ Treated?_____
Have you ever had a Varicocele? Yes No When? _____ Treated? _____
Have you ever had problems with low sex drive? Yes No When? _____ Treated? _____
Have you ever had Erectile Dysfunction? Yes No When?_____ Treated?_____
Have you ever had Premature Ejaculation? Yes No When?_____ Treated?_____
Have you ever had Diabetes Mellitus? Yes No Type I or TypeII When?_____ Treatment?_____
Have you ever had Retrograde ejaculation? Yes No When? _____ Treated? _____
Have you ever had Mumps? Yes No What age? _____
Have you ever had Testicular Cancer? Yes No When?_____
If so, did you receive radiation or chemotherapy? Yes No Surgery for removal of testes? Yes No
Have you ever had any genetic testing? Carrier screening or Karyotype? Yes No Results: _____

Family History:
What is your ethnicity? **European African American Mediterranean Asian Hispanic Ashkenazi Jewish French Canadian Other:** _____
Any history of infertility, genetic disorders, birth defects, cancers? Yes No Describe: _____

Physician Group
OF ARIZONA, INC.

Clinic Name:_____

Physician/Provider being seen today:_____

PATIENT INFORMATION

Date	Patient last name	Patient first name	Patient middle name
Primary Address		City	State / Zip
Alternate Address		City	State / Zip

Gender	DOB	Status:	☐ Married ☐ Widowed	☐ Single ☐ Divorced	☐ Separated	Race	Ethnicity	Preferred phone number

Social Sec. #	Occupation	Employer	
Employer address		City	State / Zip
Driver's license #	How did you find out about our office? ☐ Health Fair ☐Internet ☐Print Ad (Newspaper) ☐Online Scheduling ☐Direct Mailer ☐Physician Referral ☐ Friend ☐ Insurance ☐Other: _____		

RESPONSIBLE PARTY INFORMATION

Relationship to patient	Last name	First name	Preferred phone number
Home address		City	State / Zip
Social Sec. #	Occupation	Employer	Employer phone
Company address		City	State / Zip
E-mail address		May we send you e-newsletters? ☐ Yes ☐ No	

INSURANCE INFORMATION (Must be filled out completely for verification purposes)

Check here if you have NO insurance ☐

Primary insurance company	Co-pay amount	Policyholder name	Policyholder DOB	Patient relationship to insured: Self / Spouse / Child / Other
Insurance company address			Effective date	Phone
Group or policy #			Medicare #	Medicaid #

2nd insurance company	Co-pay amount	Policyholder name	Policyholder DOB	Patient relationship to insured: Self / Spouse / Child / Other
Insurance company address			Effective date	Phone

INJURY INFORMATION (Must be filled out completely)

Reason for visit?	What type of injury are we seeing you for? (indicate right or left, if appropriate)	
Was this an: ☐ Accident ☐ Injury	Date of accident or injury	Place of accident or injury: ☐ Work ☐ Auto ☐ Home ☐ School Other:
Name of school	Sport/Activity	How was injury sustained?
Is this employment related? ☐ Yes ☐ No	If so, who is your company's industrial carrier?	
Name and address of place of injury		

Name and address of referring physician	Phone (required)
Emergency contact information (full name, relationship to patient)	Phone (required)

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to of all the terms herein.

_____ Date

x_____ Signature of Responsible Party/Patient

Authorization for telephone, cell phone and/or electronic communications:
I authorize the Physician Group of Arizona and all third-party providers and practitioners who provide health care services to me, along with their billing and collection agents, to contact me on my cell phone and/or home phone, including through the use of pre-recorded messages, artificial voice messages, automatic telephone dialing services, or other computer-assisted technology, or by electronic mail, text messaging or any other form of electronic communication for the purposes of payment for services or for health care related notice.

☐ Agree ☐ Decline

x_____ Initial

(Puede obtener una copia de este formulario en Espanol, si la pide.) Effective Date: 8/1/2013

Joint 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 INFORMATION.

PLEASE REVIEW IT CAREFULLY.

1. **Purpose:** _____ and its professional staff, employees, and volunteers and all of its affiliated entities (referred to collectively as Practice) follow the privacy practices described in this Notice. The Practice is required by law to maintain the privacy of your medical information. This Notice describes how we may use and disclose your medical information. Not every use and disclosure in a category will be listed. Your medical information is stored electronically and is subject to electronic disclosure.

2. **Organized Health Care Arrangement.** The Practice and its medical staff participate together in an organized health care arrangement to provide health care to you at the Practice. This Notice applies to physicians and other members of the Medical Staff who have agreed to abide by its terms concerning the services they perform at the Practice. This Notice does not create an agency relationship, a joint venture, or any other legal relationship between those covered by this Notice. Under this arrangement, the Practice may share your medical information as necessary for treatment, payment and health care operations relating to the organized health care arrangement.

3. **Uses and Disclosures for Treatment, Payment, and Health Care Operations.** We will use and disclose your medical information for treatment, payment and health care operations. Treatment involves providing and coordinating your care. For example, we may disclose your information to a specialist to help diagnose or treat you. Payment involves uses and disclosures to assist in obtaining payment for our services. For example, we may disclose your information to health plans or other payors to determine whether you are enrolled with the payor or eligible for health benefits, submit claims for payment, and provide information to entities that help us submit bills and collect amounts owed. Health care operations involves our standard internal operations, such as quality assurance activities, peer review, arranging for legal services, providing appointment reminders and training.

4. **Other Uses and Disclosures Not Requiring an Authorization.** Your medical information may be used and disclosed as described below:

   - Practice directory to anyone who asks about you by name (may include your name, general condition, and your location in the Practice).
   - Religious affiliation and directory information to a practice chaplain or member of the clergy.
   - Family members or close friends involved in your care or payment for your treatment.
   - A government disaster relief agency if you are involved in a disaster relief effort.
   - To inform you of treatment alternatives or benefits or services related to your health. If we receive anything of value for making these communications, we will notify you of this fact, and you will have an opportunity to opt out of future communications.
   - To contact you to raise funds for the Practice, but information used and disclosed for fundraising will be limited to your name and other limited information permitted by law. You will have the opportunity to opt out of receiving fundraising communications.
   - As required by law.
   - Public health activities, including disease prevention, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product problems; notification of recalls; infectious disease control; notifying government authorities of suspected abuse, neglect or domestic violence (if you agree or as required by law).
   - Health oversight activities (e.g., audits, inspections, investigations, and licensure activities).
   - Lawsuits and disputes (e.g., as required by a court or administrative order or in response to a subpoena or other legal process).
   - Law enforcement (e.g., in response to legal process or as required or allowed by law).
   - Coroners, medical examiners, and funeral directors.
   - Organ and tissue donation organizations.

Joint Notice of Privacy Practices
(continued)

- Certain research projects as approved by an Institutional Review Board or if certain conditions are met.
- To prevent a serious threat to health or safety.
- To military authorities if you are a member of the armed forces.
- National security and intelligence activities.
- Protection of the President or other authorized persons or foreign heads of state, or to conduct special Investigations.
- Inmates or others in custody to a correctional institution or law enforcement
- Workers' Compensation (in compliance with applicable laws).
- To business associates (individuals or entities that perform functions on our behalf) (e.g., to install a new computer system) provided they agree to safeguard the information.

5. **Substance Abuse Information.** Alcohol and drug abuse information has special privacy protections. The Practice will not disclose any information identifying an individual as being a substance abuse patient or provide any medical information relating to the patient's substance abuse treatment unless (i) the patient consents in writing; (ii) a court order requires disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits, or program evaluation; or (v) it is necessary to report a crime of a threat to commit a crime, or to report abuse or neglect as required by law.

6. **Your Authorization Is Required for Other Uses and Disclosures**. Except as described above, we will not use or disclose your medical information unless you authorize (permit) the Practice in writing to use or disclose your nformation. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. You may revoke your authorization, and thereby stop any future uses and disclosures, by notifying us in writing.

7. **Your Medical Information Rights**. You have the following rights regarding your medical information, provided that you make a written request to invoke the right on the form provided by the Practice:

   - **Right to request restriction.** You may request limitations on how we use or disclose your medical information for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular surgery). We are not required to agree to your request, except for requests to restrict disclosures to a health plan for purposes of payment or health care operations when you have paid in full out-of-pocket for the item or service covered by the request and when the disclosure is not required by law. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
   - **Right to confidential communications.** You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted and how payment will be handled.
   - **Right to Inspect and copy**. You have the right to look at and obtain a copy of your medical records, billing records, and other records used to make decisions about your care. We may charge you a fee for our postage and labor costs and supplies to create the copy. Under limited circumstances, your request may be denied and you may request review of the denial by another licensed health care professional chosen by the Practice. The Practice will comply with the outcome of the review. If your information is stored electronically and you request an electronic copy, we will provide it to you in a readable electronic form and format.
   - **Right to request amendment.** If you believe that the medical information we have about you is incorrect or incomplete, you have the right to request that your records be amended. Under limited circumstances, the Practice may deny your request for amendment. If denied, you will receive an explanation for the decision and information explaining your options.
   - **Right to accounting of disclosures.** You may request a list of instances where we have disclosed your medical information for certain types of disclosures. The accounting will not include disclosures that we are not required to record, such as disclosures made pursuant to an authorization. The first accounting you request within a 12-month period is free, but we will charge a fee for any additional lists requested within the same 12-month period.
   - **Right to a copy of this Notice.** You may request a paper copy of this Notice at any time, even if you have been provided with an electronic copy. You may obtain an electronic copy of this Notice at our website,

Joint Notice of Privacy Practices (continued)

8. **Other Obligations.** The Practice is required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect and are also required to comply with any federal or state laws that impose stricter standards than those described in this Notice. The Practice may change this Notice at any time and these changes will be effective for medical information we have about you as well as any information we receive in the future. We will post a copy of the current notice in the Practice and on our website. You may also get a current copy by contacting our Privacy Officer at the phone number at end of this Notice. We are required by law to notify affected individuals following a breach of unsecured medical information.

9. **Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to the Practice or the Department of Health and Human Services.

Contact the Corporate Compliance Department at 615-467-1300 * 4481 if:

- **You have a complaint;**
- **You have any questions about this Notice; or**
- **You wish to obtain a form to exercise your individual rights described in section 7 of this Notice.**

Your name and signature on this sheet indicates that you have received a copy of the Joint Notice of Privacy Practices on the date and time indicated.

If you have any questions regarding the information set forth in the Joint Notice of Privacy Practices, please do not hesitate to contact the Corporate Compliance Department at 615-467-1300 * 4481.

Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date and Time Received: _____

For Practice Use Only

We attempted lo obtain written acknowledgement of receipt of our Joint Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Patient is a minor; personal representative signed on patients behalf
- ☐ Patient verbally requested the individual above to sign on his/her behalf
- ☐ Other (please specify) _____

_____

_____ _____ _____

Registration Clerk Signature Date Time

Physician Group
OF ARIZONA, INC.

Patient Name (last, first, MI):	Date of Birth (mm/dd/yyyy):	Medical Record #:

As either the Patient or the legally authorized representative of the Patient, on behalf of the Patient receiving care in this Physician Group of Arizona, Inc., (PGA) Facility, I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient in partial consideration of health care services to be provided to the Patient in the PGA Facility, including IASIS Healthcare and its affiliates.

Consent for Services: I hereby give consent to the Facility, its contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for services they perform.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payors that are payable to the Patient or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the Facility for the exclusive purpose of paying for charges associated with the health care services provided to the Patient in the Facility. I understand and intend that all insurance companies and other third party payors will pay benefits directly to the Facility in payment of the Facility's charges and the charges of any other health care providers for whom the Facility is authorized to bill in connection with health care services provided to the Patient.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to the Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patient and the undersigned, if other than the Patient, remain responsible for all copayments, deductibles, co-insurance, and/ or non-covered services regardless of amount paid by insurance or third party payor. I understand and agree than any amounts not paid within 30 days of the date of the Facility's bill or statement for payment shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay a 20% collection fee, all costs and reasonable attorney's fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to the Facility. Patients that present as self-pay will receive a discount on specified services when services are paid in full on the day of visit.

Medicare/Medicaid/Tricare Patient's Certification: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

Release of Information: The Facility is required by law to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

The following applies if initialed at the end of this paragraph: Because of the Patient's strongly held religious beliefs, this consent does not include consent to administer blood or other blood products unless the Patient subsequently agrees otherwise. The Patient understands that this limitation may cause some health care providers to decline to provide care, and may, in the opinion of some providers, adversely affect the outcome of the care.

DATE:_____ INITIALS:_____

The undersigned signs this document either as the Patient or the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing act. This document will remain in effect unless revoked in writing.

DATE:_____ SIGNATURE:_____

WITNESS TO SIGNATURE:_____ RELATIONSHIP IF OTHER THAN PATIENT:_____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED OR BEEN OFFERED A COPY OF PGA'S NOTICE OF PRIVACY PRACTICE.

DATE:_____ INITIALS:_____

STAFF USE ONLY: IF UNABLE TO OBTAIN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES, A DOCUMENTED REASON BY THE PGA STAFF MEMBER MUST BE ENTERED BELOW IN ACCORDANCE TO PGA POLICY:

Physician Group
OF ARIZONA, INC.

The Arizona Department of Health Services licenses this office.

As required by Arizona Department of Health rules and other statutes, rules and requirements, this office has provided you with a copy of your Patient Rights. By your signature below, you acknowledge receipt of your Patient Rights.

Per my request, I read the laminated copy of the patient rights in the office and do not want to take a copy home with me._____

Per my request, I was given a paper copy of the patient rights to take home with me_____

Printed Name: _____

Relationship to Patient: _____

Signature: _____

Date and Time Received: _____

ARIZONA ASSOCIATES WOMEN'S HEALTH

Dear patient:

As courtesy to all patients and Doctor, if you are unable to attend your scheduled appointment and/or need to reschedule or cancel, we will appreciate a 24hr cancellation call in order to serve better to every ones needs to be seen.

If failing to give us a call within the requested time, we will have a **$25.00 charge fee for no show** to all office visits and/or procedures including ultrasounds.

Feel free to contact us at 480-257-2700 or by fax at 480-257-2701

Thank you for your cooperation and understanding,

Sincerely,

Arizona Associates for Women's Health

_____	_____	_____
Patient's name and Date of birth	Signature	Date

ph 480-257-2700 **fax** 480-257-2701 azwomenshealthcare.com
4135 S. Power Rd., Suite 113, Mesa, AZ 85212 1492 S. Mill Ave., Suite 307, Tempe, AZ 85281

Physician Group of Arizona

AZ Associates for Women's Health

PHARMACY INFORMATION

PATIENT NAME: _____ **D.O.B.**_____

PHARMACY: _____

PHONE: _____

OR

CROSS STREETS: _____

OR Zip Code_____

Last Updated: June 29, 2016

Physician Group
OF ARIZONA, INC.

ADVANCE DIRECTIVES

Please choose one:

[ ] I brought my Living Will/Durable Power of Attorney today and I would like a copy put in my medical record.

[ ] I do not wish to have any advance directives on file.

[ ] Please give me the following forms to review. I will read the information and decide if I want to bring them back into the office and keep on file.

____Advanced Directives Info and FAQ

____Power of Attorney Form

____Mental Power of Attorney Form

____Living Will Form

____DNR (Do Not Resuscitate) Form (leave this one filled out and in plain sight at home).

_____ _____ _____

Printed Name Signature Date