Malin Medical PLLC
1780 N. State Route 89
Chino Valley, AZ 86323
Ph (928) 460-5214 Fx (928) 441-2915

Patient Name: ______________________________ DOB: ____________________

Mailing Address: ____

City: ____________________________ State: __________ Zip Code: ____________

Gender: Male / Female

Phone Number: ______________________ Alternate Number: ______________________

Email: ____

Responsible Party (if Patient is a MINOR)

Name: ______________________________ Relationship to Patient: ______________

Contact Information: ____

Emergency Contact Name: _________________________ Relationship: ______________

Contact Information: ____

INSURANCE INFORMATION

Primary Insurance: ____________________________ Effective Date: ______________

ID #: ______________________ Group #: ___________________________

SS #: ______________________ (ONLY required, if Medicare/Tricare- Policyholders SS#)

Secondary Insurance: ____________________________ Effective Date: ______________

ID #: ______________________ Group #: ___________________________

SS #: ______________________ (ONLY required, if Medicare/Tricare- Policyholders SS#)

I hereby authorize Malin Medical PLLC to furnish the above insurance companies all medical information necessary to process any appropriate claims. I authorize payment of medical benefits to Malin Medical PLLC. I accept responsibility for all accrued charges including those charges which my insurance company does NOT cover.

____ ______________

Signature Date

Please fill out to the best of your ability

Family History

	Father	Mother	Siblings	Children
Diabetes				
Cancer				
Heart Disease				
Rheumatoid Arthritis				

	Living	Deceased
Father		
Mother		
Siblings		
Children		

Extended family pertinent health and psychiatric conditions

Paternal *(father's side)*	
Maternal *(mother's side)*	

Personal History

Where were you born? ________________________ Raised? ________________________

Any problems with birth? ____

Highest level of education: ( ) High School ( ) Some College ( ) College Graduate ( ) Advanced Degree

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Life Partner

Who do you live with? ____

How would you describe your employment status?

( ) Full-time # of hours: _________ ( ) Part-time # of hours: _________ ( ) Seasonal # of hours: _________

( ) Retired ( ) Disabled; do you receive SSI benefits? ( ) Yes ( ) No If yes; for how long: ______________________

Do you have any religious beliefs thar could affect your healthcare? ( ) Yes ( ) No

Social History

	Yes	No	How Long	How Much a Day
Smoker				
Former Smoker				
Alcohol				
Caffeine				
Illicit Drugs				

Allergies

	Reaction
Drugs	
Foods	
Insects	

Health Maintenance

Last Colonoscopy	
Last Bone Density	
Last Lab Work	

Men

Last Prostate Exam	

Women

Age of first period		Were periods regular	
Menopause?		At what age?	
Date Last Period?			
Date Last Pap?			
Date Last Mammogram?			
# of Pregnancies?		# of Live Births?	
# of Miscarriages?		# of Abortions?	

Patient Name: ________________________________ Physician Initials: ______________

Current: Please list ALL medications (including over-the-counter and vitamins):
use back of page if more space is needed.

Name / Strength	Dose (# of times per day)	How long: (years / months)
1		
2		
3		
4		
5		

Please select all conditions you have now or previously have been diagnosed with:

Diabetes		Urinary Issues		Anemia	
High Blood Pressure		Migraines / Headaches		Jaundice / Liver Disease	
High Cholesterol		Pulmonary Embolism		Chronic Neck Pain	
Hypo / Hyperthyroidism		Chronic Sinusitis		Chronic Back Pain	
Asthma		Emphysema / COPD		Rheumatoid Arthritis	
Hepatitis		Heart Burn / Ulcers		Strokes	
Kidney Disease		Kidney Stones		Cataracts	
Tuberculosis		Epilepsy (Seizures)		Gallstones	
HIV / AIDS		Seasonal Allergies		Vascular Issues	
Psoriasis / Eczema		Heart Murmur		Arthritis	
Angina / Chest Pain		Crohn’s Disease / Colitis		Other Skin Conditions	

Heart Conditions; Type:	
Cancer; Type & Status:	
Psychiatric; Anxiety, Depression, Bipolar:	

List any other medical conditions you have been diagnosed with: ______________________________________

____

____

Surgeries	**Date**

Hospitalizations	**Date**

Patients name: ______________________________ Physicians Initials: __________

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Authorization to Release Information

Patient Name: ____ DOB: _________________________

Many of our patients allow family members, such as their spouse, parents or others to request medical or billing information. Under the requirements of HIPPA, we are NOT allowed to give this information to anyone without the patient's consent.

If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to the persons that are indicated below.

I authorize Malin Medial PLLC to release my medical and/or billing information to the following individuals.

1. ____ ________________________
Name of Person Relationship

2. ____ ________________________
Name of Person Relationship

3. ____ ________________________
Name of Person Relationship

____ __________________
Signature Date

You have the right, at any point in time, to revoke this consent in writing.

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HIPPA Privacy Notice

This office is required by federal regulations, known as HIPPA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices.

This office is permitted by federal privacy laws to make uses and disclosures of your health information for the purposes of treatment, payment and healthcare operations. Protected Health Information (PHI) is the information we create and obtain in providing our services to you.

The health information about you is documented in a medical record and/or computer record. Such information may include documenting your symptoms, medical history, examination, test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Malin Medical PLLC does not release this information without your written consent.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE – please print, sign and date below

____ ____________________

Printed Name – Patient/Legal Guardian Date

____ ____________________

Signature of Patient/Legal Guardian Relationship *(if not signed by patient)*

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current, a Contexture company. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?
People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in twocases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing
You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

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Chino Valley, AZ 86333
P 928-460-5214
F 928-441-2915

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

Thank you for choosing Malin Medical. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Malin Medical strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

OFFICE HOURS

Our office is available Monday-Thursday 8:30am to 5:00pm and Friday 8:30am to 4:00pm
closed 12:00pm-1:00pm for lunch
We may be reached at *928-460-5214*.
If you need an appointment for prescription refills or test results, please call during regular business hours.

APPOINTMENTS

Malin Medical is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates. When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact or insurance information. While we strive to schedule appointments appropriately, ***emergencies can and do occur in Primary Care***. We strive to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date.
To ensure quality care, Malin Medical, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit). Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare can be determined. We encourage you to schedule appointments for preventative health visits, physicals, pap exams, chronic medical conditions, prescription renewals and sick visits.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of the medical needs of our patients please be courteous and call Malin Medical promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. This is how we can best serve the needs of our patients.
If it is necessary to cancel your scheduled appointment, we require that you call one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care.

NO SHOW POLICY

A “no show” is someone who misses an appointment without canceling it within one (1) business day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in your medical chart as a "no show". An administrative fee of $35.00 will be billed to your account. You will be sent a letter alerting you to the fact that you failed to show for a scheduled appointment and did not cancel the appointment within one (1) business day in advance along with the bill for the administrative fee. A copy of the letter will be placed in your medical record. Three (3) "no-shows" within two (2) calendar years will result in a discharge from our practice. We will provide 30 days of medical care to you from the date of the letter

*****Please note that No-Show charges are patient responsibility and will not be billed to your insurance company.***

INSURANCE

Malin Medical accepts most insurance plans. If you have specific questions about your insurance, please call your Insurance Company. They will be able to assist you with info about your specific plan provisions. It is **patient responsibility** to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of insurance payment. Patients are also **required** to present their insurance cards at **EVERY** office visit.

Patients are responsible for co-pays at time of service. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract) by our billing department.

Patients are responsible to change their PCP, prior to being seen, if on a medical insurance that is an **HMO.**

PAYMENTS

Malin Medical accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Malin Medical.

It is the policy of Malin Medical to make all reasonable attempts to collect outstanding balances should they accrue, including, convenient payment arrangements. Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection.

FORMS/LETTERS

We understand that at times, various forms or letters may be required to assist you with your healthcare needs. The staff at Malin Medical will be happy to complete forms and write medical letters as necessary upon your request. However, because this can be time consuming, please allow 7-10 days for completion of requested forms/letters.

MEDICAL RECORDS

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to receipt of these materials. All patients can request a copy of their medical records for a fee of $25.00. We will send records free of charge to another provider as a professional courtesy. The law allows Medical Offices 30 days to complete requests for records. However, our medical records department puts forth every effort to respond to these requests in a timely manner.

PRESCRIPTION REFILLS & PHARMACY INFORMATION

Please inform Malin Medical of which Pharmacy you use and update us if this should change. Please contact your pharmacy before our office when requesting a refill, the pharmacy will send a request if you are out of refills and **allow 72 hours** for this request to be handled. We encourage our patients to review their medications prior to their office appointments and to request refills at that time, if needed.

Malin Medical

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

RECEIPT ACKNOWLEDGMENT

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Malin Medical OFFICE POLICIES & PROCEDURES FOR PATIENTS form.

______________________________	______________________________
Printed Name	DOB
______________________________	______________________________
Signed Name	Date

Thank You!

Malin Medical LLC

Medical Record Release / Transfer

Patient Name: ______________________________ DOB: ____________________

Mailing Address: ______________________________ Phone: ____________________

City, State & Zip: ____

Authorizes:

Malin Medical
1780 N. Hwy 89
Chino Valley, AZ 86323
Phone: 928-460-5214 Fax: 928-441-2915

To **RELEASE / RECEIVE** the information as described below:
(circle one)

Provider Name/Hospital: ____

Address: ____

City, State, Zip: ____

Phone: ______________________________ Fax: ____________________ *(required)*

Notice to recipient: This information has been disclosed to you from records that Federal Law protects. These records are not subject to redisclosure. Federal Regulations prohibit you from making further disclosure of Substance Abuse information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of mical or other information is not sufficient for the purpose.

Reports Requested:

- ☐ Clinical visit notes
- ☐ Discharge summary
- ☐ Test results: ____
- ☐ Lab results. Dates: ____
- ☐ Other: ____

Dates of Service (for records to be sent):

- ☐ Past 60 days
- ☐ Past 90 days
- ☐ Past 6 months
- ☐ Past 12 months
- ☐ Other: ____

Purpose for Request: ____

I understand that I don not have to sign this authorization in order to obtain health care benefits, only that by not signing, my records can not be transferred. I understand that I may revoke this authorization in writing at any point in time. However, once the office has disclosed health information to the intended party the person or organization that received it may re-disclose it as privacy laws may no longer apply to protect it.

______________________________ ____________________

Patient/Guardian Signature Date

Opt Out Form

If you do not want your health information shared through Health Current, (a Contexture company), please complete, and return this form to your healthcare provider. Your healthcare provider will return the form to Health Current.

This is the "Opt Out Form" described in the Health Current Notice of Health Information Practices. If you opt out, your healthcare providers will not be able to access your health information through Health Current, Arizona's health information exchange (HIE)— even in an emergency. If you are filling out this form for another person, the references to "you," "I" and "my" in this form refer to that other person.

If you do **not** want your health information shared through Health Current, fill in your name and date of birth below. Then, check the box that says, "Opt Out." Sign the form and give it to your healthcare provider.

Patient Name:____**Date of Birth**: ________________

Street Address:____

City:____**State:**_____________**Zip:**_______________

☐ **Opt Out**: I do not want any of my health information shared through Health Current.

Signature of Patient or Patient's
Parent/Guardian/Healthcare Decision Maker:____

Print Name:____**Date:**__________________________

If signed by a person other than the patient, please indicate your authority to sign for the patient (check one):

☐ Spouse ☐ Parent/Guardian ☐ Caregiver with authority to make healthcare decisions

If you are signing on behalf of more than one patient (such as your children), you must fill out a separate form for each patient.

Provider Office Only: This section must be completed before sending via secure fax to Health Current.

Organization/Provider: ____

Print Name:____Date:_____________________

Signature:____Phone:____________________