MediTouch Upload & Update

Entered By:________________

Date:______________________

____

YEAR

Patient Information

Patient Name:________________________________ Date of Birth: _____/_____/_____ Gender: M / F

Address: ____ Apt,Suite,Unit#:________________

City: ____________________________________ State:_______________ ZIP:_______________

Home#:(______)______-________Work#:(______)______-________Cell#:(______)______-________

Occupation: __________________________________ Referred By:___________________________

Email:___________________________________ Marital Status: Single / Married / Divorced / Widowed

Emergency Contact List

Name: _________________________ Date of Birth: ____/____/____ Phone#: __________________

Relationship: _________________________

Are you currently covered by health insurance? **Yes / No**

Insurance Company:_________________________

Subscriber/Policy ID#:____________________________ Group#:___________________________

Are you the Primary Insured, Policy Holder? **Yes / No**

(If you answered No; please fill out the Policy Holder's information)

Policyholder's Name:_________________________ Policy Holder's Date of Birth: _____/_____/______

******PLEASE ALLOW OUR STAFF TO MAKE A COPY OF YOUR DRIVERS LICENSE & INSURANCE CARD******

Release of Medical Information

I _____________________, give permission for my protected health information to be disclosed for purposes of communicating results, findings, and care decisions to the family members listed below.

Name of Authorized Individuals	Relationship to Patient	Date of Birth
______________________________	____________________	___/___/____
______________________________	____________________	___/___/____
______________________________	____________________	___/___/____

______________________________ ______________________________ _____/_____/_____

Printed Name Signature Date

Patient Responsibility & Assignment of Benefits

Our practice is committed to providing you with the best possible health care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions or concerns about our fees, or any content written in our Financial Policy below.

As a courtesy, we will submit claims for all services rendered to your insurance company. Please note your individual health insurance policy is a contract between you and your insurance company, and we cannot guarantee benefit coverage and/or payment. Coverage is based on medical necessity, plan limitations, and guidelines. Please keep in mind that some of our services may not be covered by your insurance policy. By providing for care, you agree that you are responsible for all services and charges, regardless of your insurance.

While providing care for your medical need's certain tests and/or services are necessary for diagnosis, treatment, and maintenance of good health. All lab work performed in our office will be sent to Labcorp, Sonora Quest, or a third-party laboratory, and billed to your insurance. If these tests and/or services are not covered by your health insurance; you may receive a separate bill from Labcorp, Sonora Quest, or third-party laboratory for those services rendered.

It is important that you understand that you are responsible for all charges that may occur during your visit. In addition to paying for any insurance co-payment, co-insurance, or deductible balances at the time of service, you may also be responsible for services not covered by your insurance carrier. Insurance companies may set certain guidelines and/or limitations, understand it is your responsibility to abide by the guidelines set by your individual insurance policy. If your insurance carrier denies the medical claim, the patient is responsible for timely payment of the account.

Cancellation & Late Fees

A 24-hour notice is required if you are unable to keep your appointment. Missed appointments and appointments not cancelled within a 24-hour notice will be subject to a fee of $50.00 and must be paid before you are able to be rescheduled. ________ (Initial)

If you are more than 15 minutes late for your scheduled appointment (other than weekly TRT visits) and fail to call informing the practice in advance you will be subject to a late fee of $25.00. ________ (Initial)

I have read the financial policy for the practice and understand that I am responsible for all charges on my account. It is my financial responsibility to supply payment for any charges not covered by my insurance plan including, but not limited to co-insurance, co-payments, and deductibles. I understand that co-payments for the office are due at the time of service.

______________________________________ ______/______/______

Printed Name Date

____

Signature

HIPAA – Notice of Privacy Practices

This notice, effective immediately, describes how medical information about you may be used and disclosed as well as how you can get access to this information. Please review carefully. Our office is required by law to maintain the privacy and confidentiality of your protected health information in addition to providing our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment – We may disclose your health care information to other healthcare professionals within our practice for treatment, payment, or healthcare operations.

Payment – We may disclose your health care information to your insurance company provider for payment or health care operations. We have your permission to disclose your health care information to your insurance company for appealing claims on your behalf.

We may disclose your health care information as necessary to comply with State Workers' Compensation laws, Public Health Authorities, Emergency situations, Judicial an Administrative proceedings, Law Enforcement and Medical Examiners. Your health care information may also be disclosed to Research that has been approved by an Institutional Review Board, when necessary to prevent a health or safety issue, to military or national security and government benefit purposes, for company approved marketing purposes, showing gratitude and appreciation for referrals and change of ownership.

We reserve the right to change and amend this Notice of Privacy Practices at any time. Our office is required by law to maintain the privacy of your health information as well as provide you with notice of its legal duties and privacy practices with respect to your health information.

I understand and have been provided with a Notice of Privacy Practices, which offers a description of the information uses and disclosures. I understand and had the right to review this notice prior to signing the consent, the right to object the use of my health information for directory purposes and the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

______________________________ ____/____/____

Printed Name Date

____

Signature

ALERT TO ALL PATIENTS
NO CALL - NO SHOWING APPOINTMENTS

Hello All Patients,

A new protocol is in effect 01/01/2019 regarding the importance of calling 24 hours in advance to cancel a scheduled appointment and calling prior to your appointment time to notify the office that you will be late to your scheduled appointment. If the appointment is not canceled 24 hours in advance or you no show an appointment there will be a fee of $50. Also, if you are more than 15 minutes late to your appointment there is a late fee of $25 and it is up to the providers discretion if you can still be seen that day or need to be rescheduled to another day. These fees must be paid for prior to scheduling your next appointment. This is to ensure each patient has the availability to schedule an appointment if needed in that time slot. We appreciate your cooperation in advance.

Sincerely,
MVC Staff

Please sign/print your name below stating you understand the new protocol and that you are aware of this new update effective 01/01/2019.

____

Signature   Print

Date: ____________   Employee Initial: __________

Vitality Internal Medicine
18205 N. 51st Ave Ste 129
Glendale, AZ 85308

Vitality Internal Medicine
4653 S. Lakeshore Drive Ste 2
Tempe, AZ 85282

Vitality Internal Medicine
4643 N. 12th Street Ste 101
Phoenix, AZ 85014

Scottsdale Internal Medicine
13840 N. Northsight Blvd Ste 121
Scottsdale, AZ 85260

McKellips Internal Medicine
3049 E. McKellips Road Ste 5
Mesa, AZ 85213

Vitality Internal Medicine
10320 W. McDowell Road Ste 5015
Avondale, AZ 85392

Men's Vitality Center
The Nation's Leader in Men's Health
Vitality
INTERNAL MEDICINE

Name ______________________________ Date: ____________________

Electronic Prescription Pharmacy Preference

Please choose your preferred retail and/or mail order pharmacy for approved prescriptions to be sent electronically.

Local Pharmacy	**Mail Order Pharmacy**
Pharmacy Name: ______________________	Pharmacy Name: ______________________
Phone Number: ______________________	Phone Number: ______________________
Address / Cross Streets: ______________________ ______________________	Address / Cross Streets: ______________________ ______________________

Lab test Results Communication Preference

The foundation of good healthcare is built on timely and thorough communication. We want to give solutions for those who may not be available to accept phone calls during traditional office hours. Additionally, we take our responsibility to protect your privacy seriously. Regardless of which option you choose, if at any time you have questions regarding test results, we are happy to discuss them with you further. Carefully read the options below and choose the option that best fits your needs by initialing it. Thank you!

______ **Phone/Voicemail**
Please call me to review my test results. If you do not reach me, you may leave a detailed message on my voicemail with my results.

______ **Phone only**
Please call me to review my review my test results. If you do not reach me, please leave a message for a return call. I only want to receive test results by speaking to a staff member, and DO NOT want detailed messages left on my voicemail.

______ **Email only**
Please send my test results at ______________________________.
If I have any questions, I will call the office and speak with a staff member.

______ **No call**
Please do not call, I will go over my test results at my next office visit.

Patient Name: ________________________ Phone Number: ________________

Patient Signature: ________________________ Date: ________________

Health History Form

Your answers to this form will help your healthcare providers better understand your medical concerns and conditions.

Name ________________________________ Date of Birth _______________ Age ______ Today's Date ___________

PAST MEDICAL HISTORY

Medical Problems/Hospitalizations (i.e. diabetes, cancer, high blood pressure, high cholesterol, depressions, ect.)	**Surgical History** (i.e. tonsillectomy, appendectomy, hernia, hysterectomy, colonoscopy, ect.) Include month/year

FAMILY MEDICAL HISTORY

Father ☐Living, Any Medical Conditions: ____
☐Deceased, Cause of Death: ____
Mother ☐Living, Any Medical Conditions: ____
☐Deceased, Cause of Death: ____
Brothers ____# ☐Living, Any Medical Conditions: ________________________________
☐Deceased, Cause of Death: ____
Sisters ____# ☐Living, Any Medical Conditions: ________________________________
☐Deceased, Cause of Death: ____
Specific Illness in Family History: (i.e. colon cancer, breast cancer, prostate cancer, heart disease, stroke, etc.) ☐None
If so, please state disease and who: ____

SOCIAL HISTORY

Tobacco Use: ☐Never ☐Former ☐Current _____ #packs/day _____# years Date stopped smoking:_______________

Alcohol: ☐None ☐Rarely ☐Social 1-2 Drinks/Day ☐Greater than 2 drinks/day ☐Greater than 6 drinks/day

Is your alcohol use a concern for you or others? ☐No ☐Yes

Illicit Drug Use: ☐Never ☐Former ☐Current:____________________________ Stopped Use Date:_______________

Caffeine Use: ☐None ☐Coffee ☐Tea ☐Soda _________ # cups/day

Education: ☐High School ☐Some College ☐Degree(s)_______________________________________

Occupation:____

Marital Status: ☐Single ☐Married ____ years ☐Divorced ☐Widowed Spouse's Name:________________________

Number of Children/Ages:____

Special Interest/Hobbies:____

____

Do you have Advanced Directives? ☐Yes ☐No **Power of Attorney for Medical Care?** ______________________

Health History Form

Allergies (If any, please list name of agent and reaction such as rash/hives, swelling) ☐ No Known Drug Allergies

Current Prescription Medication ☐ NONE

Name	Dose	How Often	Reason For Use

Non-Prescription/Herbals/OTC/Vitamins ☐ NONE

Name	Dose	How Often	Reason For Use

PREVENTATIVE SCREENING/IMMUNIZATIONS

Exam/Test (*indicate last date performed*)	Immunizations (indicate last date administered)
☐Cholesterol (Lipid Panel) ______	☐Pneumovax (Pneumonia) ______
☐Glucose (Diabetes) ______	☐Influenza (Flu) ______
☐Cardiovascular Disease (EKG) ______	☐Zostavax (Shingles) ______
☐Osteoporosis (Bone Density) ______	☐Tdap (Tetanus/Diphtheria/Pertussis) ______
☐Prostate Cancer (PSA/DRE) ______	☐Td (Tetanus/diphtheria) ______
☐Breast Cancer (Mammogram) ______	☐Hepatitis B ______
☐Cervical Cancer (Pap Smear) ______	☐Hepatitis A ______
☐Colon Cancer (Colonoscopy) ______	☐Other: ______ ______
☐Lung Cancer (Chest Xray) ______	
☐Abdominal Aorta (AAA) ______	
☐Carotid Disease (Ultrasound) ______	
☐Echocardiogram ______	
☐Last Menses (Period) ______	

Health History Form

REVIEW OF SYSTEMS Please check any recent or recurring problems:

Constitutional	**Respiratory**	**Genitourinary**	**Psychiatric**
☐Fatigue ☐Fever ☐Night Sweats ☐Weight Gain _____lbs ☐Weight Loss _____lbs ☐Exercise Intolerance **Eyes** ☐Dry Eyes ☐Irritation ☐Vision Changes ☐Cataract History **Ears/Nose/Mouth/Throat** ☐Ringing in Ears ☐Difficulty Hearing ☐Dizziness/Vertigo ☐Ear Pain ☐Nose/Sinus Issues ☐Snoring ☐Frequent Colds ☐Frequent Infections ☐Frequent Nosebleeds ☐Frequent Sore Throats ☐Hoarseness ☐Bleeding Gums ☐Dry Mouth ☐Mouth Breathing ☐Mouth Ulcers	☐Cough ☐Coughing up Blood ☐Shortness of Breath ☐Pain with Breathing ☐Wheezing ☐Snoring ☐Sleep Apnea **Cardiovascular** ☐Arm Pain with Exertion ☐Chest Pain with Exertion ☐Chest Heaviness ☐Irregular Heart Beats ☐Known Heart Murmur ☐Lightheaded on Standing ☐Shortness of Breath w/ Exertion ☐Swelling (Edema) **Hematologic/Lymphatic** ☐Easy Bruising/Bleeding ☐Swollen Glands ☐Anemia **Gastrointestinal** ☐Abdominal Pain ☐Black/Tarry Stool ☐Blood in Stool ☐Change in Appetite ☐Indigestion ☐Heartburn ☐Frequent Belching ☐Hemorrhoids ☐Trouble Swallowing ☐Nausea ☐Vomiting ☐Vomiting Blood	☐Blood in Urine ☐Difficulty Urinating ☐Pain with Urination ☐Incomplete Emptying ☐Urinary Loss of Control ☐Urinary Frequency ☐Urinary Hesitancy ☐Post-Void Dribbling ☐Erectile Dysfunction **Musculoskeletal** ☐Back Pain ☐Joint Pain ☐Muscle Aches ☐Muscle Weakness ☐Fractures ☐Arthritis ☐Osteoporosis ☐Use of Assist Device **Neurologic** ☐Dizziness/Vertigo ☐Poor Balance ☐Headaches ☐Migraine ☐Memory Loss ☐Numbness ☐Restless Legs ☐Seizures ☐Weakness	☐Anxiety ☐Stress ☐Panic Attacks ☐Depression ☐Mania ☐Sleep Problems ☐Alcohol Overuse ☐History of Addiction ☐Suicidal Thoughts ☐Do Not Feel Safe **Integumentary (Skin)** ☐Change in Mole ☐Dry Skin ☐Eczema ☐Rash ☐Growth/Lesion ☐Itching ☐Jaundice (yellow skin/eye) **Allergic/Immunological** ☐Sneezing ☐Hives/Rash ☐Itching ☐Runny Nose ☐Sinus Pressure

Men Only	Women Only
☐Pain or Lump in Testicle ☐Penis Burning/Itching/Discharge ☐Prostate Disease/Problems ☐Night-Time Urination ☐Sexual Problems/Concerns ☐Low Sex Drive	☐Vaginal Itching/Burning/Discharge ☐Night-Time Urination ☐Breast Tenderness/Discharge ☐Breast Lump ☐Ovarian Cysts Total Pregnancies _________ Births _________ Miscarriages _________ Abortions _________ Age Menses/Period Started _________