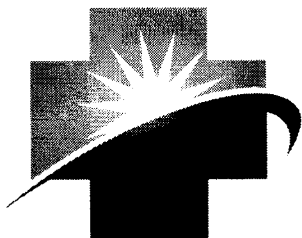


ARRAY
MEDICAL CENTER
SURPRISE

18761 N Reems Road Suite #400, Surprise, AZ 85374

Patient Name:____ Date:_______________
Email:___________________________________ SS #/SIN:______-_____-________ DOB:________________
Home phone:_____________________ Cell Phone:______________________
Check appropriate Box: □Minor □Single □Married □Divorced □Widowed □Separated Gender: □ Male □Female
Patient's Address:____ City:_____________________
State:__________________ Zip:_______________
Spouse or Guardian name:____
Person to contact in case of an emergency:_________________________ Relationship:_________________
Phone:____________________
Name of the person responsible for this account:_________________________ Relationship to Patient:_________________

Primary Care Phys.: _________________________________ Clinic:_________________________________
Phone:____________________
Cardiologist *(If Applicable)*: _________________________________ Clinic:_________________________________
Phone:____________________
Do you have an Advanced Directive? Yes / No **(If Yes, please provide a copy)** **Circle applicable for emergency:** DNR / Full Code

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Array Medical Center Surprise and/or Array Medical DME** (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or services provided after my insurance company(s) have determined my benefits. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

______________________________	______________________________	____________
Patient Signature	Print Name	Date

ARRAY
MEDICAL CENTER
SURPRISE

Patient Name:______________________________ Date: ______________

MEDICAL HISTORY:

Please circle if **YOU** have history of or are suffering now from any of the following:

HIV/ARC/AIDS	Diabetes	Multiple Sclerosis	Thyroid
Alcoholism	Emphysema	Osteoporosis	Tumor growth
Anemia	Epilepsy	Pacemaker	Ulcers
Anorexia	Fractures	Parkinson's	Vaginal infections
Appendicitis	Heart disease	Pinched nerve	Whiplash
Arthritis	Hernia	Pneumonia	Bulimia
Asthma	Herniated disc	Polio	Chemical dependency
Bleeding Disorder	High Cholesterol	Prostate	Venereal disease
Auto Immune problems	Kidney Disease	Psychiatric	Hepatitis
Bronchitis	Liver Disease	Rheumatoid arthritis	Stroke
Cancer	Migraine headache	Depression	Suicide attempt
Miscarriage			

Please circle if your **FAMILY** has history of or are suffering now from any of the following:

HIV/ARC/AIDS	Diabetes	Multiple Sclerosis	Thyroid
Alcoholism	Emphysema	Osteoporosis	Tumor growth
Anemia	Epilepsy	Pacemaker	Ulcers
Anorexia	Fractures	Parkinson's	Vaginal infections
Appendicitis	Heart disease	Pinched nerve	Whiplash
Arthritis	Hernia	Pneumonia	Bulimia
Asthma	Herniated disc	Polio	Chemical dependency
Bleeding Disorder	High Cholesterol	Prostate	Venereal disease
Auto Immune problems	Kidney Disease	Psychiatric	Hepatitis
Bronchitis	Liver Disease	Rheumatoid arthritis	Stroke
Cancer	Migraine headache	Depression	Suicide attempt
Miscarriage			

Have you been treated by a physician for any health condition in the past year? YES NO

Describe:____

Date of last physical exam:________________

LIST MEDICATIONS:____

____

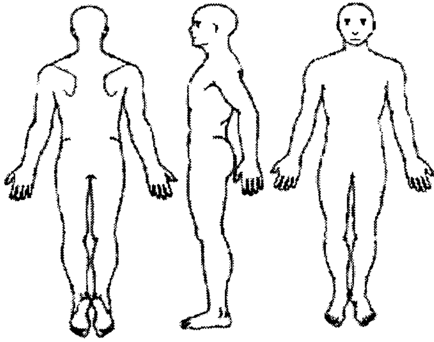
LIST ALLERGIES:____

SURGICAL HISTORY:

1. ____________________________________ Date:__________
2. ____________________________________ Date:__________

Any metal implants? YES NO Gunshot wounds? YES NO

Describe Major Complaints rating your symptoms on a scale of 1 to 10. 10 being the worst.



1.______________________________ Best:__________ Worst:________
2.______________________________ Best:__________ Worst:________
3.______________________________ Best:__________ Worst:________
4.______________________________ Best:__________ Worst:________
5.______________________________ Best:__________ Worst:________

How much of the time do you experience symptoms? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Symptoms developed from: _______Work_______Auto accident_______Accident_____Illness

______Gradual onset_______Other Date of onset:_____________

Symptoms have persisted for #:__________Hours_______Days________Weeks_______Months______Years

Symptoms_________Come and go (or are)_____________Constant

Name and location of doctors previously seen for present condition:______________________________

____

____

Are you pregnant: YES NO Date of last menstrual cycle:______________________________

Circle which activities **aggravate** your condition:

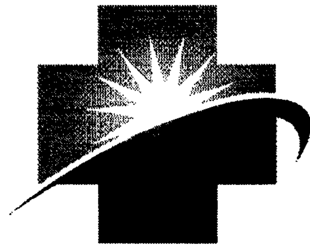
Bending	Reaching	Straining at stool	Coughing	Turning head
Lifting	Sneezing	Walking	Lying down	Sitting

Circle which activities **relieve** your condition:

Bending	Sitting	Lifting	Standing	Reaching
Walking	Lying down	Turning head		

Please circle any additional symptoms you might be experiencing:

Blurred Vision	Diarrhea	Insomnia	Pins/Needles in leg
Buzzing in ears	Dizziness	Light bothers eyes	Gets sick easily
Cold feet/hands	Flushed face	Loss of balance	Shortness of breath
Cold sweats	Fainting	Loss of taste	Confusion
Stiff neck	Fatigue	Muscle jerking	Pins/Needles in arm
Headaches	Fever	Constipation	Head feels heavy
Numbness in fingers	Numbness in toes	Ringing in ears	Depression/weeping



ARRAY
MEDICAL CENTER
SURPRISE

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS

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Patient Signature　　　　　　　　Print Name　　　　　　　　Date

Array Medical Center

This office makes every possible attempt to maintain patient privacy as per HIPPA (1996)

APPOINTMENTS: Patients are seen by appointment. For urgent and acute situations, we often schedule "work-in" appointments. Work-in appointments are made to address one acute problem, only so that patients with scheduled appointments are not kept waiting. We apologize in advance for any unforeseeable delay you may experience. **If you are more than 15 minutes late for your appointment you will be asked to reschedule. Cancellations must be made 24 hours prior to your appointment.**

***** WE CHARGE $25.00 FOR MISSED APPOINTMENTS*****

Social Security Numbers: We handle patient social security numbers and personal information in a confidential manner, but we may release personal and medical information to another doctor's office in the event of a referral. We use SSN for insurance and billing purposes. This is required information that we ask from each of our patients.

MINORS: All children under the age of 18 must be accompanied by parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area. A staff member will always be available to sit with your child during your treatment if needed.

CONDUCT: The golden rule, **"Treat others as you wish to be treated"** will always be followed in our office. If you as a patient cannot be kind to the staff or other patrons, we can ask kindly for the appointment to be rescheduled. If you see any misconduct inform a staff member who can assist you.

PAYMENT: payment is due from each patient at the time of service. We accept several different kinds of payment options. We gladly accept cash, check, Visa, Master card, Discover, American Express, HSA and HRA.

In the event your account gets turned over to collections, you will be responsible for the collections fee up to 25% on top of the balance that is owed to Array Medical Center.

INSURANCE: we participate with several major insurance carriers. Our office policies concerning the deductible and HAS/HRA plans are as follows: Patients are responsible for their coinsurance, deductibles, and co-pays in full. Payments are due at the time of service and are based on the patient's insurance company's contracted rates. I consent to Array Medical Center billing my insurance company for my treatment.

DIVORCEMENT: We reserve the right to refuse service to anyone at any time for any reason. If our clinic makes the decision to divorce you as a patient, you will receive a written notice. In addition, you will be given 30 days to find your new primary care provider before we completely refuse to schedule you.

ACKNOWLEDGMENT: I have read, understand, and agree to follow the above office policies.

Patient / Guardian Signature: ______________________________ Date: _______

Printed Name of Patient: ______________________________ Date: _______

ARRAY MEDICAL CENTER – CONSENT TO TREAT

I hereby request and consent to treatment by the providers in this office. I understand and consent to be evaluated physically. I consent to the performance of chiropractic manipulation, manual therapy techniques, other chiropractic procedures, including but not limited to various types of physical therapeutic activities and modalities. I consent to other procedures whether medical, chiropractic, or therapeutic such as diagnostic tests, exams, evaluations or x-rays when warranted on me) or the minor named below who I am legally responsible for) by the Doctor of Chiropractic, family nurse practitioner practicing in this office and/or any future practitioners of this office or their technicians.

I understand and am informed that results are not guaranteed.

I understand and am informed that in the practice of medicine, the practice of chiropractic, there are some risks to treatments and services including but not limited to:

Manipulation: Increased pain or discomfort, fractures, disc injuries, strokes, dislocations and sprains.

Therapeutic Modalities and Procedures: Additional pain or discomfort. Exercise and/or massage may cause increased risk of acute myocardial infarction (heart attack) in patients with known or possible cardiac conditions.

Radiographs: Ionizing radiation can be harmful to a fetus for those who are pregnant or might be pregnant.

Allergy testing and treatment: Local reactions including but not limited to redness, itching and swelling. Systemic reactions including but not limited to rashes, sneezing, nasal stuffiness, cough, chest tightness, shortness of breath, wheezing or anaphylactic shock.

I do not expect the doctor or support staff to be able to explain or anticipate all possible risks and complications associated with treatments. I wish to rely upon the Doctor (s), F.N.P, and support staff to exercise judgement during the course of my procedures, which are felt at the time, based upon the facts then known to him or her, to be in my best interest.

I have read or have had read to me the above consent. I have also had an opportunity to ask any questions about the content. By signing below, I agree to have the above-named procedures/practices. I intend this consent form to cover the entire course of my treatment in this office for my present condition and/or any past or future condition(s) for which I seek treatment.

Printed Name of Patient: ______________________________

Patient or Guardian Signature: ______________________________

Today's Date: ______________

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, Array Medical Center maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and procedural information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices for review that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

☐ I request the following restrictions to the use or disclosure of my health information:

☐ I have read, have no additional restrictions, and I would like to be provided with a hard copy of the Notice of Privacy Practices.

☐ I have read, the notice of Privacy Practices, have no additional restrictions, and I do NOT require a printed hard copy Date Notice Effective ____________________
Accepted ______ Denied______

Signature of Patient/Legal Representative____________________________

Witness ____________________________ Date ___________________