IM SPECIALIST, INC

PATIENT REGISTRATION

2737 West Baseline Road, Suite 24, Tempe, Arizona 85283 (602) 437-4800

Date / Fecha _____/_____/_____

_____ _____ (_____)-_____ (_____)-_____
Last / Apellido First / Nombre Home Phone No. / No. Telefono Work Phone No. / No. de Telefono (Trabajo)

_____ (_____)-_____ _____@_____
Street Address / Direccion Cellular Phone No. / Celular E-mail Address / Correo Electronico

_____ _____ _____ _____
City / Ciudad State / Estado Zip Code / Zona Postal Employer / Empleo

___ ___ ___ - ___ ___ - ___ ___ ___ ___ S M D W _____
Social Security No. / No. Seguro Social Martial Status / Estado Martial Employer Address / Direccion de Empleo

_____/_____/_____ _____ M F _____
Date of Birth / Fecha de Nacimiento Age / Edad Sex / Sexo Occupation / Ocupacion

Person Responsible for Account / Persona Responsible para la cuenta:

_____ _____ (_____)-_____ (_____)-_____
Last / Apellido First / Nombre Home Phone No. / No. Telefono Work Phone No. / No. de Telefono (Trabajo)

_____ (_____)-_____ _____@_____
Street Address / Direccion Cellular Phone No. / Celular E-mail Address / Correo Electronico

_____ _____ _____ _____
City / Ciudad State / Estado Zip Code / Zona Postal Employer / Empleo

___ ___ ___ - ___ ___ - ___ ___ ___ ___ S M D W _____
Social Security No. / No. Seguro Social Martial Status / Estado Martial Employer Address / Direccion de Empleo

_____/____/_____ _____ M F _____
Date of Birth / Fecha de Nacimiento Age / Edad Sex / Sexo Occupation / Ocupacion

INSURANCE INFORMATION / INFORMACION DE SEGURO

_____ _____ _____
Primary Insurance / Seguro Principal Subscriber/policy No. / No. Poliza Group Number

_____ _____ _____
Secondary Insurance / Seguro Secundario Subscriber/Policy No. / No, Poliza Group Number

Pharmacy _____

Referred By / Referido Por: _____

Emergency contact /
Contacto de Emergencia: _____ _____ _____
First Name / Nombre Last Name / Apellido Relation / Relacion

(_____)-_____ (_____)-_____
Home Phone No. / No. de Telefono Cell Phone No. / Cellular

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS / AUTORIZACION DE PAGOS Y INFORMACION

I request that payment of authorized insurance benefits from any applicable insurance carrier be made on my behalf to IM Specialist for any services furnished to me by the provider. I authorize medical information needed to determine these benefits or the benefits payable for the related services be released to the insurance company and its agents.
I understand that even though I have some type of insurance coverage, I am responsible for the payment of services.
Yo autorizo pagos de beneficios a IM Specialist, Inc. por servicios recibidos. Yo autorizo hacer publico cualquier informacion necesaria a la compania de seguro para determinar beneficios**. Yo entiendo que aunque tenga seguro, yo sere responsable por los servicios.**

✘_____ _____/_____/_____
Signature of Patient/ Firma de Paciente **Date / Fecha**

HIPAA –PRIVACY PRACTICES

IM SPECIALIST, INC.

Rashda Kaif, M.D
Fizzah Sheikh, PA-C

PATIENT NAME

I acknowledge that I have asked for a copy and/or have had an opportunity to review a copy of IM Specialist notice of HIPAA -Privacy Practices upon my request

I permit that the following persons may be contacted with regards to my health information.

NAME	RELATIONSHIP TO PATIENT	PHONE

(You must list your spouse and/or children's name separately – if they are not listed, we will not be able to authorize any information regarding your health, appointments and specialist information etc.)

Signature of patient or responsible party **Date**

Printed name if signed on behalf of the patient **Relationship**

2737 West Baseline Road, Suite 24, Tempe, Arizona 85283, Tel (602)437-4800

IM SPECIALIST - Payment Plan Policy – Updated 01/01/2018

As a courtesy, I M Specialist, Inc. verifies your benefits with your Insurance Company. A quote of benefits provided by your Insurance Company is not a guarantee of benefits or payment by your Insurance Company.

Please remember that you are ***100 percent*** responsible for all charges incurred: Our verification of your insurance benefits is not a guarantee of payment. We highly recommend you also contact your insurance carrier and check into coverage provided by your particular plan. Do not assume that you will not owe anything if you have more than one insurance policy.

If the amount due is less than $50
Patient must pay the entire amount before he/she can be seen

If the amount due is between $50-$150
Patient must pay 50% of the balance before he/she can be seen. Also, the patient must sign a payment plan and the remainder 50% must be paid within 30days.

If the amount due is greater than $175
Patient must pay 50% of the balance before he/she can be seen. Also, the patient must sign a payment plan and balance must be paid in 3 (three) monthly installments. Patient must be current on payment plan in order to be seen on subsequent visits. If patient misses a payment as per their signed plan, then he/she must pay the entire outstanding balance in order to be seen again.

Name_____

Sign_____

Date_____

Patient's Responsibility

Physician Patient relationship is one of the most sacred, trustworthy, honest, respectful and MUTUAL relationships. We take this responsibility very seriously and would ask for your full cooperation. Our job is to guard your health and give you the best/most current advice and guidance.
For our Success your participation is essential. This cannot be achieved without your assistance

As a Patient of I M Specialist, I understand my responsibilities are to...

- Inform provider of any changes in their health status that could affect their treatment; including complete and accurate information.
- Adhere to a prescribed treatment plan and to discuss any desired changes.
- Be a considerate and cooperative manner with IMS staff as well as other patients.
- Ask questions and seek clarification regarding areas of concern during office visits.
- Understand the consequences of refusing to comply with instructions and recommendations.
- Assist the providers in compiling complete record by authorizing I M Specialist to obtain necessary medical information from other appropriate sources.
- Keep appointments on time.
- Cancel appointments only when absolutely necessary and with at least a 24hour notice so that other patients might utilize that time.
- Accept personal financial responsibility for any charges not covered by his/her insurance.

_____ _____

Patient Signature **Date**

Form MR602: Authorization for Release of Medical Records

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please print)

Patient Name		Date of Birth	Social Security Number	
Address	City		Zip	Phone

RELEASE FROM: [Name of physician or facility releasing information]

I authorize release of my medical record from

Physician/Facility			
Address	City	Zip	Phone

RELEASE TO: [Name of physician or facility receiving information]

Please send/fax my medical record to:

Physician/Facility IM SPECIALIST, INC (RASHDA KAIF, MD AND FIZZAH SHEIKH, PA-C)			
Address 2737 W BASELINE ROAD SUITE 24	City TEMPE	Zip 85283	Phone/Fax 602-437-4800 602-437-4805 fax

RELEASE INFORMATION

Reason: [ ] Personal file [**X**] Primary Care Physician [ ] Legal
[ ] Moving out of area [ ] Specialist consultation [Other

Please release the following:

[**X**] Entire chart for continuation of care including confidential psychiatric, HIV, alcohol and drug related information

[ ] Specific Information:

- Use of this information for any other than the stated purpose is prohibited.
- This information is for the use of the designated recipient only and cannot be provided to any other agency.

CONSENT

I authorize the release of all information indicated, and I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse, or drug and alcohol abuse.
I understand that I may be charged for copies provided.

Signature of patient, parent, guardian, conservator, or patient representative (Please circle.)	Date
Witnessed by	Date

Note: This consent is valid for 90 days. It may be revoked by the signer at any time.

PATIENT HISTORY FORM

Last Name _____ First Name _____ MI ____

Date of Birth _____ Marital Status (please √) ☐ single ☐ married ☐ divorced ☐ widow

Allergies to medications:_____

Do you smoke? ☐ no ☐ yes how much? _____ **Do you drink alcohol?** ☐ no ☐ yes how much? _____

If you used to smoke when did you quit? _____

PAST MEDICAL HISTORY

CONDITIONS (please √ ALL THAT APPLY)

- ☐ ABNORMAL PAP SMEAR
- ☐ ANOREXIA-EATING DISORDER
- ☐ ARTHRITIS/GOUT
- ☐ ASTHMA/EMPHYSEMA
- ☐ BLOOD DISORDERS/ANEMIA
- ☐ BREAST LUMP/BIOPSIES
- ☐ CANCER
- ☐ CATARACTS/GLAUCOMA
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ WEIGHT ISSUES
- ☐ VAGINAL INFECTIONS
- ☐ HEART DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ HEADACHE/MIGRAINES
- ☐ HERNIA
- ☐ HEPATITIS
- ☐ HIGH CHOLESTEROL
- ☐ HIV POSITIVE
- ☐ KIDNEY DISEASE
- ☐ LEG CRAMPS
- ☐ LIVER DISEASE
- ☐ IRREGULAR PERIODS
- ☐ HEAVY PERIODS
- ☐ MULTIPLE SCLEROSIS
- ☐ POLIO
- ☐ PROSTATE ENLARGEMENT
- ☐ UNDER PSYCHIATRIC CARE
- ☐ HX OF SEXUALLY TRANSMITTED DISEASE
- ☐ STROKE/TIA
- ☐ SUBSTANCE ABUSE
- ☐ THYROID PROBLEMS
- ☐ TB
- ☐ ULCERS
- ☐ URINARY PROBLEMS (URGENCY/PAIN/LEAKAGE)
- ☐ _____

CURRENT MEDICATION NAMES AND DOSEAGE:

_____

_____

Do you take any weight loss products, herbs, & vitamins? ☐ no ☐ yes If yes please list:

_____

SURGERIES/HOSPITALIZATIONS (list year and reason for Hospitalization)

_____

_____

Do you exercise on a regular basis? ☐ no ☐ yes If yes, what activity? _____ how often? _____

FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	AGE OF DEATH	CAUSE
FATHER				
MOTHER				
SISTER(S)				
BROTHER(S)				
GRANDPARENTS				

PLEASE CHECK IF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING DISEASES:

	(RELATIONSHIP)		(RELATIONSHIP)
☐ ARTHRITIS	_____	☐ HEART DISEASE	_____
☐ ASTHMA/EMPHYSEMA	_____	☐ HIGH BLOOD PRESSURE	_____
☐ CANCER	_____	☐ STROKE	_____
☐ DIABETES	_____	☐ KIDNEY DISEASE	_____

PATIENT SIGNATURE _____ DATE _____

REVIEW OF SYSTEMS

PLEASE CHECK YES OR NO IF YOU HAVE ANY **CURRENT** MEDICAL PROBLEMS RELATING TO THE FOLLOWING SYSTEMS (if yes, please explain)

GENERAL	Yes	No
Weight change	□	□
Appetite change	□	□
Sleep problems	□	□

HEAD	Yes	No
Migraines/Headache	□	□
Head injury	□	□

EYES	Yes	No
Blurred vision	□	□
Double vision	□	□
Pain	□	□
Vision changes	□	□

ALLERGIES	Yes	No
Seasonal Allergies	□	□

NEUROLOGICAL	Yes	No
Tremors	□	□
Dizzy spells	□	□
Numbness/tingling	□	□
Weakness (hand, legs, arms)	□	□

ENDOCRINE	Yes	No
Excessive thirst	□	□
Too hot/Too cold	□	□

GASTROINTESTINAL	Yes	No
Chronic constipation	□	□
Chronic diarrhea	□	□
Abdominal pain	□	□
Nausea/vomiting	□	□
Indigestion/heartburn	□	□
Bloody stools	□	□
Hernia	□	□
Change in bowel habits	□	□

CARDIOVASCULAR	Yes	No
Chest pain	□	□
High blood pressure	□	□
Palpitations	□	□
TIA/CVA	□	□

INTEGUMENTARY (SKIN)	Yes	No
Skin rash	□	□
Boils	□	□
Persistent Itch	□	□

MUSCULOSKELETAL	Yes	No
Joint pain	□	□
Neck pain	□	□
Back pain	□	□
Other pain _____	□	□

EARS/NOSE/THROAT/MOUTH	Yes	No
Hearing loss	□	□
Ringing	□	□
Nosebleeds	□	□
Swallowing problems	□	□
Hoarseness	□	□
Ulcers	□	□

GENITOURINARY	Yes	No
Urine retention	□	□
Painful urination	□	□
Sexually transmitted disease	□	□
Stones	□	□

RESPIRATORY	Yes	No
Wheezing	□	□
Chronic cough	□	□
Shortneess of breath	□	□
Other _____	□	□

HEMATOLOGIC/LYMPHATIC	Yes	No
Swollen glands		
Blood clotting problem		
Varicose veins	□	□
Other _____	□	□

GYNECOLOGICAL	Yes	No
Menstrual problems	□	□
Breast problems	□	□
Pregnancies # _____		
Live births # _____		

Physician comments/notes

Physician Signature _____ Date _____