PO Box 7904 Cave Creek, AZ 85327
Office Hours: Mon-Thurs: 9am-4pm (closed 12pm-1pm) Fri: 9am-12pm

Phone: 480-575-0576 **Fax: 480-575-0512**
www.doctorcareaz.com

Please fill out completely and clearly. All information is required. Thank you!

Patient Name: ____
(Last) (First) (MI)
Patient Lives in: **Private Residence** **Group Home** **Assisted Living Facility** (circle one)
Name of Group Home or Assisted Living: ____
Address Where Patient Resides: ____ Unit# ______________
City: ______________________________ State: _______________ Zip: ___________ - ___________
Residence Phone: ( ) ______ - ____________ Residence Fax: ( ) ______ - ______________
Name of Caregiver: ______________________________ Caregiver Cell Phone: ( ) _____ - ________

Patient Date of Birth: ____/_____/________ **Patient Social Security Number**: _______________________

Is patient **Male** or **Female** (circle one) Marital Status**:** **Married** **Single** **Widowed** (circle one)
Does Patient have Durable Power of Attorney (POA)? **Yes** **No** (circle one)
If Yes, copy of POA completed form is required
POA/Emergency Contact Name: ____________________________ Phone: ( ) ______-____________
Patient/POA Email address: ____
POA Billing Address: ____

Patient Pharmacy Name: ____
Pharmacy Phone: ( ) ________-______________ Fax: ( ) ________-____________________

Name of Case Manager: ___________________________________ Phone: ( ) ______ - __________

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) REQUIRE A COPY OF PATIENT'S MEDICARE CARD BE KEPT ON FILE IN MEDICAL RECORD. PLEASE INCLUDE A COPY OF MEDICARE CARD AND ALL INSURANCE CARDS FRONT AND BACK. THANK YOU!

MEDICARE ID#: ________________________________(please provide a copy of your Medicare card)
(REQUIRED EVEN WITH HMO REPLACEMENT PLANS)
Primary Insurance Name: _____________________________ Member ID: _______________________
Group ID: ______________ Claims Address: ____
Insurance phone: ( ) ________ - _______________

Secondary Insurance: _________________________________ Member ID# ______________________
Group ID: ______________ Claims Address: ____
Insurance phone: ( ) ________ - _______________
Is there any other Insurance that is applicable? Yes No (circle one)
If Yes, provide Name of Insurance _______________________ Member ID# ______________________
Group ID# ______________

CREDIT CARD INFORMATION: ****No Credit Card needed for AHCCCS patients***
Name on Card: ______________________________________ Card Number: ____________________
Expiration Date: ___________________ Security Code (3 digits on back of card) _____________________
MasterCard Visa American Express Discover (circle one)

PO Box 7904 Cave Creek, AZ 85327
Office Hours: Mon-Thurs: 9am-4pm (closed 12pm-1pm) Fri: 9am-12pm

Phone: 480-575-0576 **Fax: 480-575-0512**

www.doctorcareaz.com

Does Patient have allergies to medications? If yes, please list below:

____
____
____

Please list names and phone numbers of prior doctors/hospitals from whom we may request records:

____
____
____

Is there: (circle all that apply and provide a copy of the document, if applicable)

Living Will **Advanced Directive** **DNR**

Is Patient: (circle all that apply) **on Oxygen** **Bedridden** **in Wheelchair**

Is Patient currently on Hospice **Yes** **No** (circle one) ____________________________ Name of Hospice agency

Is Patient currently using Home Health Services **Yes** **No** (circle one) ____________________________ Name of Home Health Company

Patient approximate weight: ____________________ **approximate height**: _____________________

Current Medications:

____
____
____

NOTES:

PO Box 7904 Cave Creek, AZ 85327
Office Hours: Mon-Thurs: 9am-4pm (closed 12pm-1pm) Fri: 9am-12pm

Phone: 480-575-0576 **Fax: 480-575-0512**

www.doctorcareaz.com

PRIMARY INSURANCE ACCEPTED BY DOCTORCARE

All secondary insurance is accepted

- Medicare
- AETNA
- Bridgeway Advantage
- Bridgeway Health Solutions
- UHC Community Plan (+ ALTECS)
- APIPA – Community Health Plan or United Healthcare Community Plan
- United Health Care - Commercial Plans depending on network
- Blue Cross Blue Shield of Arizona
- Caremore
- Railroad Medicare
- Optum Health Network (formerly Lifeprint and SCAN)
- BCBS of AZ

If your insurance is not listed above please call our office to verify out-of-network insurance coverage for HMO/PPO insurance plans

Your Plan	What You Do	What We Do
Medicare	Pay your deductible ($147 for 2015) and co-insurance (20% of the allowable or co-payment for HMO or Medicare Advantage Plans)	We will file Medicare for you. We take a valid credit card that we keep on file for unpaid services and deductibles.
Medicare and a secondary insurance	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
Medicare and Medicaid	No payment due at time of service.	We will file Medicare and Medicaid for you.
Medicaid	No payment due at time of service	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
Medicaid HMO	Your card must have the name of our provider to be seen. No payment due at time of service. There may be a co-payment due depending on your policy.	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
Blue Cross Blue Shield	Pay your deductible, co-insurance or co-pay at time of service.	We will check your eligibility before every visit and will file your Blue Cross insurance for you.
United HealthCare	We ask to place a credit card on file for the balance when the claim is paid.	We do not accept out-of-network rates as payment in full. You may be charged for the balance.
Insurance we are not contracted with	Pay the visit in full at time of service. A full refund will be made after insurance paid.	We will file your insurance for you and assign benefits to you so you will receive payment from your insurance plan.
Self-pay	Pay for the visit in full at time of service. $250 for first visit $150 for each subsequent visit	We take a valid credit card that we keep on file.

PO Box 7904 Cave Creek, AZ 85327
Office Hours: Mon-Thurs: 9am-4pm (closed 12pm-1pm) Fri: 9am-12pm

Phone: 480-575-0576 **Fax: 480-575-0512**
www.doctorcareaz.com

MEDICAL RECORDS RELEASE FORM

Patient Name: ____ **Date of Birth**: _____/ _____/ ______

Address: ____Unit #: ____________
(Street)
____ ZIP: ________________________
(City, State)

Home Phone: (   ) ________ -__________________ **Cell Phone**: (   ) _______-____________________

Records Release Authorization

By my signature, I authorize **DoctorCare** to receive my pertinent medical records for the patient identified by the information listed above.

Medical Records Requested:

For the past 18 months:

Radiology (Xray, Ultrasound, CAT Scan, MRI, Special tests) Reports, EKG, Specialist Consults, Hospitalization Summaries, Labs, Updated medication list.

I authorize the release of photocopies of the following medical records to DoctorCare, its employees, and/or agents. For the purpose hereof, "medical records" includes the following:
Confidential HIV and communicable disease-related information (A.R.S. Section 36-661)
Confidential Alcohol & Drug Abuse-related information (42 CFR Section 2.1 ET SEQ)
Confidential Mental Health Diagnosis/Treatment Information
Confidential Genetic Testing Information (A.R.S. Section 12-2801)

I have given my consent freely and without coercion. I may revoke this consent at any time by notifying DoctorCare in writing. A photocopy or facsimile of this authorization can substitute for the original.

MAIL RECORDS TO: P.O. BOX 7904
CAVE CREEK, AZ 85327

FAX RECORDS TO: 480-575-0512

______________________________________ ______________________________

Patient/Authorized Signature **Date**

PO Box 7904 Cave Creek, AZ 85327
Office Hours: Mon-Thurs: 9am-4pm (closed 12pm-1pm) Fri: 9am-12pm

Phone: 480-575-0576 **Fax: 480-575-0512**
www.doctorcareaz.com

ASSIGNMENT OF BENEFITS

I understand by signing this form that I am authorizing the following:

1. Assignment of Medicare and/or Medicaid (AHCCCS) insurance benefits to Joel Cohen, M.D., medical director of MD RoomService/Doctorcare, PLLC. (PO BOX 7904 Cave Creek, AZ 85327)
2. Direct billing to Medicare and/or Medicaid (AHCCCS) - electronically or on paper claim forms.
3. Release of my medical information to Medicare and/or Medicaid (AHCCCS).
4. Dr. Joel Cohen may obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies provided.
5. I agree to pay all amounts that are **not** covered by my insurer(s) and for which I am responsible under state and federal law. I understand that these amounts may include co-payments and deductibles.
6. Beginning January 1, 2015 Medicare has authorized medical practices to bill for monthly complex care coordination services. This covers care coordination efforts by one provider performed separate from the doctor visits. The $40.39 monthly charge will cover plan of care development and changes, laboratory and X-Ray test reviews, discussion of care with other approved health providers, medication reviews, ordering and signing needed equipment, other paperwork reviews, and handling of urgent needs and phone calls during office hours and after hours (24/7 on-call). Each patient or the power of attorney (POA) will be responsible for associated copayments or deductibles. A patient or POA may stop chronic care management services by revoking consent in a written letter to the doctor's office, effective at the end of that current calendar month.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare and/or Medicaid (AHCCCS) to issue payment check(s) directly to Dr. Joel Cohen for medical services rendered to myself and/or my dependents. **I understand that I am responsible for any amount not covered by the insurance.**

Authorization to Release Information:

I hereby authorize Dr. Joel Cohen to: (**1**) Release any information necessary to insurance carriers regarding my illness and treatments; (**2**) Process insurance claims generated in the course of examination or treatment; and (**3**) Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Dr. Joel Cohen on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

____________________________________ ______________________

Patient/Authorized Signature **Date**

PO Box 7904 Cave Creek, AZ 85327
Office Hours: Mon-Thurs: 9am-4pm (closed 12pm-1pm) Fri: 9am-12pm

Phone: 480-575-0576 **Fax: 480-575-0512**

www.doctorcareaz.com

HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical data and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment of health care operations, in order to provide health care that is in your best interest.

We support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you chose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please speak with Dr. Cohen. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Internet Medical Record Storage

I, the undersigned, hereby authorize the medical office of Joel Cohen, M.D., including but not limited to Dr. Cohen, his staff and his agents, to store medical and required related information about me on a secure off-site server. Communication of this medical sensitive and related non medical data will be done with encrypted transfer over lines (i.e., wire, wireless, or cable) on the internet.

I understand that I must specifically advise Dr. Cohen in writing if I do not want certain information about me stored in this manner.

Through this authorization, I am hereby irrevocably releasing the medical office of Joel Cohen, M.D., including but not limited to Dr. Cohen, his staff and his agents, from any and all liability for any damages or costs, or both, relating to or arising out of the storage of my medical records in this manner.

This authorization shall remain in effect until I specifically notify Dr. Cohen in writing that I no longer want medical information about me stored in this manner.

Acknowledgement of Receipt of Privacy Notice

We are required by law to maintain the privacy of, and provide individuals with the notice of our legal duties and privacy with respect to protected health information. If, after having read the HIPAA Notice of Privacy Practices, you have any objections to that form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the main office number.

Your signature below is an acknowledgement that you have received the Notice of our Privacy Practices

____________________________________ _______________________

Patient/Authorized Signature **Date**