



**PO Box 7904 Cave Creek, AZ 85327**

**Office Hours: Mon-Thurs: 9am-4pm (closed 12pm-1pm) Fri: 9am-12pm**

**Phone: 480-575-0576**

**Fax: 480-522-3377**

**Email: [intake@doctorcareaz.com](mailto:intake@doctorcareaz.com)**

**[www.doctorcareaz.com](http://www.doctorcareaz.com)**

\*\*\*To all New Patients, family and/or Caregivers, our office has kindly provided a user friendly checklist for your convenience to help you expedite the process of getting established as a new patient. Please include all information below to ensure that we will be able to accommodate you as a new patient in the best way possible. If you have any questions, please feel free to contact our office at the number listed above. Thank You\*\*\*

## Admission Checklist

- ✓ Health Insurance Cards (*Photo Copies of Front and Back*).
- ✓ Medicare Card (*Photo Copy of Front and Back*).
- ✓ Power of Attorney (*POA*) Forms.
- ✓ List of Current Medications.
- ✓ Living Will and/or DNR Forms.
- ✓ Any Medical Records (*if you have any*) i.e. Lab Test Results, Clinical Notes, Radiology Results.
- ✓ Completed and signed DOCTOR CARE New Patient Admit Forms:
  - Page 1-2: Face Sheet and Demographics
  - Page 3: Medical Records Release Form
  - Page 4: Email Consent Form
  - Page 5: Assignment of Benefits Form
  - Page 6: HIPAA Patient Consent Form



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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 Debit cards)



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

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

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**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:**

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**NOTES:**



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**PRIMARY INSURANCE ACCEPTED BY DOCTORCARE**  
**All secondary insurances are accepted**

- Medicare
- AETNA
- Health Net
- UHC Community Plan (+ ALTECS)
- AZ Priority Care Plus
- United Health Care - Commercial Plans depending on network
- Blue Cross Blue Shield of Arizona Commercial
- Railroad Medicare
- Optum Health Network (formerly Lifeprint, SCAN and Phoenix Direct Hospital)
- University Family Care
- Banner University Advantage Plan (Maricopa)
- ALL commercial PPO plans (if eligible for coverage)

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

<b>Your Plan</b>	<b>What You Do</b>	<b>What We Do</b>
<b>Medicare</b>	Pay your deductible (\$183 for 2018) 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.
<b>Medicare and a secondary insurance</b>	No payment due at time of service.	We will file Medicare and your secondary insurance for you.
<b>Medicare and Medicaid</b>	No payment due at time of service.	We will file Medicare and Medicaid for you.
<b>Medicaid</b>	No payment due at time of service	We will check your Medicaid eligibility before every visit and will file Medicaid for you.
<b>Medicaid HMO</b>	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.
<b>Blue Cross Blue Shield</b>	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.
<b>United HealthCare</b>	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.
<b>Insurance we are not contracted with</b>	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.
<b>Self-pay</b>	Pay for the visit in full at time of service. \$275 for first visit \$175 for each subsequent visit	We take a valid credit card that we keep on file.



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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 (X-ray, 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: 480-522-3377

Patient/Authorized Signature

Date



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## EMAIL CONSENT FORM

### VERY IMPORTANT PLEASE READ:

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (i.e. Hotmail, Gmail, Yahoo, etc.) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. this means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so, in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website <http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>
- The guidelines state that if the patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email
- This release of information will remain in effect until terminated in writing

I DO NOT ALLOW UNENCRYPTED EMAILS

ALLOW UNENCRYPTED EMAILS

I understand the risks of unencrypted emails and do hereby give permission to DoctorCare to send me personal health information via unencrypted email

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Patient/POA Authorized Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Email Address



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## **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 your insurance 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.

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**Patient/Authorized Signature**

---

**Date**



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## **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**

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**Patient/Authorized Signature**

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**Date**