DoctorCare
There's no place like home

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

7010 E. Acoma Dr. Ste. 102
Scottsdale AZ, 85254

Mailing Address: PO BOX 7904
Cave Creek AZ, 85327

Phone: 480-575-0576

New Patient Intake Fax: 480-522-3377

Email: intake@doctorcareaz.com

www.doctorcareaz.com

Please fill out completely and clearly. Thank You!

PATIENT REGISTRATION

Patient Name: _____
(Last) (First) (MI)

SEX (Check one): Male ☐ Female ☐ Other ☐

Marital Status: (Check one): Single ☐ Married ☐ Divorced ☐ Widowed ☐

Patient Date of Birth: _____ **Patient Social Security Number**: _____

Patient Lives in: (Check one): **Private Residence** ☐ **Assisted Living Facility** ☐

Name of Group Home or Assisted Living: _____

Address Where Patient Resides: _____ Unit# _____Gate Code: _____

City: _____ State: _____ Zip: _____

Name of Main Caregiver: _____ Caregiver Cell Phone: _____

Residence Phone: _____ Residence Fax: _____

PHARMACY Name: _____

Pharmacy Phone: _____ Fax: _____

Name of Insurance/LTC Case Manager: _____ Phone: _____

Does Patient have Durable Power of Attorney (POA)? (Check One): **Yes** ☐ **No** ☐

If yes, copy of POA completed form is required

POA Name: _____ Phone: _____

Patient/POA Email address: _____

POA Billing Address: _____

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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)

Imperial Health Plan

Tricare For Life

IF YOUR INSURANCE IS NOT LISTED ABOVE, PLEASE CALL OUR OFFICE TO VERIFY OUT-OF-NETWORK INSURANCE COVERAGE FOR HMO/PPO INSURANCE PLANS

Primary Insurance

Insurance Company _____

Member ID# _____ Group ID: _____

Claims Address: _____

_____

Insurance Customer Service phone: _____

Secondary Insurance:

Insurance Company _____

Member ID# _____ Group ID: _____

Claims Address: _____

_____

Insurance Customer Service phone: _____

Is there any other Insurance that is applicable? (Check One): Yes ☐ No ☐

IF yes, please fill out below

Insurance Company _____

Member ID# _____ Group ID: _____

Claims Address: _____

_____

Insurance Customer Service phone: _____

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INSURANCE COVERAGE

Your Plan	What You Do	What We Do
Medicare	Pay your deductible ($183 for 2022) 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. **$295** for first visit **$195** for each subsequent visit	We take a valid credit card that we keep on file.

Please provide a copy of your Medicare card and ID Number Below
REQUIRED EVEN WITH HMO REPLACEMENT PLANS

MEDICARE ID#: _____ **Patient DOB: _____**

Self-Pay? (Check If Applicable) **Yes** ☐ **No** ☐

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) _____

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PATIENT DEMOGRAPHICS

Clinical Concerns: _____

Weight: _____lbs. **Height** _____'_____"

Does Patient have allergies to Medications, X-Ray Dyes, or any other substances? YES ☐ NO ☐
If yes, please list below:
_____

Check all that apply:

☐ **Living Will** *-Provide Copy for Records*
☐ **Advanced Directive** *-Provide Copy for Records*
☐ **DNR** *-Provide Copy for Records*
☐ **on Oxygen**
☐ **in Wheelchair**
☐ **Needs assistance with ADLs**
☐ **Bedridden**
☐ **Uses Walker**

Is Patient Currently using Home Health Services? YES ☐ NO ☐

If yes, what is the name of the HH company? _____

Please check below for HH services:

☐ **P**hysical **T**herapy ☐ **O**ccupational **T**herapy ☐ **S**peech **T**herapy ☐ **S**killed **N**ursing for _____

Is patient currently receiving Hospice services? YES ☐ NO ☐

If yes, what is the name of the Hospice company? _____

DoctorCare is a partner of Elevate Hospice and Palliative Care. DoctorCare may remain on services as PCP even if patient is receiving hospice services.
https://elevatehospiceaz.com https://www.facebook.com/Elevatehospiceaz

List names and phone numbers of Medical Specialists, Hospitals, and former PCP from whom we may request records:

Name of Office/Hospital	Phone Number	Fax Number

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PATIENT DEMOGRAPHICS

Check all that apply below if you have had any problems with or are currently experiencing any of the following:

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Chest Pain/Chest Tightness
- ☐ Shortness of Breath
- ☐ Swollen Ankles
- ☐ Palpitations
- ☐ Lightheadedness
- ☐ Frequent Urination
- ☐ Asthma
- ☐ Emphysema
- ☐ Arthritis
- ☐ Pneumonia
- ☐ TB
- ☐ Persistent Cough
- ☐ Abdominal Discomfort
- ☐ Indigestion
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Changes in Bowel Movement
- ☐ Unexplained Weight gain/loss
- ☐ Hemorrhoids
- ☐ Gallbladder Disease
- ☐ Colitis
- ☐ Hepatitis or Jaundice
- ☐ Difficulty Urinating
- ☐ Arteritis/ Vasculitis
- ☐ Gout
- ☐ Blood Disorders
- ☐ Depression
- ☐ Alcohol Abuse

Other_____
_____
_____

Please list all **current** Medications:

Name of Medication	Dosage/Strength	Directions

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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.

**Radiology (X-ray, Ultrasound, CAT Scan, MRI, Special tests) Reports, EKG, Specialist Consults, Hospitalization Summaries, Labs, Updated medication list, Previous Primary Care Documents **

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: 602-714-7843
EMAIL RECORDS TO: lorraine@doctorcareaz.com

_____ _____
Patient/Authorized Signature Date

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Cave Creek AZ, 85327

EMAIL CONSENT FORM
POWER OF ATTORNEY

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 understand the risks of unencrypted emails and do hereby give permission to DoctorCare to send me personal health information via unencrypted email – Please fill out entire form.**

❑ **I do ALLOW** UNENCRYPTED EMAILS - **Checking this box indicates you will allow email communications with DoctorCare.**

_____

Please Print Email Address

❑ **I do NOT allow** UNENCRYPTED EMAILS - **Checking this box indicates you will not receive any email communications with DoctorCare.**

_____ _____

Patient name Patient Date of Birth

_____ _____

Patient/POA Authorized Signature Date

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EMAIL CONSENT FORM
ASSISTED LIVING HOMES

VERY IMPORTANT PLEASE READ:

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- 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 understand the risks of unencrypted emails and do hereby give permission to DoctorCare to send me personal health information via unencrypted email – Please fill out entire form.**

❑ **I do ALLOW** UNENCRYPTED EMAILS - **Checking this box indicates you will allow email communications with DoctorCare.**

_____

Please Print Assisted Living Email Address

❑ **I do NOT allow** UNENCRYPTED EMAILS - **Checking this box indicates you will not receive any email communications with DoctorCare.**

_____ _____

Patient name Patient Date of Birth

_____ _____

Assisted Living Owner Authorized Signature Date

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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. 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

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HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure 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 nonmedical 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.

Notice of Health Information Practices Attestations- Health Current

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I have completed and returned an Opt Out Form to my healthcare provider.

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