

# ADD Clinic of Arizona

**Ahwatukee Clinic**  
12020 S. Warner Elliot Loop, Ste 101  
Phoenix, AZ 85044  
480-739-0007 Clinic

## Office Policies and Procedures

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We appreciate the confidence you have shown by choosing our office to provide medical care to you and your family. We make every effort to give you the best possible care. In order to achieve this, we ask for your assistance in the following clinic policies.

### APPOINTMENTS

Appointments are required to address any/all issues and concerns. Regular office hours are Monday through Friday from 8:00am–5:00pm with lunch from 12pm-1:00pm **McDowell** 1:00pm to 2:00pm (**hours may vary from time to time**). We reserve some appointment times for same day “sick” visits every day. We work hard to accommodate requests for same day appointments, but are not always able to do so. New patients must arrive 30 minutes prior to their appointment time. If you are an established patient, please arrive 10 minutes prior to your appointment time. If you arrive late, we may need to reschedule your appointment.

If you are unable to keep your scheduled appointment, please call our office 24hrs hours ahead to cancel so that your appointment time can be made available to other patients. It is our policy that **if you do not show for 3 appointments you will be notified by mail that you will be discharged from the practice**. Phoenix Family Medical Clinic reserves the right to bill \$25.00 for No-Show appointments.

### TEST RESULTS

If any test is not within normal range our medical assistants will call you to make a follow up appointment to go over your results. **You will be subject to co-pay if your plan requires you to pay co-pay for your visits**. If results are within normal limits our medical assistants will call you to go over results. If you should have any questions after you receive your results **a follow up appointment is required**.

### MEDICATION REFILLS

**We require 72 hours notification for all refill requests**. Please do not allow yourself to run out of medication. Your provider requires advance notice, as he/she needs to evaluate your medical records. **Narcotic medications will NOT be refilled without an office visit. Medication refills will not be refilled after hours.**

### REFERRALS

All referrals require an office visit. When your provider wants you to be referred to a specialist, it will take up to **10 business days for completion**. If it is an **urgent referral**, it will be completed within **48 hours**. You will receive all the information you need by mail or phone so that you are then able to call and schedule your appointment. If your specialist requires additional visits, it is your responsibility to verify that the specialist is contracted with your insurance prior to your visit.

### MEDICAL RECORDS

For all medical record requests, a release form will be provided and must be signed by the patient. Please allow 15 business days to process your request. Your records may be faxed to another physician’s office OR made available for you to pick up in our office. Please note: If you are picking up records from our office there is a minimum charge of \$15.00 for up to 30 pages.

### PHYSICIAN PHONE CONSULT

Our providers do not usually consult patients over the phone. If this becomes a necessity which is not a medical emergency, we reserve the right to charge you a consultation fee (**most insurance plans do not cover phone consultations, so therefore this charge will be your responsibility**).

### INSURANCE

**It is the patient’s responsibility to understand their insurance plan benefits**. We will try to assist you when possible with what is and is not covered. **The patient is responsible for services/items that the insurance does not cover.**

### PAYMENTS

The patient is responsible for payment of each office visit. If you have insurance, our billing department will file the claim with them as a courtesy. Please have your insurance card with you at each visit. **Co-payments and payments are always required on the day of service**. If you do not bring your payment with you, we reserve the right to reschedule your appointment. **Patients without insurance will need to pay for their service on the day it is rendered**. Please pay with cash, credit or debit card. We do not accept checks. **A 33% fee will be added to accounts that are sent over to collections.**

### AFTER-HOURS EMERGENCIES

If you have a true medical emergency, please call 911 or go to the nearest emergency room to receive medical assistance immediately.

**I have reviewed the policies listed above in their entirety and consent to treated.**

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Signature

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Print Name

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Date

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## Patient Information/Informacion del Paciente

Date/Fecha: \_\_\_\_\_ Email: \_\_\_\_\_  
Name/Nombre: \_\_\_\_\_ SSN./Numero de Seguro Social: \_\_\_\_\_  
Age/Edad: \_\_\_\_\_ Sex/Sexo: M/F Marital Status/Estado Civil: \_\_\_\_\_ DOB/Fecha de Nacimiento: \_\_\_\_\_  
Home Phone/Numero de Casa: \_\_\_\_\_ Cell Phone/ Numero de Celular: \_\_\_\_\_  
Address/Direccion: \_\_\_\_\_ Apartment/Apartamento: \_\_\_\_\_  
City/Ciudad: \_\_\_\_\_ State/Estado: \_\_\_\_\_ Zip/Codigo Postal: \_\_\_\_\_  
Occupation/Ocupacion: \_\_\_\_\_ Employer/ Empleador: \_\_\_\_\_

*If need arises, the doctor/receptionist may leave a message on my (circle one that apply)  
Si necesitan, el doctor/recepcionista puede dejar mensaje en mi (marquee todos los que aplican)*

Home phone/Numero de Casa Cell Phone/Numero de Celular Family Name/Nombre de Familiar: \_\_\_\_\_

## Spouse or Emergency Contact Information (or Parent/Guardian if Patient is Child)

Name/Nombre: \_\_\_\_\_ SSN/ Numero del Seguro Social: \_\_\_\_\_  
Age/Edad: \_\_\_\_\_ Sex/Sexo: M/F Marital Status/Estado Civil: \_\_\_\_\_ DOB/Fecha de Nacimiento: \_\_\_\_\_  
Home Phone/Numero de Casa: \_\_\_\_\_ Cell Phone/ Numero de Celular: \_\_\_\_\_  
Address/Direccion: \_\_\_\_\_ Apartment/Apartamento: \_\_\_\_\_  
City/Ciudad: \_\_\_\_\_ State/Estado: \_\_\_\_\_ Zip/Codigo Postal: \_\_\_\_\_  
Occupation/Ocupacion: \_\_\_\_\_ Employer/ Empleador: \_\_\_\_\_

## Medical Insurance Information/ Informacion del Seguro Medico

### Primary Insurance Company Name/ Nombre del Seguro Medico Primario:

\_\_\_\_\_

Member ID #/ # de ID de Miembro: \_\_\_\_\_ Group Number/ Numero de Grupo: \_\_\_\_\_

Subscriber Name/ Nombre del Encargado: \_\_\_\_\_ DOB/ Fecha De Nacimiento: \_\_\_\_\_

### Secondary Insurance Company Name/ Nombre del Seguro Medico Primario:

\_\_\_\_\_

Member ID #/ # de ID de Miembro: \_\_\_\_\_ Group Number/ Numero de Grupo: \_\_\_\_\_

Subscriber Name/ Nombre del Encargado: \_\_\_\_\_ DOB/ Fecha De Nacimiento: \_\_\_\_\_

Please make sure you update your information with us if there are any changes. Thank you.  
Por favor de informarnos si ay algun cambio en su informacion. Gracias.

\_\_\_\_\_  
Signature of Patient/ Guardian/ Parent

\_\_\_\_\_  
Relationship/ Relacion

\_\_\_\_\_  
Date

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## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

<b>Name (Last, First, MI.):</b>	<b>DOB:</b>
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
<b>Previous or referring Doctor:</b>	<b>Date of last physical exam:</b>

### PERSONAL HEALTH HISTORY

<b>Childhood Illness:</b> <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
<b>Immunizations and Dates:</b>	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR (Measles, Mumps, Rubella)

List any medical problems that other doctors have diagnosed:

Surgeries		
Year	Reason	Hospital

  

Other Hospitalizations		
Year	Reason	Hospital

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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List your prescribed drugs and over the counter medication, such as vitamins and inhalers		
Name of the Drug	Strength	Frequency Taken

  

Allergies to Medications	
Name of the Drug	Reaction you had

## HEALTH INFORMATION AND PERSONAL SAFETY

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

<b>Exercise</b>	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4/week for 30 min.)		
<b>Diet</b>	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?		
<b>Alcohol</b>	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?		
<b>Tobacco</b>	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Drugs</b>	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sex</b>	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Contraception:		
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like to speak with your provider about your risk of HIV/AIDS?		<input type="checkbox"/> Yes <input type="checkbox"/> No

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> <b>M</b>	
				<input type="checkbox"/> <b>F</b>	
<b>Mother</b>				<input type="checkbox"/> <b>M</b>	
				<input type="checkbox"/> <b>F</b>	
<b>Sibling</b>	<input type="checkbox"/> <b>M</b>			<input type="checkbox"/> <b>M</b>	
	<input type="checkbox"/> <b>F</b>			<input type="checkbox"/> <b>F</b>	
	<input type="checkbox"/> <b>M</b>			<input type="checkbox"/> <b>M</b>	
	<input type="checkbox"/> <b>F</b>			<input type="checkbox"/> <b>F</b>	
	<input type="checkbox"/> <b>M</b>		<b>Grandmother</b>		
	<input type="checkbox"/> <b>F</b>		<i>Maternal</i>		
	<input type="checkbox"/> <b>M</b>		<b>Grandfather</b>		
	<input type="checkbox"/> <b>F</b>		<i>Maternal</i>		
<input type="checkbox"/> <b>M</b>		<b>Grandmother</b>			
<input type="checkbox"/> <b>F</b>		<i>Paternal</i>			
<input type="checkbox"/> <b>M</b>		<b>Grandfather</b>			
<input type="checkbox"/> <b>F</b>		<i>Paternal</i>			

## OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

## HEALTH INFORMATION AND PERSONAL SAFETY

### WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ___ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam? _____		
Date of last Mammogram? _____		
Date of last DEXA Scan ? _____		
Date of last Colonoscopy? _____		

### MEN ONLY

Do you usually get up to urinate during th night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes number of times _____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam? _____		
Date of last DEXA Scan? _____		
Date of last Colonoscopy? _____		

### MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

*\*You may refuse to sign this Acknowledgement\**

I, \_\_\_\_\_ have received a copy of this Notice of Privacy Practices.

Please Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

*For Office Use Only*

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_

**PATIENT RECORD OF DISCLOSURE**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's home.

I wish to be contacted in the following manner (Check all that apply)

**Home Telephone** (\_\_\_) \_\_\_-\_\_\_\_\_  
 Okay to leave message with instructions  
 Okay to leave message with call-back number only

**Written Communication**  
 Okay to mail to home address  
 Okay to mail to work/office address  
 Okay to fax to \_\_\_\_\_

**Work Telephone** (\_\_\_) \_\_\_-\_\_\_\_\_  
 Okay to leave message with instructions  
 Okay to leave message with call-back number only

SSN \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Print)

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

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## Patient Authorization to Disclose Personal Information

**Patient:** \_\_\_\_\_  
(First Name) (Middle Name) (Last Name)

**Address:** \_\_\_\_\_  
(No. Street) (City) (State) (Zip)

**Date of Birth:** \_\_\_\_\_ **Telephone No.:** \_\_\_\_\_

ADD Clinic of Arizona is authorized to **furnish to/receive from** (circle desired choice):

Physician \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Address \_\_\_\_\_

### Optional Authorization for Release of Medical Information

#### Do Not Release Information

I authorize Phoenix Family Medical Clinic to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, test results or medical care.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

#### I authorize release of the following medical records:

I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS including information and records or copies relating to the history, diagnosis, treatment or services rendered to me in connection with any condition or disease. This includes permission to release POTENTIALLY SENSITIVE INFORMATION which may include information concerning my treatment of mental illness, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologists, if any.

I GIVE PERMISSION TO RELEASE ONLY RECORDS specifically described below:

\_\_\_\_\_  
\_\_\_\_\_  
I release ADD Clinic of Arizona and the Recipient/Disclosure listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to ADD Clinic of Arizona, provided that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This Authorization expires on \_\_\_/\_\_\_/\_\_\_ (Optional) If no expiration date is given, then this authorization shall remain in effect for a period reasonably needed to complete the request.

\_\_\_\_\_  
Patient Signature (Guardian/Parent if Minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

Please send information to the above address and/or fax. Thank you.



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### **Oxycodone/ Narcotic Pain Medication Guidelines**

**From: Dr. Jeanette Cruz, MD**

- 1. This clinic follows strict rules on prescribing Narcotic Pain medication.**
- 2. We discourage all long term use of narcotic pain medication including Oxycodone.**
- 3. If you are here just to seek narcotic pain medication or Oxycodone, please be aware that this clinic will not prescribe those medications.**
- 4. All Oxycodone/ narcotic pain medication prescriptions are FINAL. There will be no refills at all, under any circumstances.**
- 5. We believe that Narcotics Pain killers like Oxycodone do not heal or cure anything.**

**If you do not agree with these guidelines, we request that you let the front office person know, so she cancels your appointment. We thank you for your patience in reading this memo.**

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**Patient Name**

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**Patient Sign/Date**