Fountains Family Care, P.C.
Dr. Richard Le, DO
Phone: 480-726-6632
Fax: 480-726-3868

3930 S Alma School Rd Ste #1
Chandler, AZ 85248

2015 N Dobson Rd Ste #11
Chandler, AZ 85224

Patient Intake Form

Name:________________________ Gender:_______ Age:________ DOB:_______________________

Reason for Visit: ____
____
____

Current Medications: (use back of page if needed)

Name:____________________ Dose:_________________ Frequency:____________________

Name:____________________ Dose:_________________ Frequency:____________________

Name:____________________ Dose:_________________ Frequency:____________________

Name:____________________ Dose:_________________ Frequency:____________________

Name:____________________ Dose:_________________ Frequency:____________________

Allergies:

Name: ______________________ **Reaction:**____________________________
Name: ______________________ **Reaction:**____________________________

Past Medical History:

__Cancer
__Diabetes
__Heart Disease
__Hepatitis A, B, or C
__High Blood Pressure
__High Cholesterol

__Other
____
____
____
____
____

Hospitalizations/Surgeries:

Reason:_____________ Date:_________

Reason:_____________ Date:_________

Reason:_____________ Date:_________

Family History:

__Cancer
__Diabetes
__Heart Disease
__Hepatitis

__Other
____
____
____

Women Only:

Number of Pregnancies _____
Number of Living Children ___
Date of last Pap Smear _____
Date of las Mammogram _____

Social History:

-Are you sexually active? __Yes __No Number of partners in the last year? ___
-Do you wish to be checked for STDs? __Yes __No
-What is your occupation? __Work __Student Type of work:________________
-Have you ever smoked? __Yes __No # of years: ____ Packs per day: ____
-Do you smoke now?
-Do you use recreational drugs? __Yes __No
-How much alcohol do you drink in one week? ___________________
-How much caffeine do you drink in one day? ___________________
-How Often do you exercise?__________________________________

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Patient Information

Patient Name: ____

Address: ____

City: ________________ State: ____________ Zip:________________

Home Phone: __________ Work Phone: ___________ Cell Phone:__________

Marital Status: __Married __Single __Child Sex: _____ Age: _____

DOB: __________________ Social Security Number: _________________

Employer: ____________________ Occupation: ___________________

Work Address: ____

Emergency Contact: ____

Phone: ____________ Relationship: ____________________________

Parent/Guardian Information (If under the age of 18)

Parent/Guardian Name: _______________________________________

Relationship to child: ____

Address: ____

City: ______________ State: ___________ Zip: __________________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Sex: ___ Age: ____ DOB: ____________ Social Security Number: ___________

Employer: _______________ Occupation: _________________________

Work Address: ____

Do You have an Advanced Directive? (Living Will)
__Yes __No If yes, please give name: _________________________
Relationship: ____

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Insurance Information

Primary Insurance (subscriber): ____

Insurance company: ____

Relationship to patient: __________________________ DOB: ____________________

Subscriber ID Number: ____

Subscriber Employer or Plan Sponsor: ____

Group Number: ____

Additional Insurance:

Relationship to Patient: __________________________ DOB: ____________________

Subscriber ID: ____

Subscriber Employer or Plan Sponsor: ____

Group Number: ____

Secondary Insured (Subscriber): ____

Insurance Company: ____

Pharmacy:
Name: ______________________ Cross Streets: _____________________________

Authorization and Release
I authorize my insurance company to pay Fountains Family Care P.C. all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. Fountains Family Care P.C. may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits for related services, as pertaining to the HIPPA guidelines.

Name: _________________ Signature:______________________ Date: _____________

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Notice of Privacy Practices Forms

Dear Patient,

Physicians have always protected the confidentiality of health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This privacy rule protects health information that is managed by physicians, hospitals, other health care providers and health plans. As of April 14, 2003 we are compliant with the privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your physician, the hospital and health plan will need to consider the privacy rule. All health information including paper records, oral communications and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. In addition we will be taking even more precautions in our office to safeguard your health information, such as training our employees and employing computer security measures. Please feel free to ask your physician or our privacy contact (Office Manager) about exercising your rights of how your health information is protected in our office.

This document contains very important information about how your protected health information is handled by our office. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our. Notice of Privacy Practices. You may contact our privacy officers (Office Manager) at (480)726-6632 to discuss any questions you may have.

Sincerely,

Dr. Richard Le D.O.

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Acknowledgement of Receipt of Our Notice of Privacy Practices

By signing below, I acknowledge that I have been provided with a copy of the Fountains Family Care P.C. Notice of Privacy Practices, I have therefore been advised of how health information about me may be used and disclosed by Fountains Family Care P.C. I have also been informed how I may obtain access to and control this information.

Print Name of Patient or Personal Representative: ______________________________

Signature of Patient or Personal Representative: ________________________________

Date: ______________

Please list who you want to have access to your pertinent medical information. (i.e. family member, spouse, significant other)

____
____
____
____

May we leave a message on your answering machine? __Yes __No

Preferred method of contact: __Home __Cell __Work

Phone Numbers:
Home: _________________
Cell: __________________
Work: _________________

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Financial Policy

Patient Name: ___________________________ DOB: ________________________

Thank you for choosing Fountains Family Care P.C. as your healthcare provider. We are committed to providing excellent health care services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy. All patients must read and sign this form prior to receiving services.

-It is your responsibility to provide us with your most current insurance information
-If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
-We must emphasize that as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
-We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
-Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance.company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment however, is dụe in full at the time of service.
-We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. -Co-payments, co-insurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we received from your insurance company. However, you are responsible for paying the full amount determined by your inşurance company once they have paid your claim-regardless of our estimation.
-**It is your responsibility to provide us with your most current billing information.**
-You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
-We will send a statement (to the billing address you provide) notifying you of any balances you may owe, If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after Receipt of the initial statement.
-**Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due accounts may be subject to a 3% monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
-If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
-If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from any of the physicians at Fountains Family Care P.C. Failure to accept this certified letter (and/or pick it up at the post office) serves as notice of termination of services.
-In the event you submit payment by check and the bank returns the check unpaid for any reasons, we will add $25 to your original balance. In addition, we may seek all additional legal remedies provided to us under Arizona law.
-We may charge you a "No Show" fee of $25 if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment.
-Failure to keep your account balance current may require us to cancel or reschedule your appointment.

Full payment is due at the time of service. We accept cash, checks and credit cards. By signing this, I attest that I have read and understood this Financial Policy.

Printed Name of Responsible Party: ___________________________________ Date: _______________

Signature of Responsible Party: ______________________________________

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Authorization to Release Medical Information

To: ____

Address: ____

City:_____________ State: _________ Zip: _______________

Office Phone: _______________________ Fax: ________________________________

I authorize ____ to release medical
(Name of place we are requesting records from)

information to Fountains Family Care P.C.

This information will be used for the purpose of:
__Legal Reasons __Continued Care
__Insurance __Workman's Compensation
__Personal Use __Other:

Please send all medical records, lab results, X-rays, imaging and consultation reports.

I understand that I have a right to revoke the authorization at any time. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent to a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date: ______________

If I fail to specify an expiration date, this authorization will expire in one year.

Patient name: _________________________________ DOB: ________________

Patient/Guardian Signature: ______________________ Date: ________________

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Wellness/Physical Exam
Financial Agreement:

Insurance concerns, requirements and coverage are ever changing. We are making every effort to be in compliance and to reduce payment denials before they occur. Your insurance plan MAY OR MAY NOT - cover routine preventative services.

We are legally obligated to assign procedurę codes based on the services provided to you, whether it is a wellness/physical or a visit to take care of problems or both. We cannot change the coding later to cause the insurance to pay for a non-covered service.

Based on the kind of coverage you have, some or all of this cost may have to be billed to you.

Please keep in mind that while the appointment may be just for a physical or just for problems, if both; kinds of services are provided during a visit, then both services may be billed. If both services are billed; you may be responsible for paying a co-payment for each service, depending on your insurance coverage.

Lab fees are additional fees and are billed out separately. Please inform the back office and the 3 phlebotomists if your Insurance requires the use of a specific lab other than Sonora Quest.

Patient Signature: ________________________________ Date:________

Patient's Printed Name:____

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No Show Policy

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may charge a $25 "no-show" service charge to your account. This charge is not reimbursable by your insurance company. You are responsible for this charge.

If you have 3 no-show appointments within a year, you will be discharged from our practice.

Thank you.

Nội quy của văn phòng

Nếu quý vị không hủy cuộc hẹn trong vòng ít nhất 24 giờ thông báo, quý vị có thể phải chịu lệ phí huỷ bỏ $25. Quý vị sẽ tự chịu trách nhiệm cho khoản phí này.

Nếu quý vị có 3 cuộc hẹn không đến với chúng tôi trong vòng một năm, chúng tôi sẽ từ
chối phục vụ quý vị.

Xin cảm ơn

By signing below you are aware of our no show policy

Chữ ký sẽ xác nhận quý vị đã đọc và hiểu lệ phí huỷ bỏ này.

Patient Name: (Tên bệnh nhân):________________ DOB: (Ngày sinh):__________

Patient Signature: (Chữ ký của bệnh nhân):_____________ Date: (Ngày):________

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Patient's Advance Directive

To my family, my physician, my clergy, my substitute decision maker in the Durable Power of Attorney:

I, ______________________, being of sound mind, make this statement as an indication of my choice of medical care and as a directive to be followed if I become unable to participate in decisions regarding my health care. These instructions reflect my commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only to prolong the process of my dying if I should be in an incurable or irreversible physical condition with no reasonable expectation of recovery.

These instructions apply if I am: (a) in a terminal condition; or (b) permanently unconscious; or (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding and withdrawing treatment.

If I am in any one of the conditions described above, I have indicated my wishes in regard to the following forms of treatment: (Please check your choices)

Cardiac Resuscitation:	I Do Want: (__)	I Do Not Want: (__)
Mechanical Respiration:	I Do Want: (__)	I Do Not Want: (__)
Feeding Tubes:	I Do Want: (__)	I Do Not Want: (__)
Kidney Dialysis:	I Do Want: (__)	I Do Not Want: (__)
Chemotherapy:	I Do Want: (__)	I Do Not Want: (__)
Antibiotics:	I Do Want: (__)	I Do Not Want: (__)
Intravenous Fluids:	I Do Want: (__)	I Do Not Want: (__)

These directives express my right to refuse treatment and they are instructions to my substitute decision maker as constituted in the Durable Power Of Attorney instrument. I intend that my instructions be carried out unless I have rescinded them in a new written declaration or by a clear oral expression that I have changed my mind.

Signature:____ Date:___________________

Witness Signature:___________________________________ Date:___________________

Witness: My designated decision maker is _______________________.
Whose address is: ____. Phone:_________________

The standard operating procedures of most healthcare facilities assume that you would want life-sustaining procedures unless you indicate otherwise.

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Patient's Advance Directive

Gửi tới gia đình tôi, bác sĩ của tôi, tu sĩ của tôi, người đưa ra quyết định thay thế tôi trong Giấy ủy quyền:

Tôi, ____________________, đang minh mẫn và không chịu tác động tâm lý, đưa ra tuyên bố này như một chỉ dẫn về lựa chọn chăm sóc y tế của tôi và như một chỉ thị phải tuân theo nếu tôi không thể tham gia vào các quyết định liên quan đến chăm sóc sức khỏe của mình. Những hướng dẫn này phản ánh cam kết của tôi về việc từ chối điều trị y tế trong các trường hợp được chỉ ra dưới đây.

Tôi chỉ thị bác sĩ chăm sóc của tôi từ chối hoặc dừng lại phương pháp điều trị cho việc kéo dài sự sống tôi nếu tôi phải ở trong tình trạng thể chất không thể chữa khỏi hoặc không có kỳ vọng hồi phục.

Những hướng dẫn này được áp dụng nếu tôi: (a) ở trong giai đoạn cuối cùng của bệnh nan y; hoặc (b) hôn mê vĩnh viễn; hoặc (c) nếu tôi còn ý thức nhưng bị tổn thương não không thể hồi phục và sẽ không bao giờ lấy lại được khả năng đưa ra quyết định và bày tỏ mong muốn của mình.

Tôi chỉ đạo rằng việc điều trị chỉ giới hạn trong các biện pháp để giúp cho tôi thoải mái và giảm đau, bao gồm bất kỳ cơn đau nào có thể xảy ra bằng cách giữ lại và dừng lại điều trị.

Nếu tôi đang ở trong bất kỳ tình trạng nào được mô tả ở trên, tôi đã chỉ ra mong muốn của mình đối với các hình thức điều trị sau: (Vui lòng kiểm tra lựa chọn của bạn)

Hồi sức tim phổi:	Tôi muốn: (__)	Tôi không muốn: (__)
Sử dụng máy trợ hô hấp:	Tôi muốn: (__)	Tôi không muốn: (__)
Đặt ống dinh dưỡng:	Tôi muốn: (__)	Tôi không muốn: (__)
Lọc thận:	Tôi muốn: (__)	Tôi không muốn : (__)
Hóa trị:	Tôi muốn: (__)	Tôi không muốn: (__)
Thuốc kháng sinh:	Tôi muốn: (__)	Tôi không muốn: (__)
Truyền nước biển:	Tôi muốn: (__)	Tôi không muốn: (__)

Những chỉ thị này thể hiện quyền từ chối điều trị của tôi và chúng là những hướng dẫn cho người ra quyết định thay thế tôi như được quy định trong văn bản Giấy ủy quyền. Tôi dự định rằng các hướng dẫn của tôi sẽ được thực hiện trừ khi tôi đã hủy bỏ chúng trong một tuyên bố mới bằng văn bản hoặc bằng một lời nói rõ ràng rằng tôi đã thay đổi ý định.

Chữ ký: ____ Ngày: __________________

Chữ ký của Nhân chứng: _________________________________ Ngày: __________________

Nhân chứng:

Tôi chỉ định người đại diện để ra các quyết định về sức khỏe của tôi là: __________________________

Địa chỉ: ____ Số điện thoại: ________________

Các quy trình vận hành tiêu chuẩn của hầu hết các cơ sở chăm sóc sức khỏe giả định rằng bạn muốn các quy trình duy trì sự sống trừ khi bạn có chỉ định khác.