Fountains Family Care

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 Information/Thông Tin Về Bệnh Nhân

Name(Tên):___________________________________Date of Birth(Ngày sinh):______________

Address(Địa chỉ):___________________________________City(Thành phố):_________________

State(Tiểu bang):____ Zip(Số vùng):_________

Primary Phone(Điện thoại chính):_________________________

Secondary(Điện thoại # 2):______________________________

Email (Địa chỉ email):____

Marital Status(Tình trạng hôn nhân): □Married(Có gia đình) □Single(Độc thân) □Child(Đứa trẻ)

Gender(Giới tính):_________Social Security Number (Số an sinh xã hội):_________________

Emergency Contact Name (Tên thông tin khẩn cấp):______________________________________

Phone(Điện thoại):____________________Relationship(Mối quan hệ):_______________________

Patient/Guardian information (under 18)

Người Chịu Trách Nhiệm/(nếu bệnh nhân dưới 18 tuổi):

Parent/Guardian Name(Tên bảo hộ chính thức):___________________

Relationship to patient (Mối quan hệ):____________

Gender(Giới tính):__________Date of Birth(Ngày sinh):___________

Social Security Number(Số an sinh xã hội):_______________

□ Check if address is same as above(Đánh dấu nếu địa chỉ giống như ở trên)

Address(Địa chỉ):__________________________________

City(Thành phố):______________ State(Tiểu bang):____ Zip(Số vùng):________

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Advanced Directive(Living Will)

Chỉ Thị Chăm Sóc Sức Khỏe (Ý Nguyện Trị Liệu)

□Yes (Có) □No(Không) If yes,(Nếu có,)

Name(Tên):____________________Relationship(Mối quan hệ):______________

Miscellaneous Questions/Câu Hỏi Linh Tinh

Pharmacy(Tên Tiệm Thuốc Tây):____________________________________

Cross Streets(Ngã Tư Đường):__________________________________

Do you suffer from allergies?(Quý vị có bị dị ứng gì không?)

□ Yes(Có) □ No(Không)

If yes, please list - all medications and reactions(Nếu có, viết vào ô đây – tất cả thuốc và phản ứng): ____

Insurance Information/Thông Tin Về Bảo Hiểm

Can skip this section if your card(s) are scanned/Có thể bỏ qua phần này nếu mang thẻ vào

Insurance Company(Tên hãng bảo hiểm):___________________________________

Name on card(Họ tên trên thẻ):______________________________

Relationship (if different then Insured)/ Mối quan hệ(nếu khác với bệnh nhân):_______________________________

Subscriber ID#(Số ID của hội viên):________________________________

Group#(Số Nhóm):______________________________________

- **Additional Insurance/Bảo Hiểm Thứ Cấp**
    - Secondary/*Bảo Hiểm Phụ

    Insurance Company(Tên hãng bảo hiểm):____________________________

    Subscriber ID#(Số ID của hội viên):________________________________

    Group#(Số Nhóm):______________________________________

    - Extra/Bảo Hiểm Khác

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Insurance Company(Tên hãng bảo hiểm):____________________________

Subscriber ID#(Số ID của hội viên):________________________________

Group#(Số Nhóm):______________________________________

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 healthcare 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 HIPAA guidelines.

Sự Cho Phép Phát Hành, Đăng Tin

Tôi thừa nhận, bảo hiểm của tôi sẽ trả các dịch vụ mà tôi nhận được ở Fountains Family Care P.C..Tôi hiểu rằng nếu bảo hiểm của tôi không trả toàn bộ số tiền cho Fountains Family Care P.C.cho các dịch vụ mà tôi đã nhận được, tôi sẽ chịu trách nhiệm với số tiền còn lại hoặc số tiền trả từng phần. Fountains Family Care P.C. có thể sử dụng thông tin chăm sóc sức khỏe của tôi và có thể tiết lộ thông tin đó cho công ty bảo hiểm của tôi và các người chăm sóc khác trong cộng đồng, và hãng bảo hiểm của quý vị nhằm mục đích nhận thanh toán cho các dịch vụ và xác định bảo hiểm cho các dịch vụ liên quan, theo hướng dẫn của HIPAA.

Name(Tên bệnh nhân):____

Signature(Chữ ký bệnh nhân) :____________________________________Date(Ngày):_________

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Notice of Privacy Practices

(HIPAA)

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.

Tôi ký tên dưới đây là đồng ý cho những người thân của tôi biết về tình trạng sức khỏe của tôi và có quyền liên lạc với văn phòng Fountains Family Care, PC để hỏi thăm và bàn bạc về tình trạng sức khoẻ của tôi.

Patient Name (Tên bệnh nhân):____

Signature (Chữ ký bệnh nhân):____

Date(Ngày):_____________

Please list who can access to your pertinent medical information

Liệt kê những ai có quyền biết về sức khỏe của tôi

- Name(Họ tên):_______________________
    - Relationship(Mối quan hệ):_____________________
- Name(Họ tên):_______________________
    - Relationship(Mối quan hệ):_____________________
- Name(Họ tên):_______________________
    - Relationship(Mối quan hệ):_____________________
- Name(Họ tên):_______________________
    - Relationship(Mối quan hệ):_____________________

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Privacy Practice

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 right 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 question you may have.

Sincerely,
Dr. Richard Le D.O.

Fountains Family Care

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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 denial before they occur. Your insurance plan may or may not cover routine preventative services.
We are legally obligated to assign procedure 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 use the insurance to pay for a non-covered service.
Based on the kind of coverage you have some or all of this cosy may have to be billed to you.
Please keep in mind that while the appointment may be just a physical or just for problems. If both kinds of services are provided during a visit, then both services may be 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 phlebotomist if your insurance requires the use of a specific lab other than Sonora Quest.

Name:_______________ Date:_________________________ Signature:_________________________

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Financial Policy

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 the services rendered.
- We must emphasize that as medical providers, our relationship is with you, the patient, and 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 a participating provider 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 due in full at the time of service.
- We charge what is usually 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 deductible are due at 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 insurance company once they have pain your claim-regardless of our estimation
- **It is your responsibility to provide us with your most currently billing information**
- **You 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. There will be a finance charge of 3% per every 30 day cycle unpaid bill. The first statement due in 30 days (no charge). Pass 30 days, 3% will be added for every 30 day cycle unpaid. You 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 fee and court cost 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 cost 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. Failure to accept this certified letter (and/or picking it up at the post office) serves as notice of termination of services.
- In the event you submit a payment by check and the bak reuters the check unpaid for any reasons, we will add $25 charge to your original balance. In addition, we may seek all additional legal remedies provided to us under Arizona Law.
- Failure to keep your account balance current may require us to cancel and/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.

Name:________________________________ Date:_________ Signature:______________________

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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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Authorization to Release Medical Information

This form is to request records from any *other* health care provider(s). If you have any pertinent records please fill out that office's info below.(*)Minimally we will need the doctor's or office's name and phone number. If you have no records you wish to request please fill out the name/signature on the bottom should our office need to request any future records that are not sent to us.

*To:____

*Office Phone:_________________________ Fax:_______________________________

Full Address:____

This information will be used for the purpose of:

- ❏ Legal
- ❏ Insurance
- ❏ Personal
- ❏ Continued Care
- ❏ Workman's Compensation
- ❏ Other______________________

Please send patient's medical notes, lab results, imaging reports, etc

- ❏ Full record
- ❏ Specifically:____

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 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.

Name(Tên):____ DOB:___________

Signature:____ Date:_____________

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Intake form

Name(Tên):______________________________DOB:______________ Age:____ Gender: M / F

Reason for Visit:____

Current Medications: (use back of page if needed)
Thuốc hiện giờ đang uống (nếu cần thiết thì viết thêm trang sau)

Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency

Allergies/Dị ứng

Name/Tên dị ứng	Reaction/ Phản ứng
Name/Tên dị ứng	Reaction/ Phản ứng
Name/Tên dị ứng	Reaction/Phản ứng

Medical History

Last Tetanus shot:_________________

Personal

- ❏ Cancer (Ung thư)
- ❏ Diabetes/High blood sugar (Tiểu đường)
- ❏ Heart disease (Bệnh tim)
- ❏ Hepatitis A,B,C (Bệnh gan A, B, C)
- ❏ High Blood Pressure (Huyết áp cao)
- ❏ High Cholesterol (cholesterol cao)
- ❏ Other:______________________________

Family

- ❏ Cancer
- ❏ Diabetes/High blood sugar
- ❏ Heart disease
- ❏ Hepatitis A,B,C

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Hospitalizations/Surgeries

____
Reason Date

____
Reason Date

____
Reason Date

Last Colonoscopy:_____________________________

Women Only

# of Pregnancies:__________

Living children:___________

Last Pap Smear:___________

Last Mammogram:__________

Social History

- Sexually active?
  - ☐ Yes # of partners in last year:_____
  - ☐ No
- Check for STDs?
  - ☐ Yes
  - ☐ No
- Occupation:____________________
- Have you ever smoked?
  - ☐ Yes # of years:____________ # Packs per day:__________________
    - ■ Currently smoke?
      - ☐ Yes # Packs per day:___________
      - ☐ No
  - ☐ No
- Recreational Drugs?
  - ☐ Yes
  - ☐ No
- Alcohol intake per week:_____________________
- How often do you exercise:____