ARIZONA LIVER HEALTH™

REGISTRATION FORM

PATIENT INFORMATION

ACCOUNT # _____

Today's Date: [Date]		PCP:	
Patient's last name:	First:	Middle:	Marital status:
Maiden Name:	Date of Birth:	Age:	Select: Male Female
Address: [Address/ P.O Box, City, ST ZIP Code]		Email:	
Social Security no.:	Home phone no.:	Cell phone no.:	
Occupation:	Employer:	Employer phone no.:	
Referred to clinic by:			
PREFERRED PHARMACY:		PHONE:	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:					

IN CASE OF EMERGENCY

Emergency contact #1:	Relationship to patient:	Home phone no.:	Work phone no.:
Emergency contact #2:	Relationship to patient:	Home phone no.:	Work phone no.:

Ethnicity : Non-Hispanic or Latino ◯ Hispanic/Latino ◯ Race: White ◯ Hispanic ◯ African American ◯

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ARIZONA LIVER HEALTH or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

ARIZONA LIVER HEALTH™

Patient's name:

Allergies / Alergias

Medical Conditions/ Condiciones Médicas

Prior Surgeries & Hospitalizations/ Cirugías previas y Hospitalizaciones

Medications/ Medicamentos	Dose/ Dosis	Frequency/ Frecuencia

ARIZONA LIVER HEALTH™

HIPAA Protected Health Information Form

Name:_____ DOB:_____

I_____authorize Arizona Liver Health to release and/or discuss protected health information pertaining to my care to the below listed individuals. I realize that if I've listed an emergency contact on my registration paperwork, and I want them to have access to my protected health information, that I must list them below. I also understand that I may revoke access to the listed individualsat any time. I also understand the withdrawal must be in writing.

Name/ Relationship/ Telephone Number

1. _____
2. _____
3. _____
4. _____

_____ I **do not** authorize my medical records to be released or discussed with anyone.

_____ _____

Signature of Patient or Legal Representative Date

ARIZONA LIVER HEALTH™

Cancellation/ No-Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 72 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

Please sign that you have read, understand and agree to this Cancellation and No-Show policy.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

Medical Records Release- TO ALH

I **authorize** the provider listed below to provide medical records to Arizona Liver Health,formerly *The Institute for Liver Health*.

Provider Name: _____

Address:_____City:_____State:_____Zip Code:_____

Phone: (_____)_____Fax: (_____) _____

Medical records may include confidential information related to HIV, communicable disease,alcohol, drug abuse and mental health diagnosis and treatment.

____Yes, I authorize ____I **do not** Authorize

Records Requested:

Complete Medical Records	Operative/ Discharge
Pathology and Procedures	Progress Notes
Hospital Reports	Radiology Reports
Labs and Reports	Other_____

I understand that:

- I may revoke this authorization at any time, except to the extent that is has already been acted upon
- Treatment will not be conditioned on my providing this authorization, unless the provision of healthcare is solely for the purpose of created protected health information for disclosure to a third party
- Once this information is release, it may be re-disclosed by the recipient and may no longer be protected information

_____ _____

Signature of Patient or Legal Representative Date

healthcurrent

imagine fully informed health

Notice of Health Information Practices

(Participant) participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information.

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 complete and return an Opt Out Form to my healthcare provider.

Signature Date

Aviso de Prácticas de Información de Salud

(Participant) participa en una organización sin ánimo de lucro, organización no gubernamental de intercambio de información sobre la salud (HIE-por sus siglas en ingles) llamada Health Current. Esto no le generará ningún costo y puede ayudar a su medico, proveedores de salud y planes de salud a coordinar mejor su cuidado compartiendo de forma segura su información médica. Este aviso explica cómo funciona el programa HIE y le ayudará a entender sus derechos con repesto al mismo bajo las leyes estatales y federales.

Yo reconosco que he recibido y leído el Aviso de Prácticas de Información de la Salud. Yo estoy consiente que mi proveedor participa en el HIE (Arizona's Health Information Exchange). Yo estoy consiente que mi información de la salud será compartida de manera segura atrávez del sistema HIE, al menos de que llene una forma de Optar Por No.

Firma Fecha