WINDSONG PRIMARY CARE

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Social Security #: ____ - ___ - ____ Maiden or any other name(s): _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

May we leave messages on your voicemail(s): _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Please specify: _____

Marital Status (circle one): Divorced / Married / Partner / Single / Unknown / Widowed / Legally Separated

Spouse/Partner name: _____

Employer Name: _____ Employer Phone #: _____

Additional information:

Mailing address (if different from above): _____

Email address: _____

Race: _____ ☐ Declined to specify

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Declined to specify

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Pharmacy Name and Location: _____

Permissions:

Who do we have permission to speak to regarding your health information, both medical and administrative?

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Name: _____ Relation: _____ Phone #: _____

Patient Signature: _____ Date: _____

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Financial information:

Responsible Party Name: _____

Invoice address: _____

Responsibly Party Contact Phone Number: _____

*****If you have benefits under someone other than yourself, please make sure to complete.**

*****If you are the beneficiary and have provided copies of your cards, you may skip.**

Primary Insurance Company Name: _____Co-Pay? _____

Policy Holders Name (if not the patient): _____

Insurance Company ID number: _____

Secondary Insurance Company Name (if applies): _____Co-Pay? _____

Policy Holders Name (if not the patient): _____

Insurance Company ID number: _____

Please initial each box:

☐ I understand that it is my responsibility to update the Windsong Primary Care / Windsong Physical Therapy with any changes to all the above information.

☐ The information printed above regarding my demographic and financial information is correct to the best of my knowledge. I authorize Windsong Primary Care / Windsong Physical Therapy, which is a DBA entity of Davis Orthopaedics, LLC to bill my health insurance for all services rendered. I give permission to furnish my information to my insurance company regarding my treatment.

Patient Signature: _____ Date: _____

Patient Name Printed: _____Date of Birth: _____

WINDSONG PRIMARY CARE

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we have shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our uses and Disclosures:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

  Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:

  - Preventing disease • Helping with product recalls • Reporting adverse reactions to medications

  - Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

• We can use or share health information about you:

  • For workers' compensation claims

  • For law enforcement purposes or with a law enforcement official

  • With health oversight agencies for activities authorized by law

  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

- Effective 04/20/2020
- Questions about this notice, please contact: Windsong Primary Care & Windsong Physical Therapy

  Attn: Practice Manager

  3221 N Windsong Drive

  Prescott Valley, AZ 86314

  (928) 910-7010

- Windsong Primary Care and Windsong Physical Therapy DBA's of Davis Orthopaedics, LLC will never market or sell your information.
- If you provide us with your personal email, we can provide access to our patient portal where you will have access to your chart, medication lists and be able to make changes to your demographic information.

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Acknowledgement and Consents (Please initial each box):

☐ I acknowledge that I have received a copy Notice of Privacy Practices.

☐ Windsong Primary Care / Windsong Physical Therapy, which is a DBA entity of Davis Orthopaedics, LLC is contracted with most major insurances. I acknowledge that it is my responsibility as the patient and the insured to know the provisions of my insurance, who is contracted, the plan coverage, my deductible, co-insurances, and co-pays. If we are contracted with your insurance, we must follow our contract and the requirements. If you have a co-pay, copays are due at the time of service and will be collected upon check in. If we are not contracted with your plan, we will follow the Windsong Primary Care / Windsong Physical Therapy Self Pay fee schedule and the fees will be collected at the time of service.

☐ I acknowledge that I am financially responsible for payment of any services that are not covered, including deductibles, co-pays, co-insurances, and uncovered services. Returned checks are subject to a $35 return check fee.

☐ I acknowledge that it is asked of me to provide at least 24 hours when cancelling an appointment. There are times that this cannot be done but if a pattern arises, we will discuss it with you. If it happens again, a no-show charge of $35.00 may be assessed. This same charge may be assessed if you continuously arrive late to an appointment. You may not be seen depending on the circumstances.

☐ I acknowledge that there is a $35.00 no show fee for missed appointments.

☐ I acknowledge that if I have an HMO health insurance plan and I need to see another medical provider, that it is my responsibility to contact Windsong Primary Care at least 3 business days in advance. This is to notify them and request them to obtain an online referral with the HMO insurance. If I have not been referred to this medical provider prior, I may need an appointment to discuss and have documentation for my insurance.

☐ I (or my authorized representative) give general consent to treatment. I authorize Windsong Primary Care & Windsong Physical therapy and the staff to conduct diagnostic examinations, test and procedures and to provide any medications or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my disease, illness or injuries. I acknowledge that I will be recommended that I have yearly physical examinations.

☐ In giving my general consent to treatment, I acknowledge that I retain the right to refuse any examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my individual treating health care providers.

☐ As a medical practice not only do we have a responsibility to care for you, our patient, to the best of our abilities, but we have a responsibility to create a work environment to where our employees are treated with courtesy and respect. As such, no verbal or physical violence, threats, or harassment towards any employee, by phone or in person will be tolerated and is grounds for immediate dismissal from the practice without other written notice than is here written.

☐ I acknowledge that Windsong Primary Care will not prescribe long term pain medications. Every patient will have a full medication review with their provider and a notification of prescriptions that will either be prescribed, or a referral will be given to an appropriate prescribing provider. Only a 30-day temporary fill may be given.

Patient Signature: _____ Date: _____

Patient Name Printed: _____Date of Birth: _____

3221 N Windsong Drive Prescott Valley, AZ 86314 (P) 928-910-7010 (F) 928-910-7011

WINDSONG PRIMARY CARE

HEALTH HISTORY

Name_____Date_____DOB_____Age____Occupation_____

MEDICAL HISTORY

Place a check by "yes" or "no" to indicate if you have had any of the following?

	Yes	No
Allergies	____	____
Diabetes	____	____
High Blood Pressure	____	____
Heart disease	____	____
Stroke (CVA)	____	____
Cancer or tumors	____	____
Lung problems	____	____
Arthritis-joint difficulties	____	____
Frequent headaches	____	____
Dizziness-blackouts	____	____
Seizures-nerve disorders	____	____
Immunity disorders	____	____
Joint replacements	____	____
Sleep disturbances at nigh	____	____
Changes in bowel or bladder habits	____	____
Changes in stool color or rectal bleeding	____	____
Increased hunger or thirst	____	____
Frequent urination	____	____
Indigestion or heartburn	____	____
Nausea or vomiting	____	____
Changes in memory	____	____
Unusual fatigue or weakness	____	____
Frequent or easy bruising or bleeding	____	____
Frequent muscle cramping	____	____
Do you awaken due to pain	____	___
Do you smoke	____	____ Number per day
Do you drink	____	____ Number per day

Are you currently receiving regular medical care for a condition not specified above? YES NO

If yes specify_____

Medications taken_____

THERAPY GOALS

What goals do you seek to achieve?

Relief of muscle, joint, or back pain

Increased flexibility

Weight management

Increased muscle tone and strength

Improved balance and coordination

Increased aerobic fitness

Stress management

Improved posture

Other_____

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Medication List and Renewal Sheet++

Please fill in all information as detailed as possible

Name (Printed):_____Date of Birth:_____

Date: _____Provider (MD or NP) Name:_____

Medication Allergies: _____

Other Allergies: _____

Prescribed Medications:

Medication Name	Dose	Directions	Name of Prescriber	Needs Refilled
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

Local Pharmacy Name: _____

Address:_____ City: _____ St:___ Zip: _____

Phone Number: _____Fax Number: _____

Mail Order Pharmacy Name: _____

Address:_____ City: _____ St:_____ Zip: _____

Phone Number: _____Fax Number: _____

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Over the Counter Medications and Supplements

OTC & Supplements	Dose	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

Other Information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Patient Name: _____ **Date of Birth:** _____

Personal History:

Religion: _____ Education level: _____ Occupation: _____

Where and when have you traveled outside of the United States?: _____

_____

List any serious operations or hospitalizations: _____

_____

List any allergies: _____

Tobacco: Current? Y or N – In the past? Y or N – How Long? _____ How much? _____ /day

Alcohol: Current? Y or N – In the past? Y or N – How Long? _____ How much? _____ /wk

Caffeine: Current? Y or N – In the past? Y or N – How Long? _____How much? _____ /day

List any immunizations that you had in the past 5 years and when: _____

_____

Last Physical Exam: _____ Full labs: _____ DEXA: _____ Mammo: _____/NA

List any current or past major illnesses or conditions that you have(d)and anything I may need to know:

_____

_____

_____

_____

_____

_____

Family History:

List immediate family members, current living status and any major illnesses or causes of death:

Mother: _____

Father:_____

Siblings:_____

_____

Children: _____

_____