Community Hospital Clinics

Community Hospital Clinic, Wickenburg, 523 Rose Lane, Wickenburg, AZ 85390
Community Hospital Clinic, Congress, 26750 B. Santa Fe Road, Congress, AZ 85332
Community Hospital Clinic, Wittman, 32919 Center St, Wittman, AZ 85361

Please Print

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN: _____ Male Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Cell: ( )_____ Work: ( )_____

State Born In: _____ Marital Status: ☐M ☐S ☐W ☐D Smoker: ☐Current ☐Never ☐Former

Race: _____ Ethnicity: _____ Primary Language: _____

If we are unable to contact you personally, may we leave a message in reference to your healthcare results, information, etc. on your answering machine? Yes No Patient's Initials: _____

Employer: _____ Occupation: _____ Phone: ( ) _____

Is this an industrial claim? ☐Yes ☐No If Yes, industrial form completed? ☐Yes ☐No Date of Injury: _____

Guarantor Name: _____ Guarantor SS# _____ Phone: ( ) _____

Guarantor Address: _____

Guarantor Date of Birth: _____ Relation to Patient: _____

Subscribers Name: _____ Date of Birth: _____ SS# _____

Primary Insurance: _____ Policy # _____ Group # _____

Secondary Insurance: _____ Policy # _____ Group # _____

Please be sure to bring and present your insurance card(s) to each of your visits with us.

In Case of Emergency, please notify the following person:

Name: _____ Relationship to Patient: _____

Home Phone: ( )_____ Cell: ( )_____ Work: ( )_____

Do you currently have a Living Will in place? Yes No Do you have a Medical Power of Attorney? Yes No

If yes, please provide a copy to our office to keep on file.

Preferred Pharmacy: ☐ Hospital Pharmacy ☐ Other _____

Email Address: _____

Signature of Patient or Representative: _____ Date: _____

Printed Name of Patient or Representative: _____

Relationship to Patient (attach evidence if appropriate): _____

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NAME:_____

DOB: _____

ACCT#:_____

SERVICE AGREEMENT

CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I voluntarily consent to diagnostic procedures and medical treatment deemed necessary by authorized providers and employees of the hospital and clinic staff.

NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have been offered a copy of a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

I received a copy of the Patient Bill of Rights. _____Patient initials

I declined a copy of the Patient Bill of Rights. _____Patient initials

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered the hospital and clinic's Notice of Privacy Practices which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures and I understand that I may contact the hospital's Privacy Officer, designated on the notice, if I have a question or complaint.

I received a copy of the Notice of Privacy Practices. _____Patient initials

I declined a copy of the Notice of Privacy Practices. _____Patient initials

PERSONAL BELONGINGS

I understand and agree that the Wickenburg Community Hospital and Community Hospital Clinic shall not be liable for the loss or damage to any money, jewelry, glasses, dentures or other articles of financial or personal value.

Patient initials:_____

RELEASE OF INFORMATION

In consideration for the treatment to be given by Wickenburg Community Hospital and Community Hospital Clinics, I hereby agree to the confidentiality of medical records relating to this service including, without limitation, any psychiatric treatment. For the time period of this service, I agree, understand and authorize all records generated by this treatment and/or admission to the hospital (or treatment for whom the undersigned has legal authority to execute this consent form) can be reviewed by any person or organization authorized by law. I also authorize that these records can be reviewed by and released to a third party payer who may provide insurance payment to the hospital or clinic. Provider may release any and all parts of the patient's medical records to persons or entities engaged in the activities stated below:

A. Insurance and Quality Review: Persons or corporations (including insurance companies, worker's compensation payers, hospital or medical service corporations, welfare governmental agencies, or the patient's employer), or their designees, which may be liable under contract to the Provider, other party, patient, family member, or employer of the patient, for the purposes of securing payment for all or part of a Provider's charges, quality assurance, accrediting agencies, and provider/ physician liability insurance carriers to enable them to carry out their functions.
B. Billing and Collections: Agents or employees of the Provider that process or duplicate medical records for billing and reimbursement purposes.
C. Medical Audit: Persons or entities authorized by the Provider for purposes of conduction medical audit activities.
D. Other Providers: Physicians and personnel involved in the patient's care to provide and manage the patient's health care. Also, information may be given to other health care providers to assure continuity of care.
E. State or Regional Health Information Exchange, currently the Health Information Network of Arizona.

Patient initials:_____

This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION** (except psychotherapy notes), **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines below.

Patient initials:_____

FINANCIAL AGREEMENT

I agree that for the services provided to the patient by hospital, clinic and other health care providers, I will pay the account balance of the patient or make financial arrangements satisfactory to the hospital, clinic or any other providers, prior to discharge.

If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. I understand the hospital has a financial assistance policy and the financial responsibility for these services may be reduced or waived for those who qualify.

I understand that should my account become delinquent, it may bear interest at the legal rate and if my account is referred to an attorney for collection, I am responsible to pay reasonable attorney fees and collection expenses.

Patient initials:_____

ASSIGNMENT OF BENEFITS

I irrevocably assign and transfer to the hospital all rights, benefits, and other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include allocating and authorizing direct payment to the hospital of all insurance and health plan benefits payable for hospitalization or for outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment.

Patient initials:_____

For Medicare/Medicaid Beneficiaries Only: I certify that the information given by me in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any service furnished to me by, or in Wickenburg Community Hospital and Community Hospital Clinics, including physician services. I authorize any holder of medical or other personal information to release any information necessary to determine these benefits or related services to the health care financing administration and agents.

Patient initials:_____

PATIENT/GUARANTOR SIGNATURE

I, the undersigned, as the Patient, Patient Representative, or legal guardian of a minor/incapacitated Patient, hereby certify I have read, and fully understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms.

Patient	Patient Name / MR#
Witness	Guarantors
Date	Relationship to Patient

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NAME:_____

DOB: _____

ACCT#:_____

Medical History/Review of Systems:

Check below any medical problem(s) that you currently have or have been treated for in the past.

F=Family History S=Self

F	S		F	S	
		AIDS / HIV			**High Blood Pressure**
		Anemia / Low blood count			**Incontinence**
		Anesthesia Complications			**Kidney / Bladder Problem / UTI**
		Anxiety / Depression			**Liver Disease / Hepatitis**
		Arrhythmia / Palpitations / Irregular Heart			**Mouth / Throat / Speech Problem**
		Asthma / COPD / Bronchitis			**Musculoskeletal Problem**
		Bleeding Problems			**Nose / Sinus Problem**
		Blood Clots			**Numbness / Weakness**
		Bowel / Colon Problems			**Obesity**
		Cancer			**Pneumonia / TB**
		Chest Pain			**Prostate Problem**
		Cholesterol or Lipid Problems			**Radiation Treatment**
		Chronic Pain			**Recent / Recurrent Infections**
		Circulation Problems in your Legs			**Reflux / Stomach Ulcers**
		Congestive Heart Failure / CHF			**Rheumatic Fever**
		Dental or Tooth Problems			**Seizures / Convulsions**
		Diabetes			**Sleep Apnea**
		Dialysis			**Shortness of Breath**
		Dizziness / Fainting / Memory Problems			**Stomach Problems**
		Ear / Vision Problem			**Swelling in feet / ankles**
		Fatigue			**Swallowing Problems**
		Gout			**Thyroid Problem**
		Gallbladder Disease			**Use of diet pills now or in the past**
		Headaches / Migraines			**Vein Stripping / Varicose Veins**
		Heart Attack			**Stroke / Mini-Stroke / TIA**
		Chest Pain			**Any Other:**

Please list any previous admission to a hospital or surgery you have had and list approximate dates:

_____

_____

_____

Please list any other personal medical history:

_____

_____

Please <u>circle</u> all that apply: Do you have a **Pacemaker**, **Cardiac Stents**, or **Metal in your body**?
If you have a Cardiac Stent Card, please provide a copy to our office to keep on file.

Vaccinations: ⍞Tetanus/Diphtheria/Pertussis __/__ Flu __/__ ⍞Pneumonia __/__ ⍞Shingles __/___

Social History:

Marital Status? _____

Tobacco use? Yes ⍞ No year started/stopped: _____ frequency:_____

Alcohol use? ⍞ Yes ⍞ No frequency: _____

Illicit drug use? Yes ⍞ No frequency and type: _____

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Medications List or attach copy of current med list

Name of Medication	*Dosage*	*Frequency*
EXAMPLE: ASPIRIN	*EXAMPLE: 81MG*	*EXAMPLE: 1 TAB BY MOUTH PER DAY*

Allergies:

Drug or Food Name	*Reaction*

Community Hospital Clinic is licensed with the State of Arizona as an Outpatient Treatment Center and with the Centers for Medicare and Medicaid as a Rural Health Clinic. This certification insures that the clinic meets or exceeds State and Federal standards of care and compliance with associated law and ensures that quality care will be provided to the community we serve. Our practice is unique in the community since we are under the Wickenburg Community Hospital's direction and are supported by an extended care team.

Calling the Clinic: During regular office hours, one of our trained Patient Service Representatives will be happy to assist you with questions, scheduling appointments, or taking a message. After office hours, call the office number and you will be put in touch with the answering service for emergent needs or leave a message for the next business day.

New Patients: If you are new to our clinic, we like to set up a longer appointment on your first visit. This will allow you time to get to know your provider and allow time for the additional one-time paperwork. Please bring your insurance cards and identification card. These will be kept on file for future reference and processing of insurance. Any co-pay, co-insurance or self-pay amounts will be collected at the time of your appointment. Patients without insurance are welcomed as self pay.

Walk In Visits: During regular office hours, we are happy to see patients who have urgent needs but no appointment. You will be assigned to the practitioner who specializes in walk-in care.

Requesting records: Should you ever need copies of your health records for any reason, simply complete an authorization for the release of your health information and we will be happy to complete your request. Copies of test results (labs, radiology, etc) may be obtained at the time of check out or you may call Health Information Management (HIM) at (928) 684-4364. Records can be picked up at the HIM department, mailed, or faxed. If requesting you're entire or seasonal records please allow 10 business days. The first request will be free of charge; a possible charge of $.75 per page may be applied for repeat request of the same records. You will be informed of any charges prior to the completion of any requests.

Note: for copies of radiology images please contact the Health Information Management department at (928) 684-4364.

Requesting Prescription Refills: If you have not been seen within one year, please call the office to schedule an appointment prior to asking for a prescription refill. Please call your Pharmacy for any prescription refills. Please allow 72 hours for prescription refill requests to be completed.

Leaving Phone Messages: Whenever you need to speak to a provider's medical assistant, the front office patient service representative will send a message electronically to the back office. If the message is urgent, please inform the front office so the back office staff may address your concerns as quickly as possible. Our medical staff discourages phone medicine. Please allow 24 hours for routine messages to be addressed. If you are ill or have a new problem, please schedule an appointment so you can be evaluated by one of our providers.

Clinic Services:

- Infants, children, adolescents, adults and seniors
- Wellness exams
- Women's and men's health issues
- DOT/CDL exams
- Worker's compensation
- Minor dermatological procedures
- Many other services are available to ensure that we meet your complete healthcare needs. If our providers determine that you need to see a specialist, we will assist you in establishing that relationship. Many specialists are available in our community.

Medical Testing: We offer many minor laboratory tests within the clinic and specialized and/or more complex laboratory tests can be completed at the comprehensive laboratory located at Wickenburg Community Hospital. Wickenburg Community Hospital provides a broad range of radiology testing including: general x-ray, fluoroscopy, CT scans, MRIs, ultrasound, DEXA (bone density and body mass index) scans, digital mammography and related services. Other therapies that may be ordered: physical therapy, occupational and speech therapy, infusion therapy, nuclear stress testing, stress treadmill and cardiopulmonary services.

Immunizations:

- Infant and children's immunizations
- Adult immunizations, including flu and pneumonia vaccines

Innovation:

- Electronic Medical Records: we use a complete electronic medical records system that is designed to streamline documentation, capture vital information and put your medical records securely at your provider's fingertips.
- Results reporting (PACS/RIS): We have full electronic access to your radiology test results that were performed at the Wickenburg Community Hospital. Furthermore, our providers can access your x-ray images by computer right in their office.
- Connectivity to labs: laboratory results arrive at the practice in various formats; however, the majority of your results are delivered electronically as an integrated part of your electronic medical record.
- Connectivity to your pharmacy: most of your prescriptions and refills are completed electronically through an industry standard secure electronic connection with your pharmacy.
- Sound masking technology: throughout the clinic we have installed a sound masking system that makes all of your conversations completely private by emitting a low-frequency sound that will suppress voice sounds. This technology, melded with music in all of the halls of the clinic, is designed to ensure that your comfort and confidence is our priority.

Community Hospital Clinic is a group of dedicated healthcare professionals who understand that establishing health relationship s with our patients is key to good health Our healthcare team includes Patient Service Representatives, Managers, Nurses, Medical Assistants and our Providers. Our Providers are Physicians and Advanced Practitioners.

What are Advanced Practitioners?

A **Physician Assistant (PA)** is trained in the same medical model as Physicians. The PA's medical training advances their expertise in all areas of medicine in a consolidated time frame. Training roughly consists of 108 weeks of primary care medicine and can further enhance their chose medical specialty in a structured residency program and/or hand-in-hand with their supervising physician. Physician Assistants are board-certified through the NCCPA (National Commission on the Certification of Physician Assistants). They are licensed Advanced Practitioner professionals who are trained to work in a variety of medical practices serving all specialties. In addition, they interpret laboratory and x-ray results, prescribe and manage medications. PAs have prescribing privileges, DEA licensure and can establish and build a patient-based practice under the supervision of a physician.

A **Nurse Practitioner (NP)** is trained in the same nursing model as Registered Nurses. Advanced education promotes their expertise as R.N.s who are prepared, through education and clinical training, to provide a wide range of preventative and acute healthcare services. NPs complete graduate-level education that leads to a master's degree in nursing. They are trained to take health histories, provide complete physical examinations, diagnose and treat many common acute and chronic problems. In addition, they interpret laboratory and x-ray results, prescribe and manage medications, provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance. NPs in Arizona have prescribing privileges, DEA licensure and can establish and build a patient-based practice as independent practitioners.

Meet Our Providers:

- **Todd Kravetz MD** — *Board Certified Internal Medicine*
- **Dennis Barraco DO, PHD** — *Emergency Medicine, Family Practice*
- **Jeremy Bramwell DO** — *Family Practice*
- **Nancy Carter PA-C** — *Family Practice*
- **Lea Way FNP-C, PA-C** — *Family Practice*
- **Jena Savage PA-C** — *Family Practice*
- **Matt Jones, FNP-C** — *Family Practice*
- **Denae Newman, FNP-C** — *Family Practice*
- **Amie Boucher, FNP-C** — *Family Practice*

Patient's Rights and Responsibilities:

Rights: Each patient will receive access to medical care without discrimination. Each patient will be treated with respect and dignity. Each patient will be insured privacy and confidentiality. Each patient will be accorded personal safety. Each patient will be entitled to know his/her physician or caregiver. Each patient is entitled to information concerning his/her diagnosis or treatment. Each patient is entitled to participate in making decisions regarding his/her care. Each patient is entitled to formulate advanced directives. Each patient is entitled to refuse treatment. Each patient is entitled to an explanation of any proposed transfer of care. Each patient is entitled to receive financial information. Each patient is entitled to know office rules and regulations.

Responsibilities: Each patient is responsible for providing complete health information. Each patient is responsible for following instructions concerning his/her care. Each patient is responsible for settling office bills promptly. Each patient is expected to obey office rules. Each patient is expected to respect and be considerate of others. Each patient is encouraged to voice problems and concerns.