Dignity Health Medical Group

Adult Demographics

PATIENT INFORMATION

Last Name		First Name	Middle
Social Security Number	Date of Birth	☐ Male ☐ Female	Marital Status

Race: ☐ African American (Black) ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian
☐ Hawaiian/Pacific Islander ☐ Hispanic ☐ Other ☐ Two or More Races

Ethnicity : Hispanic/Latino/Spanish origin ☐ Yes ☐ No	Language	Preferred Language for Health Care Information	
Mailing Address	City	State	Zip

Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Secondary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Preferred Notify Method: ☐ Home ☐ Cell ☐ Work Other: ( )

E-Mail Address

Emergency Contact:	Relationship to patient	Emergency Contact Number:

RESPONSIBLE PARTY'S INFORMATION (IF OTHER THAN PATIENT)

Last Name	First Name	Middle	Relationship to Patient
Social Security Number	Date of Birth	Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )	
Mailing Address	City	State	Zip

FAMILY AND FRIENDS ACCESS (OPTIONAL)

I do NOT permit DHMG to share my protected health information with any individuals aside from myself. ☐

Full Name:	Full Name:	Full Name:
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:

INSURANCE INFORMATION

Primary Insurance Carrier	Workman's Comp ☐	Insurance Billing Address:
Certificate/Policy Number:	Subscriber Full Name:	Subscriber Date of Birth:
Secondary Insurance Carrier	Insurance Billing Address:	
Certificate/Policy Number:	Subscriber Full Name:	Subscriber Date of Birth:

Do you have an Advanced Directive in Place (Living Will and/or Medical Durable Power of Attorney)? ☐ Yes ☐ No

FOR OFFICE USE ONLY

Date:	Medical Record #	Primary Care Physician	PCP Phone Number

Advanced Directives: ☐ Patient refused
☐ Scanned in Chart ☐ Pt Completed AD at Home ☐ Provided AD Informational Brochure ☐ Pt Requested More Information

Dignity Health Medical Group

PATIENT NAME: _____
MRN: _____
DOB: _____

_____ **CANCELLATIONS, LATE PATIENTS, AND NO SHOWS**: Our goal at Dignity Health Medical Group is to maximize the time your provider spends with you and minimize your wait time. In order to do so, we have a standardized policy for no shows, cancellations, and late arrivals;

- **Cancellation**: We require 24 hour notice of cancellation for any appointments.
- **Late**: You will be considered late if you arrive 15 minutes after scheduled appointment time.
- **No Show**: If you do not arrive for a scheduled appointment and do not provide the office notice within at least 24 hours you will be considered a no show.
  - No show #1- Documented
  - No show #2- Warning letter mailed out to patient
  - No show #3- Discharged from office

_____ **FAMILY AND FRIENDS**: You have the option to list 3 individuals which you give permission to know about appointment dates, times, and/or billing information. These individuals may NOT give consent for any in office procedures, immunizations, etc.

_____ **MEDICATION REFILLS**: Please contact your preferred pharmacy to request medication refills. Once the request has been received, refills will be completed within 3 business days.

_____ **FINANCIAL RESPONSIBILITY**: This may include co-payments, co-insurance and services not covered or paid by your insurance carrier. This financial responsibility also applies if your insurance carrier is not contracted with Dignity Health Medical Group. **It is your responsibility to ensure that all services rendered by Dignity Health Medical Group on your behalf are paid in full within thirty (30) days of the statement date**

We do not change billing codes once they have been submitted to your insurance company.

Depending on your insurance coverage at the time of your visit to the clinic, you may be asked to make a deposit on your account prior to seeing a physician. Deposits will be applied toward charges incurred but may not represent payment in full for services. Additional charges may be warranted by use of x-ray, supplies, and/or more complex services as required for care.

It is important that you bring proof of insurance each time you visit the clinic. Failure to do so may result in your not being seen or being required to make a full payment at the time services are rendered. Please make every effort to let us know if your insurance carrier (primary or secondary insurance) or your personal information (home address, employer, and phone number) has changed since your last visit.

We understand that insurance coverage can be confusing and we are committed to helping you with any questions you may have. **Please feel free to call Patient Billing Services directly at 602.406.3860 or toll free at 877.877.8311.**

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PATIENT NAME: _____

MRN: _____

DOB: _____

_____ **TELECOM AGREEMENT:** You agree that by signing below you consent and request that Dignity Health Medical Group, its affiliates, and those acting on its/their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include [AOF-Legal] those concerning the patient's care, scheduling, reminders, prescriptions, advertisements or telemarketing messages concerning our benefits and services. Calls can be made to any number you provide or we obtain even if listed on a national or state Do Not Call registry. You understand that consent is not a condition of care.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

_____ **HEALTH INFORMATION EXCHANGE (HIE) STATE PARTICIPATION ACKNOWLEDGEMENT:** I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Dignity Health's participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

I have read and understood the above.

_____ _____

Guarantor/Responsible Party or Patient Signature Date