

**PLEASE PRINT CLEARLY**

Patients Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Telephone \_\_\_\_\_

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Mailing Address (PO Box) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Street Address –if different from above \_\_\_\_\_ Marital Status: \_\_\_\_\_

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Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
 ( ) Female ( ) Male

**Patients Employer Information**

Employer Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_

**Emergency Info**

(Someone other than you, not you or your home)

**Emergency Phone Number:**  
 ( ) \_\_\_\_\_ - \_\_\_\_\_

**Winter visitor Only please list your permanent address:**

Mailing Address (PO Box) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Phone Number ( ) \_\_\_\_\_ - \_\_\_\_\_

**This information below must be filled out completely in order to file your claim.**

Primary Insurance Company Name/Address/City/State and Zip:	ID #	Group #
Secondary Insurance Company Name/Address/City/State and Zip:	ID #	Group #

**Responsible Party Information –The guarantor information is the person that is the primary card holder such as your spouse, if a minor child who is this child insured under such as the mother or father.**

**Guarantor** Last Name \_\_\_\_\_ **Guarantor** First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Telephone \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_

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Guarantors Street address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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Guarantors Social Security Number \_\_\_\_\_ Guarantors Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
 ( ) Female ( ) Male

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Guarantors Employer Name \_\_\_\_\_ Guarantors Employer Phone Number \_\_\_\_\_  
 ( ) \_\_\_\_\_ - \_\_\_\_\_

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Guarantors Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I hereby authorize John C. Lincoln Health Center in Anthem to treat the above named patient. I authorize release of medical information necessary to process insurance claims concerning my illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits for medical care rendered to my dependents or myself. I understand that I am financially responsible for any amounts not covered by my health insurance. It is your responsibility to notify us of changes to the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## General Information and Medical History

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medications you are currently taking - *List dosage*

Prescription Medications:

\_\_\_\_\_

\_\_\_\_\_

Over the Counter Medications:

\_\_\_\_\_

\_\_\_\_\_

Supplements:

\_\_\_\_\_

\_\_\_\_\_

Advanced Directive     Living Will     Power of Attorney for healthcare

\*\*\*\*\*If you would like a copy of an advanced directive please ask one of the receptionists for a copy. If you have an advanced directive please supply us with a copy.

**Social History:** This section is about you the patient and not family members. Please place a mark next to the appropriate items.

**Child No History**     \_\_\_\_\_

Alcohol	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	How Much	<input type="text"/>	How Often	<input type="text"/>			
Caffeine	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	How Much	<input type="text"/>	How Often	<input type="text"/>			
Exercise	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	How Much	<input type="text"/>	How Often	<input type="text"/>			
Children	<input type="checkbox"/>	How many		<input type="text"/>							
Drug Use	<input type="checkbox"/>	Past History			<input type="checkbox"/>	Present	<input type="checkbox"/>	No History			
Employment	<input type="checkbox"/>	Full Time		<input type="checkbox"/>	Part Time	<input type="checkbox"/>	Retired	<input type="checkbox"/>	Disabled	<input type="checkbox"/>	Unemployed
Marital Status	<input type="checkbox"/>	Married		<input type="checkbox"/>	Divorced	<input type="checkbox"/>	Single	<input type="checkbox"/>	Widowed	<input type="checkbox"/>	Significant Other
Tobacco Use	<input type="checkbox"/>	Chew		<input type="checkbox"/>	Cigars	<input type="checkbox"/>	Less than 1 PPD	<input type="checkbox"/>	Greater than 1 PPD	<input type="checkbox"/>	Never smoked
	<input type="checkbox"/>	Previous Smoker		<input type="checkbox"/>	Date Stopped	<input type="text"/>					

Place a check next to items below that pertain to **your** health only!

**No Serious Illnesses**

	Date Diagnosed	
Alcoholism	<input type="text"/>	Other Illnesses not listed with dates diagnosed
Allergies	<input type="text"/>	
Arthritis	<input type="text"/>	
Asthma	<input type="text"/>	
Cancer (What type) _____	<input type="text"/>	
Depression	<input type="text"/>	
Diabetes	<input type="text"/>	
Drug Addiction	<input type="text"/>	
Gastrointestinal Disease	<input type="text"/>	
Glaucoma	<input type="text"/>	
Heart Disease	<input type="text"/>	
High blood pressure	<input type="text"/>	
High Cholesterol	<input type="text"/>	
High blood pressure	<input type="text"/>	
Kidney Disease	<input type="text"/>	
Liver Disease	<input type="text"/>	
Mental Illness	<input type="text"/>	
Suicide Attempts	<input type="text"/>	
Thyroid Disease	<input type="text"/>	

**Please list your surgical history along with dates:**

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**Family History: List medical history about your family members!**

Adopted No Family History \_\_\_\_

Father Living: \_\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

If Deceased age at passing: \_\_\_\_\_

Mother Living: \_\_\_\_\_ Yes \_\_\_\_ No \_\_\_\_

If Deceased age at passing: \_\_\_\_\_

**Family History** –check box that applies for any relative who has been treated for the following conditions:

	Mother	Father	Mother's Father	Mother's Mother	Father's Father	Father's Mother	Siblings
Alcoholism							
Allergies							
Arthritis							
Asthma							
Cancer							
Depression							
Diabetes							
Drug Addiction							
Gastrointestinal Disease							
Glaucoma							
Heart Disease							
High blood pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Mental Illness							
Suicide Attempts							
Thyroid Disease							

**Do you have allergies to any medication(s)?**

No \_\_\_\_\_

Yes \_\_\_\_\_ (please list what you are allergic to below as well as what type of reaction the allergy causes?)

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**Do you have allergies to food?**

No \_\_\_\_\_

Yes \_\_\_\_\_ (please list what you are allergic to below as well as what type of reaction the allergy causes?)

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**Privacy Notice Acknowledgment and  
Patient Communication and Consent**

*Pharmacy Name you would like to use and the cross streets:*

\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

I wish to be contacted in the following manner:

\_\_\_\_\_ Okay to call my home and leave a message. Phone Number: \_\_\_\_\_

\_\_\_\_\_ Do not call my home only call this number:(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

- Due to the privacy rules **if you do not** list anyone below we **will not** be able to discuss anything regarding your health with anyone other than you. I give permission to the following individuals listed below to discuss information regarding my health.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- If a **minor child** please list who may bring your child to the doctor and make medical decisions in your absence.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Must Sign Below for all information given:**

**My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Notice of Privacy Practices from John C. Lincoln Health Center in Anthem.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Person Authorized to Signed

\_\_\_\_\_  
If not patient relationship to patient (parent, legal guardian, personal representative, etc.)

# Financial Policy

We are dedicated to providing the best possible care and service to you and your family. Your complete understanding of your financial responsibilities is an essential element of care and treatment.

**Non-Covered Services:** It is the patient's responsibility to know their insurance coverage benefits and present their card at each visit. We ask that you contact your insurance carrier to review your benefits prior to being seen. You will need to verify coverage for all preventive care such as physicals, routine immunizations, employment screening, Department of Transportation physicals, radiology services and labs. There are numerous insurance plans and we cannot be responsible for ordering services that you are requesting that may or may not be a covered benefit on your plan.

**Change in Insurance Plans:** You are expected to notify our office if your insurance coverage changes. We ask you to update your record at each visit to our office. It is your responsibility to notify the office immediately of these changes. Balances left over 90 days will become the responsibility of the patient. Insurance carriers give us a 90 day period to submit claims to them for payment. After that time it will be denied as past timely filing. If we are unable to process your claim due to incorrect information given we will have no other choice but to bill you directly for our services.

**Payment is required at the time of service:** Patients who are not covered by health insurance, on a plan that we do not participate with, or if we are not able to verify your coverage must pay at the time of service. Any unpaid or denied claim over 90 days old becomes the responsibility of the patient. Patients who have plans that we do participate with are asked to pay their co-payment, co-insurance, deductibles, or any non-covered services at the time of their visit. We charge a \$25.00 fee for any returned checks over and above what your financial institute may charge.

**Collection Agency Fees:** Should your account become severely delinquent, the patient or guarantor agrees to pay all costs of collection including attorney fees, collection fees and contingent fees to collection agencies of not less than 35%. The Contingency fees will be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

**Motor Vehicle Accidents:** We do not bill for any motor vehicle accidents regardless of fault. You must pay in full at the time of service. You will be supplied with the necessary forms to turn in to the insurance carrier.

**Missed Appointments:** New patients must arrive at least 30 minutes prior to their scheduled appointment to fill out the necessary paperwork and verify eligibility with your insurance carrier. Established patients are asked to arrive at least 15 minutes prior to their appointment. Due to the high volume of no show appointments we have implemented a policy that if we log three no show appointments in a calendar year we will ask that you seek a new provider. You are mailed a letter each time we log a "No Show"

**Minors:** For all services rendered to minor patients, we will look to the parent or guardian with whom brought the patient to the appointment for payment.

I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

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Signature of Patient or Responsible Party if a minor

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Date

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Printed Name of Patient (or Minor)

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Date

## **IMPORTANT INFORMATION FOR OUR VALUED PATIENTS**

To serve you better and more efficiently, we need your understanding and cooperation on the following:

### **Treatments and prescriptions:**

Treatment for illnesses and prescriptions will not be done over the phone. If you are having a problem you will need to schedule an appointment with your primary care physician. If it is after hours you will need to go to the closest urgent care, emergency room or call 911 if it is life threatening. Urgent care is for non life threatening emergencies. If you need a refill on your medication you must call the pharmacy first and allow 72 hours for your request to be filled. You must have been seen within the last six months for any refills. If you need to change your medication you must schedule an appointment to discuss options available. **DO NOT** wait until you are out of your medication to request a refill. It is your responsibility to track your prescriptions. If you need them immediately you must schedule an appointment with the physician.

### **Lab, X-rays and Referrals:**

Please do not call us for your x-ray or lab results for at least 5 business days after you have had the test. If after the 5 business days you have not heard from us then call us to get the results. We make every effort to get them to you within this time frame.

### **After Hour calls:**

Please do not call during non business hours which are prior to 8 a.m. and after 5 p.m. for routine issues, medication refills or treatment questions. If you are ill and feel you need to be seen you will need to go to the closest emergency room or if life threatening call 911.

The answering service is set up for physicians only and for true emergencies. The answering service is instructed not to put through calls that are not from a physician or is non-life threatening.

**Urgent Care** is open Monday through Friday 8a-8p, Saturday and Sunday 8a-2p. Our phones are open the following hours:

Monday through Thursday 8:00 a.m. to 12:00 p.m. and then again 12:30 p.m. to 5:00 p.m. Fridays from 8:00 a.m. to 12:00 and then 12:30 to 4:00 p.m. If after hours you are ill you must call 911 or go to the closest emergency room.

## **NOTICE TO OUR URGENT CARE AND FAMILY PRACTICE PATIENTS**

In order to comply with accepted guidelines of the Arizona Board of Medical Examiners and the Federal Drug Enforcement Agency, John C. Lincoln Urgent Care and Gavilan Peak Family Practice will operate under the following policy regarding the prescribing of narcotic analgesic (pain relieving medication):

1. If a patient is seen in urgent care for an acute injury or medical condition requiring narcotic pain medications, a maximum of a two weeks supply will be ordered as deemed necessary by the physician on duty. All future refills if needed must be obtained by your primary care doctor or specialist. No exceptions.
2. Refills of narcotic pain medications for chronic conditions must be obtained from your primary care doctor or specialist. The urgent care providers will not prescribe these medications.
3. Patients of Gavilan Peak Family Practice, who require chronic pain medications must schedule an appointment for all refills and must sign a controlled substance contract. Narcotics will not be filled on weekends, holidays or during your provider's absence. Ask a receptionist to see a copy of the contract. If you are not able to get in to Gavilan Peak Family Practice, you will need to call your insurance carrier's member services department and they will be able to assist you in locating other primary care offices.
4. In the event of an adverse reaction or intolerance to a prescribed narcotic pain medication, it will be necessary to return the unused portion of the medication to the office before an alternative medication can be prescribed!

**This policy will be strictly enforced.**

**Hearing from  
John C. Lincoln Health Center in Anthem  
is Just Five Easy Steps Away!**

Your doctor will tell you the approximate date your information will be available. Typically this can take up to 5 business days or more. If you have not heard from our office after 5 business days please call us to obtain your results. If your information is ready sooner than expected, you'll be called.

**Just Follow this Simple Guide to Retrieve Your Information:**

**Step 1**

Using a "Touch-Tone" Telephone  
(A phone that beeps when you dial) Call:

**480-675-5956**

**Step 2**

To Listen to the Prompts in English, Press 1.

**Step 3**

Dial Your Identification Number:  
Your Social Security number is your ID#.

ID#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Step 4**

Record Your Name. End Your Recording by Pressing 1.

**BE SURE TO LISTEN TO YOUR ENTIRE MESSAGE**

**Step 5**

After Listening to Your Message, Press 1 to Repeat, 2 to Delete or 3 to Save.

**You Can Now Hang Up Your Phone! That's All There is to It!**

Below is a list of phone numbers to assist you in reaching our office and in choosing the correct option. We hope this will help alleviate your frustration when calling our office.

*Call the main office number 623-434-6444 and choose one of the first three prompts:*

- Gavilan Peak Family Practice Dr Pyter, Dr. Allen and Dr. Tracey and Nurse Practitioner Rebecca Matthews Option 1
- Urgent care Option 2
- Pinnacle Radiology Option 3

Once you have chosen the option above follow the instructions under the appropriate highlighted area below:

### **OPTION 1: (Gavilan Peak Family Practice)**

- Appointments or speak to the receptionist Press 1
- Physicians medical assistants Press 2

Dr. Tracey's Medical Assistant option 1  
Dr. Pyter's Medical Assistant option 2  
Dr. Allen's Medical Assistant option 3

- Pharmacists or physicians only Press 3
- Billing department or call direct (623) 434-6451 Press 4
- Referrals Referral Department or call direct (623) 434-6443 Press 5
- Prescription refills Press 6
- Medical Records Press 7

### **OPTION 2: (John C. Lincoln Urgent Care)**

- Billing department Press 1
- Receptionist Press 2
- Urgent care medical assistant Press 3

### **OPTION 3: (Pinnacle Radiology)**

- Radiology Receptionist Press 1