Up 2 Par Medical Clinic, reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Up 2 Par Medical Clinic.

_____	_____
Signature of Patient	Date
_____	_____
Name of Patient Printed	Date
_____	_____
Relationship to Patient Representative	Date
_____	_____
Signature of Patient Representative	Date

(Required if the patient is a minor or an adult who is unable to sign this form)

24 Hour Cancellation/Reschedule & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Up 2 Par Medical Clinic reserves the right to charge a fee of $50.00 for all missed appointments ("no-shows") and appointments which, absent a compelling reason, are not cancelled or rescheduled with a 24-hour advance notice.

"No-show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. If your account is sent to collections, 40% of the total bill will be added for collection fees.

Multiple "no-shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Printed Name **Date**

_____

Signature

2775 S 8th Ave Yuma, AZ 84364 PH: (928) 341-0700 Fax: (928) 341-0900

Financial Responsibility

Verification of eligibility and benefits are conducted every time you have an office visit. However, per your insurance, this is not a guarantee of payment.

A copayment may apply if an illness is evaluated or procedure is performed during a Well Exam.

Please, be advised that you may be subject to a deductible, co-insurance amount or co-payment which we may not be aware of until the claim for the office visit has been processed by your insurance carrier.

Should there be a remaining balance due after your insurance carrier has processed the claim; a statement will be sent to you for payment.

Also, please be advised that failure to provide correct, new or additional insurance information in a timely manner may result in additional financial charges. This includes any private insurance coverage as well as AHCCCS.

In the event that I have failed to pay for the services provided by this office, and the account is placed for collection, I understand and agree that an additional amount equal to 40% of the balance owing at the time the account is placed for collection, will be added to the current balance owing. In addition to a collection fee of 40% of the balanced owed, I agree to pay interest at the rate of (10%) ten percent per annum until the amount owed is paid in full. I further agree to pay all attorneys fees and court costs, necessary to collect this balance.

I have read the above statement and understand my financial responsibility.

_____ _____

Signature of Patient Date

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PLEASE PRINT

PATIENT INFORMATION **Pharmacy of choice: _____**

Name: _____ MI____ Prefix: ____ Social Security # _____-____-_____
Last First

Home Phone (____) ____-_____ Cell Phone (____) _____-_____ D.O.B: ____/____/____ Sex: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: (PO Box if Required) _____City:_____ State: _____ Zip: _____

Marital Status: _____ Race: _____ Ethnicity: _____

Referred to clinic by: _____

Email Address: _____

PATIENT EMPLOYER

Employer: _____ Employment Status: _____

Phone (____) ____-_____ Student Status: _____

GUARANTOR INFORMATION

Name: _____

Address: _____

_____
City State Zip

Phone #: (____) ____-_____

Social Security # _____-____-_____

GUARANTOR EMPLOYER

Name: _____

Address _____

_____
City State Zip

Phone #: (____) ____-_____

Relationship to Patient: _____

INSURANCE INORMATION

PRIMARY: _____ ID#_____ Group#: _____

Policy Holder: _____ D.O.B: ____/____/____

Social Security # _____-____-_____ Employer: _____

SECONDARY: _____ ID#_____ Group#: _____

Policy Holder: _____ D.O.B: ____/____/____

Social Security # _____-____-_____ Employer: _____

EMERGENCY CONTACT:

Name: _____ Phone #: (____) ____-_____
Last First

Relationship to Patient: _____

ASSIGMENT OF BENEFITS-FINACIAL ARRANGEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Up2Par Medical Clinic and any assisting physicians and or billing agents for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original.

I AM AWARE THAT THESE CHARGES ARE ESTIMATES ONLY AND THAT I MAY RECEIVE ADDITIONAL BILLING.

Patient, Parent, or Guardian _____ Date ____/____/____
Signature

Health History Questionnaire

Patient Name: _____ Date: _____

Print and fill out completely

Current medications (prescribed and over the counter) and supplements

Name of medication	Reason you take it for?	Dose/Strength	How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- **Currently not taking any medication**

Current medical problems

- Asthma
- Cardiac disease
- Dizziness
- Hypertension
- Depression
- Cholesterol
- Headaches
- Migraine
- Blood Transfusion
- Seizures
- Stroke
- Fatigue
- Gall bladder
- Stomach, bowel problems
- Kidney or bladder problems
- Anemia
- Cancer (Type of…) _____
- Diabetes Type 1 or Type 2

Additional information: _____

(Diagnosis, treatment, etc.)

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Medical History

Medication allergies/intolerance: **Type of reaction:**

_____ _____
_____ _____
_____ _____

Surgeries:

List any surgeries and dates. Try to be as **Specific** as possible

Type	Date

Hospitalizations:

List any hospitalizations, other than surgeries, and dates:

Reason	Date

Family History

Members	Alive/ Deceased	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Disorder	Cancer
Father			○	○	○	○	○	○
Mother			○	○	○	○	○	○

Additional Family history:

_____

Siblings: Brothers _____ Sisters _____ Healthy: Yes or No
Children: Sons _____ Daughters _____ Healthy: Yes or No

Social History

Do you use Tobacco products?

- ○ Current ○ Never ○ Former

Type of product

- ○ Cigars ○ Chew ○ Cigarettes ○ Vape

If former:

How long has it been since last smoked? _____

Alcohol:

Did you have a drink containing alcohol in the past year?

- ○ No ○ Yes

If yes, how often did you have a drink containing alcohol in the past year?

- ○ Never ○ Weekly
- ○ Less than monthly ○ Daily or almost daily
- ○ Monthly

If yes, in the past years, how many drinks did you have on a typical day? _____

How often did you have six or more drinks on one occasion in the past year? _____

Sexual History:

Had Sex in the past 12 months: Yes: ____ No:____

- ○ Men ○ Women ○ Both Men & Women

Use Protection? Yes: ____ No: ____

Prevention Strategies: Abstinence: ____ Condoms: ____ Other: ____

Have you ever had an STD? Yes: ____ No: ____

- ○ Chlamydia ○ Gonorrhea ○ Syphilis ○ Herpes ○ Other

Miscellaneous:

Are you currently:

- ○ Employed ○ Unemployed ○ Retired

Recreational drug use

- ○ Yes ○ No ○ Former

Do you exercise?

- ○ Regularly ○ Rarely ○ None

Marital Status:

- ○ Single ○ Married ○ Divorced ○ Widowed

Preventive Health History (Please fill out completely)

Have you had a Diabetic eye exam this year? Yes: ____ No: ____
Have you had a hemoglobin A1C blood test this year? Yes: ____ No: ____

Colonoscopy:

No: _____ Yes: _____ Date:_____

- ○ Benign Polyps
- ○ Pre-Cancerous Polyps
- ○ Cancer
- ○ Diverticulosis
- ○ Hemorrhoids
- ○ Unknown

Mammogram:

No: _____ Yes: _____ Date:_____

- ○ Suspicious Calcifications
- ○ Benign Calcifications
- ○ Breast Cancer
- ○ Unknown

Bone Density:

No: _____ Yes: _____ Date:_____

- ○ Normal
- ○ Osteopenia
- ○ Osteoporosis

Pap Smear:

No: _____ Yes: _____ Date: _____

- ○ Normal
- ○ Abnormal

Advanced Directives

Do you have Advanced Directive?	○ No	○ Yes
Do you have a Living Will?	○ No	○ Yes
Do you have a Medical Power of Attorney?	○ No	○ Yes

If you answered yes to any of this questions please give a copy to the receptionist.

Preventative Medicine:

Tetanus	○ No	○ Yes	Date: _____
Pneumococcal	○ No	○ Yes	Date: _____
Influenza	○ No	○ Yes	Date: _____
Meningococcal	○ No	○ Yes	Date: _____
HPV	○ No	○ Yes	Date: _____
Shingles Vaccine	○ No	○ Yes	Date: _____
Allergy to eggs	○ No	○ Yes	

Signature:_____ Date: _____