Access2Care
Family Medical Center
Olu Onisile, MD

PATIENT INFORMATION

Thank you for choosing Acces2Care Family Medical Center. In order to serve you properly, we need the following information. **Please Print.** All information will be confidential.

Date_____ Patient's Name_____
First MI Last
SSN_____ Male____ Female_____ Birthdate_____Home Phone_____

Address_____ City_____ State_____ Zip_____
Minor_____ Single_____ Married_____ Divorced_____ Widowed_____ Separated_____

Patient's or Parent's Employer_____Work Phone_____

Work Address_____ City_____ State_____ Zip_____

Parent's Name if Minor _____
Person to contact in case of emergency_____ Phone_____
Who may we thank for referring you? _____

Responsible Party (if different from above)

Name of person responsible for this account_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

SSN_____ Birthdate_____ Home Phone_____ Bus Phone_____

Pharmacy Information

Pharmacy Name_____ Pharmacy Number_____

Address_____ Cross Street_____

Insurance Information

Name of Insured_____ Relationship to Patient_____

DO YOU HAVE ADDITIONAL INSURANCE? YES____ NO____(If yes, complete the following):

Name of Insured_____ Relationship to Patient_____

Insurance Company_____ Insurance Phone_____

ID Number_____ Group Number_____ Union or Local Number_____

_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also agree that if I change PCP, I will not be allowed back in this practice.

X_____ _____ _____
Signature of patient or parent if minor | Patient's Name | Today's Date

4607 N. 12th Street ♦ Phoenix ♦ AZ ♦ 85014 ♦ Tel: (602) 222-8727 ♦ Fax: (602) 222-8757
11,000 N Scottsdale Rd #295 ♦ Scottsdale ♦ AZ ♦ 85254 ♦ Tel: (480) 757-1111 ♦ Fax: (480) 306-8025

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PATIENT CODE OF CONDUCT

Code of Conduct for Patients

To Provide a safe and healthy environment for staff, visitors, patients and their families. **Access2Care Family Medical Center** expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights of safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or you are unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be made.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all their patients the time and quality of care they deserve.
- Questions about your billing can be addressed to the office manager.
- Our practice follows a zero tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of our cell phone and other electronic devices. When interacting with any of our staff please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children while in the office.

The following behaviors are prohibited:

- Possession of firearms of any weapon.
- Intimidating of harassing staff or other patients.
- Making threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication.
- Physical assault or threatening to inflict bodily harm.
- Making verbal threats to harm another individual or destroy property.
- Damaging business equipment of property.
- Making menacing or derogatory gestures.
- Racial of Cultural slurs or other derogatory remarks.
- No animals are allowed in the office including service animals.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

X_____ _____ _____

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Controlled Substance Agreement

You must agree to each of the following statements before we will prescribe a controlled medication to you:

- ✓ I am aware controlled medications are prescribed for many reasons, such as to relieve severe pain, relax muscles, suppress a cough, calm anxiety or induce sleep.
- ✓ I understand my medication may produce many unpleasant side effects, including sleepiness, drowsiness, nausea, vomiting, constipation, difficulty urinating, itching, mouth dryness, allergic reaction, decreased libido and sexual function, slowed reflexes and breathing rate, painkiller tolerance, and other undesirable problems.
- ✓ I am aware that after taking my medication for a period of time I may develop tolerance to it. I am also aware I may become physically dependent on my medication and may experience withdrawal symptoms if I stop taking it abruptly. I understand I am putting myself at risk for psychological dependence or addiction if I abuse my medication and use it to achieve feelings of well being or mood change apart from its prescribed, medicinal purposes. I recognize tolerance, dependence, and addiction are risks that must be taken into consideration when this medication is prescribed.
- ✓ I realize my medication has potential for deadly interactions with other substances, especially those that suppress the central nervous system such as benzodiazepine tranquilizers, barbiturates, antihistamines, opiates, alcohol, and some herbal supplements. Therefore, I will not use alcohol or illegal drugs while on this medication.
- ✓ (Women Only!) I am aware if I carry a baby to delivery while taking this medication, my baby will be physically dependent on it. I am also aware this medication is not generally associated with birth defects, but that there is still a possibility that my baby will develop them. Therefore, if I become, or plan to become, pregnant while taking this medication, I will immediately inform my obstetrician and my PCP.
- ✓ **I will only take my medication as directed by my PCP. I will not take more medication than prescribed and I will not ask for or receive early refills under any circumstance. I realize refills will be written only during scheduled monthly appointments but never via phone / fax.**
- ✓ I promise to not alter my medication in any way – I will take my medication whole and it will not be broken, chewed, crushed, injected, snorted, etc. I understand potential, deadly toxicity could occur due to rapid absorption if I take my medication inappropriately.
- ✓ I will not seek or obtain prescriptions for a controlled substance from any source other than my PCP. In other words, I will not seek or obtain controlled medication prescriptions from other clinicians, emergency departments, dentists, and so forth.
- ✓ I agree to inform my PCP whenever an outside provider prescribes new medications or diagnoses any new medical conditions.
- ✓ I will not give my controlled medication to anyone else; likewise, I will not take anyone else's medication.
- ✓ I will only use one pharmacy to fill my controlled medication prescriptions.
- ✓ **I will keep my medication in a safe place and protect it from theft. I will make sure that it does not get misplaced, wet, or destroyed. I understand my PCP will not give me additional refills if I lose my medication or if my medication is stolen.**
- ✓ I agree to allow my PCP to order any urine, blood, or breath testing needed to make sure I am using my medications correctly. I understand I may be tested at any time while I am taking a controlled medication.
- ✓ I authorize my PCP to order pill counts of my medication as needed to verify I am taking it properly. I understand my PCP may ask me to bring him/her my pills in their original container at any time while I am on controlled medication.
- ✓ I realize my medication slows my reflexes and reaction time. Because of this, I will not be involved in any activity that may be dangerous to myself or someone else while I am on controlled medications; this includes driving a car, working in unprotected heights, and using dangerous equipment. I understand I should not care for another individual who is unable to care for himself/herself while I am under the influence of this medication.
- ✓ I understand if I violate any of the above terms, my doctor will most likely terminate my status as a patient with Acces2Care Family Medical Center.

X_____ _____ _____

Patient's Signature | Patient's Name | Date

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PATIENT HEALTH HISTORY

PAST HISTORY

Please indicate all illnesses and/or injuries:

❑ Heart Disease	❑ Stroke	❑ Gallbladder Disease	❑ Hepatitis
❑ High Blood Pressure	❑ Gout	❑ Cancer (DESCRIBE) _____	❑ Seizures
❑ Rheumatic Fever	❑ Pneumonia	❑ Bleeding Tendencies	❑ Kidney Dysfunction
❑ Heart Murmur	❑ Tuberculosis	❑ Thyroid Trouble (DESCRIBE) _____	❑ Blood Transfusions
❑ Enlarged Heart	❑ Pleurisy	❑ Kidney Stones	❑ Other _____
❑ High Cholesterol	❑ Hiatal Hernia/Reflux	❑ Phlebitis	❑ Other _____
❑ Diabetes	❑ Stomach Ulcer	❑ Sexually Transmitted Diseases	❑ Other _____

OPERATIONS

Please indicate all operations you have had and the dates:

❑ Tonsillectomy _____	❑ Sinus Surgery_____	❑ Hysterectomy_____
❑ Adenoidectomy _____	❑ Throat Surgery (OTHER THAN TONSILS) _____	❑ Appendectomy_____
❑ Tubes in Ears_____	❑ Heart Surgery_____	❑ Hernia Repair _____
❑ Other Ear Surgery_____	❑ Gallbladder _____	❑ Other_____
❑ Nose Surgery_____	❑ Blood Vessel Surgery_____	❑ Other_____

Have you ever had problems with anesthesia? ❑ Yes ❑ No

Have you ever been told you or a relative has malignant hyperthermia? ❑ Yes ❑ No

Have you ever been told you have a latex allergy? ❑ Yes ❑ No

MEDICATIONS

Current Medications including Aspirin, Vitamin Supplements, Herbs	Reason	Dose (How many mgms?)	Frequency (How often?)

ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETICS OR MATERIALS

LIST:

FAMILY HISTORY

❑ Do you have a family history of trouble with anesthesia? ❑ Yes ❑ No

❑ Do you have a family history of easy bleeding? ❑ Yes ❑ No

❑ Do you have a family history of allergy/asthma? ❑ Yes ❑ No

❑ Do you have a family history of diabetes? ❑ Yes ❑ No

❑ Do you have a family history of cancer? ❑ Yes ❑ No

❑ Do you have a family history of heart disease? ❑ Yes ❑ No

❑ Do you have a family history of any other diseases? ❑ Yes ❑ No

(DESCRIBE)_____

SOCIAL HISTORY

Do you use tobacco? ❑ Yes, I've smoked _____ packs of cigarettes per day for _____ years ❑ Yes, I smoke cigars or a pipe ❑ Yes, I use snuff/chew

❑ No, I have never smoked ❑ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

❑ Does anyone in the family smoke? Who? _____

Do you drink alcohol? ❑ Yes ❑ No, never (or rarely) ❑ No, but I used to If yes, what and how much? _____

Were you ever a heavy drinker? If yes, what and how much? _____

Children: Number of children: _____ Daycare: ❑ Yes ❑ No Number of days per week _____

Regular exercise: ❑ Yes ❑ No What type? _____ How often? _____

Work in a noisy environment? ❑ Yes ❑ No Do you wear hearing protection? ❑ Yes ❑ No What type? _____

Do you own hearing aids? ❑ Yes ❑ No How long? _____ Do you wear them? _____

The above information is accurate to the best of my knowledge.

X_____ _____ _____

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HIPAA Release Form

Patient Name: _____ Date of Birth:_____

Release of Information
I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to the following person(s):

_____

_____

_____

_____

_____

___Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:
___my home
___my work
___my cell number:

If unable to reach me:
___you may leave a detailed message
___please leave a message asking me to return your call
___do not leave a message

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

We are required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by Access2Care Family Medical Center, and of your individual rights and our legal duties with respect to confidential information.

Ways in which we may use and disclose your protected Health information:
We may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing mental health care and related services.
- **Payment** means activities such as obtaining payment for the mental health care services we provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

We may contact you to provide appointment reminders or other services that may be of interest to you. We will disclose your protected health information to any person you identify that is involved in payment for your care.

We will use and disclose your protected health information when required by federal, state or local law. There are certain situations in which as a medical office we are required by ethical standards to reveal information obtained during your visit to persons or agencies even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, we are required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to us your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, we are required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if we are required by a court of law (court order) to turn over records to the court or if we are ordered to testify regarding those records.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand our use of your information for treatment, payment and health care operations as stated above.

X_____ _____ _____

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