AVIATOR MEDICAL CENTER

Patient Registration Form

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Email: patientcare@aviator.health
www.aviator.health

Patient Demographics

First name | M.I. | Last name

Mailing address

City/State/Zip

E-mail address

Cell phone | Home phone

Sex
- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Other

Sexual Orientation
- ◯ Heterosexual
- ◯ Bisexual
- ◯ Homosexual
- ◯ Other

Marital Status
- ◯ Single
- ◯ Married
- ◯ Divorced
- ◯ Widowed
- ◯ Separated
- ◯ Other

Race
- ☐ American Indian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Asian
- ☐ Caucasian
- ☐ Other
- ☐ Decline to specify

Preferred pharmacy (Name, Location)

☐ **FREE DELIVERY**

Check here if you would like Free home delivery of your medications from FirstChoice Pharmacy

Height (feet) | Inches | Weight in lbs | Occupation

Date of Birth | SSN | Drivers license or ID# | State

Emergency Contact Name | Emergency Contact Phone #

Primary Medical Insurance *(Skip this section if uninsured)*

Insurance company name | Policy holder name

Policy holder DOB | Group ID | Patient relationship to policy holder

Policy number

Secondary Medical Insurance *(Skip this section if uninsured)*

Insurance company name | Policy holder name

Policy holder DOB | Group ID | Patient relationship to policy holder

Policy number

Medical history

Do you have any of the following conditions?

- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart failure
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Urinary problems
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Migraines
- ☐ Prostate problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Psychiatric disorder

Please list any other medical problems not listed above

Please list any **medications** you are currently taking and dosing/frequency as best as you can

Family history

Does anyone in your blood related family have any of the following conditions?

- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Cancer
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart failure
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Urinary problems
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Migraines
- ☐ Prostate problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Psychiatric disorder

Please list any other medical problems not listed above

Allergies

Surgical history with approximate dates

Tobacco use
Do you smoke? If yes, how many packs per day and how many years

Alcohol use
Do you drink alcohol? If yes, how much and how often

Recreational drug use
Have you ever or do you currently use any recreational drugs? If yes, please clarify

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How did you hear about our practice?

What is the reason for today's visit?

Please list the names of any other doctors you are seeing and their specialty

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Preventative Screening & Other Common Tests

Please list if any, approximate dates of screening tests

Colonoscopy(50+)

Pap smear (Women 21+)

Bone density (Women 45+)

Mammogram (Women 40+)

EGD

Sleep study (Sleep trouble)

Prostate exam (Men 50+)

Stress test

Eye exam (Annual)

HgbA1c (Diabetics)

AAA Screen (Men Smokers 65+)

CT Lung (Smokers +50)

Alcohol Use Screening

PHQ9 (Annual Depression)

PSA (Men 50+)

Flu Vaccine

Shingles Vaccine

Pneumococcal Vaccine

Dementia screening

Other testing

Consent, Privacy Agreement & Disclosures

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our office staff or the doctor. 1) As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. 2) Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We accept all forms of payment. 3) Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctors. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. 4) We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible. 5) If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service. 6) All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered. 7) You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied. 8) Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to the office. 9) Patients who are 90 days past due on their balance may be sent to collections, unless a payment plan has been put into place 10) Our preferred method of payment is cash or credit card. There is a service fee of $30.00 for all returned checks. Your insurance company does not cover these fees. 11) In fairness to all of our patients, we understand that emergencies occur, but repeated no shows or cancellations with less than 24 hours' notice will result in a fee of $30.00. 12) Patients who come to the office fifteen minutes later than scheduled appointments might be asked to reschedule. Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However such a revocation will not be retroactive.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law. We may obtain your prescription history in order to ensure you are being prescribed medication that will not conflict with others you may already have received or are receiving by other providers. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment. We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers’ Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.
Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By registering below, I have read and understood all of the above. Additionally, I authorize Canyon West Medical to contact me at the phone number and/or e-mail listed above with regards to appointments and medical communications. I understand that two no shows/cancellations, non-compliance with treatment regimen may result in my termination of care. I authorize CanyonWest Medical to request medical records from other medical providers/pharmacies as needed with regards to my medical care.

Advanced Directive Planning

In the event of serious medical illness, have you designated any individuals to make decisions for you? If yes please list the name and phone number of your decision maker

- [ ] I do have an advanced directive and will provide it
- [ ] I DONT have an advanced directive and am not interested in making one now
- [ ] I DONT have an advanced directive but would like a free form provided to me to designate my wishes

In the event that I am incapacitated and have not yet established an advanced directive, would you like all life saving measures be taken? For example, breathing machine/ventilator, rescue CPR, just made comfortable?

*** If you have questions about this section, please let your doctor know to further explain the different options during your meeting**

Signature

Today's Date