Dear Valued Patient/POA,

Thank you for allowing Mobile Valley Physicians to participate in your medical care as your Primary Care and/or Podiatry Provider.

To Start The Enrollment Process, We Will Need:

- **The attached registration form completed and signed,**
- **A copy of your most current insurance card,**
- **A complete list of your current medications,**
- **Name and phone number of your current PCP so that we can request medical records, if necessary.**

If you need assistance with completing the New Patient Registration Form, or have questions regarding our podiatry services, please don't hesitant to contact our office to speak with one of intake coordinators.

Once the registration is received by our office we will verify insurance, and contact you (or your power of attorney), to go over coverage and schedule an appointment.

Note: We try to process all new patients within 72 hours, and have them seen within five (5) business days. However delays can occur if our intake office needs more information, or your insurance requires a one-time prior-authorization. That said, if you have a serious concern and need to be seen quickly, please let our office know so we accommodate you as best we can.

If you have any questions please feel free to contact our office.

Sincerely,
Mobile Valley Physicians, LLC

Email: intake@mobilevalleyphysicians.com
Phone: 480-589-2890
Fax: 480-436-6599

☐ **Primary Care**

Podiatry ☐

Last Name:____________________ **First Name:**____________________ **SSN:**______________

Nickname (if any)**:**_____________ **DOB:**_______________ ☐**Married** ☐**Single** ☐**Divorced** ☐**Widowed**

Address:____

Race (*leave blank to decline*): ☐ **American Indian/Alaska Native** ☐ **Black/African American** ☐ **Asian**
☐ **Hawaiian/Pac. Islander** ☐ **Caucasian** ☐ **Other**

Ethnicity *(leave blank to decline)*: ☐**Hispanic/Latino** ☐ **Not Hispanic/Latino**

Home Phone:___________________________ **Cell Phone:**___________________________

Email:_______________________________ **Fax Number:**__________________________

Preferred Contact: **Home Phone** **Cell Phone** **Text Message** **Email**

INSURANCE INFORMATION

Primary Policyholder Information

Medicare Insurance

Medicare #:_________________________
Policyholder:________________________
Policyholder DOB:____________________
Policyholder SSN:____________________

Secondary Insurance

Insurance Name:_____________________
Policy #:___________________________
Group #:___________________________
Policyholder:________________________

FINANCIAL INFORMATION

Name:_____________________ Relationship:_______
Address:_____________________________________
City:________________ State:______ Zip:________
Home Phone:____________ Cell Phone:____________

EMERGENCY CONTACT INFORMATION

Medical Power of Attorney:______________________
Relationship:___________ Phone:_________________
Emergency Contact:____________________________
Relationship:___________ Phone:_________________

CURRENT PHYSICIANS/SPECIALISTS

	Name	Phone
Primary Care		
Cardiology		
Pulmonology		
Nephrologist		
Urologist		
Psychiatrist		
Other		

HOW DID YOU HEAR ABOUT MVP:

PAST MEDICAL HISTORY

Last Name:______________________ First:________________________ DOB:________________

Please check ALL boxes that apply.

IMMUNE SYSTEM
- ☐ Seasonal Allergies
- ☐ Low Immune System
- ☐ Other__________________

BLOOD DISORDERS
- ☐ Hemolytic Anemia
- ☐ Iron Deficiency Anemia
- ☐ Other__________________

CANCERS
- ☐ Bone Cancer
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Melanoma
- ☐ Renal Carcinoma
- ☐ Skin Cancer
- ☐ Thyroid Cancer
- ☐ Other__________________

CARDIAC
- ☐ Blood Clot
- ☐ Heart Attack (MI)
- ☐ Heart Failure (HF)
- ☐ Heart Valve Disease
- ☐ High Blood Pressure (HTN)
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Irregular Heart Beat (Tachycardia/Bradycardia)
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Atrial Flutter
- ☐ Peripheral Vascular Disease
- ☐ Coronary Artery Disease (CAD)
- ☐ Other__________________

ENDOCRINE/HORMONE
- ☐ Diabetes, Type I
- ☐ Diabetes, Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other__________________

GASTROINTESTINAL
- ☐ Cirrhosis (liver)
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Gallbladder Disease
- ☐ Hepatitis
  Type__________________
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Reflux (GERD)
- ☐ Stomach Ulcer
- ☐ Other__________________

KIDNEY/URINARY TRACT
- ☐ Acute Renal Failure
- ☐ Chronic Renal Failure
- ☐ Kidney Stones
- ☐ Urinary Reflux
- ☐ Other__________________

LUNGS/PULMONOLOGY
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Bronchitis
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Pulmonary Edema/Effusion
- ☐ Emphysema
- ☐ Other__________________

MENTAL HEALTH HISTORY
- ☐ Anxiety
- ☐ Post Traumatic Stress Disorder
- ☐ ADD
- ☐ Obsessive-Compulsive
- ☐ Schizophrenia
- ☐ Bipolar
- ☐ Depression
- ☐ Substance-Related Addiction
- ☐ Other__________________

MUSCLE/BONE/TISSUE
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Other__________________

NEUROLOGY
- ☐ Alzheimer's Disease
- ☐ Stroke
- ☐ Dementia
- ☐ Headaches
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Traumatic Brain Injury (TBI)
- ☐ Multiple Sclerosis
- ☐ Other__________________

SKIN
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other__________________

OTHER
- ☐ Glaucoma
- ☐ Sleep Apnea
- ☐ Other__________________

ADDITIONAL HEALTH HISTORY TO NOTE

HOSPITALIZATION
Hospital Name:__________________

Reason:__________________

Date:__________________

PAST MEDICAL HISTORY

Last Name:____________________ First:______________________ DOB:________________

Please check ALL boxes that apply.

ADVANCED DIRECTIVES

Living Will
☐ Yes On File ☐ None

DNR
☐ Yes On File ☐ No

Organ Donation
☐ Yes On File ☐ No

TOBACCO/ALCOHOL

Tobacco
☐ Nonsmoker
☐ Current Use
☐ Cigarettes:____ /day
____ years smoked
☐ Cigars:____ /day
____ years smoked
☐ Past Use

Alcohol
☐ Non-Drinker
☐ Current Alcoholic
☐ Past History of Alcoholism
☐ Current Drinker
☐ Frequency
☐ Rare ☐ Social ☐ Regular
_______Times/Week

SURGICAL HISTORY (WITH YEARS)

____

____

____

FAMILY HISTORY

MOTHER:____

FATHER:____

MEDICATIONS	DOSAGE

KNOWN ALLERGIES:____

____

CONSENT TO TREATMENT & MEDICAL INFORMATION RELEASE

Patient Name:____ **DOB:**____________________

Authorizations

I authorize ***Mobile Valley Physicians (MVP)*** to provide treatment, services, and procedures which may include, but are not limited to: labs, imaging consults, medical and surgical treatments or procedures under the instructions of MVP providers. I understand this consent will remain valid as long as I am enrolled with MVP. I understand by signing this consent form, I am authorizing any member of the MVP clinical team and my insurance payer to access my information and records, as needed . I request that payment of authorized Medicare benefits be made to Mobile Valley Physicians. I acknowledge that I have read and/or received a copy of Mobile Valley Physicians' Patient Notice of Privacy Practices effective June 20th, 2017.

By signing below, I (the Patient or Legal Representative), have read and agree to the conditions outlined in MVP's Consent to Treatment Agreement and authorize MVP to proceed with services.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I request that the any requested records be sent to:

Mobile Valley Physicians
Phone: 480-589-2890 Fax: 480-436-6599

Purpose of Release

- ☐ Appointment/Continuation of Care
- ☐ Changing Physician(s)
- ☐ Other:________________________

Information to be Released

- ☐ Demographics Sheet
- ☐ Office Notes/H&P
- ☐ Laboratory Tests
- ☐ X-Rays/Scans

I authorize the release of photocopies of the above-noted medical records in the possession or control of Mobile Valley Physicians, its employees and/or agents. I understand that the information in my health record may include information relating to behavioral, mental, and/or physical conditions/services in which I have received.

Participation with Health Current: MVP is enrolled with Health Current, Arizona's Health Information Exchange (HIE)**,** that allows participating providers, first responders, hospitals, labs, community behavioral health and physical health providers, post-acute cares, etc. to securely share patient information and records.

HIE Disclaimer: Patients have the right to request a copy of their health information that is available through Health Current, Arizona's health information exchange (HIE). Patients also have a right to request a list of the persons who have accessed their health information through the HIE in the last three years. If you want to request any of this information, please complete and return this form to your healthcare provider. You will receive a response to the request within 30 days. Please note, Health Current may https://healthcurrent.org/ only send data to an address within the United States of America or its territories. If you are filling out this form for another person, the references to "I" and "my" in this form refer to that other person.

Opt Out: By initialing here, I do **not** want any of my information shared through Health Current_______

I have given my consent freely and without coercion. I understand I may revoke this authorization at any time providing I notify Mobile Valley Physicians in writing. I understand that the revocation will not apply to information that has already been released in response to this signed authorization. I understand that a photocopy/ facsimile of this authorization is considered acceptable in lieu of the original.

Signature:____ **Date:**____________________

Printed Name:_______________________________________ **Relationship:**________________

CHRONIC CARE MANAGEMENT PROGRAM

Mobile Valley Physicians (MVP) participates in the Chronic Care Management Program (CCM). This is available to all **Medicare Beneficiaries** with two or more chronic conditions. This program will provide you with a care coordinator who will work closely with all the parties involved to ensure you receive the highest level of care possible. We will work to reduce hospitalizations/associated costs and eliminate any gaps in care. By participating in this program, you are allowing the MVP CCM Team to monitor your conditions, provide care oversight and update the medical provider as needed should there by any changes of condition. While Medicare does cover the CCM Program, if you don't have a supplemental/secondary insurance, you may be responsible for a co-pay for the service. We will submit a claim to Medicare once we have provided 20 minutes of non-face-to-face care per month. Only one provider can bill Medicare for this service, please notify MVP if there is another provider that is providing you with this service. You can opt-out of the CCM Program at anytime with a verbal notice. By signing below, you are agreeing to enroll in the Chronic Care Management Program, giving MVP permission to bill Medicare for the service provided.

Patient Name:____

Patient/MPOA Signature:_________________________________ **Date:**________________

This completed form can be emailed to ccm@mobilevalleyphysicians.com

If you choose to opt-out, please initial here: x___________

Mobile Valley Physicians, LLC
21410 N 19th Ave, Suite 126 Phoenix AZ 85027
Email: intake@mobilevalleyphysicians.com
Phone: 480-589-2890
Fax: 480-436-6599

PATIENT NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments

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

If you have any questions about this notice or if you need more information, please contact:

Mobile Valley Physicians, LLC
Attn: Office Manager
Phone: (480) 589-2890
Email: mvp1@mobilevalleyphysicians.com
21410 N. 19th Ave Suite 126 Phoenix, AZ 85027

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at **Mobile Valley Physicians.** We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your healthcare.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- **Treatment.** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and under taking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors**. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research.** We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst **Mobile Valley Physicians** providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuit sand Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
- **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**
- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your health care provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
- **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We may disclose your PHI as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
- **Receive Notice of a Breach.**You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
- **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.
- **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by contacting **Mobile Valley Physicians at 480-589-2890.**

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the **Mobile Valley Physicians, LLC**, Privacy Officer, at the address listed at the beginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Humans Services, 200 Independence Ave., S.W., Washington, D.C.20201. Call(202)619-0257(or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/,for more information. **You will not be penalized for filing a complaint.**

Notice Effective 6/20/2017