Quality of Life Medical Centers
5350 E. Erickson Drive
5390 E. Erickson Drive
Tucson, Arizona 85712
(520) 733-2250 phone
(520) 733-2270 fax

Dear Patient:

Welcome to Quality of Life Medical Center (QLMC). We would like to welcome you to our practice and to make your visit with us as comfortable as possible. We would like to take this opportunity to answer some questions frequently asked by new patients.

CLINIC HOURS: Monday - Friday 8:00am to 5:00pm

APPOINTMENT POLICY: Due to the high demand for appointments, all appointments must be cancelled at least 24 hours in advance. We reserve the right to add a $25 charge to your account for missed appointments or those cancelled less than 24 hours in advance. As a reminder, we ask that all patients arrive at least 30 minutes before their scheduled appointment time so we can review all documents.

AUTOMATIC REMINDERS: Courtesy Reminders are done through an automated system. You will receive an email or text message 3 days prior to your scheduled appointment. Follow-up messages and phone calls will be done until your appointment has been confirmed. If you need to cancel your appointment please contact the office.

ONLINE PORTAL: We have an online portal where you can view, download or forward your health information to other providers. You can also view messages sent and received, send a message to a staff member or your doctor. You can request an appointment or a medication refill. You can also view upcoming and past appointments, update your patient health record, and view billing statements.

You will find the following forms in your New Patient package. Please have them filled out and signed prior to your first visit along with your picture ID and insurance card. We will also be obtaining a webcam photo for our records. We are unable to see you without proper identification.

- **PATIENT DEMOGRAPHICS:** Include all of your current personal and insurance information.
- **PATIENT RESPONSIBILITY:** States that it is your responsibility, as a patient, to know exactly what type of insurance coverage you have and what labs you are able to use should the physician order labs. You will be financially responsible for any services received if your insurance company refuses to pay. Please check your insurance benefits and coverage prior to your appointment. If your insurance company requires a referral or insurance authorization for your appointment or procedure, please make these arrangements prior to your appointment.

  As a new patient, you have been scheduled for a comprehensive evaluation. If you have medical records that may be pertinent to your present health condition, please bring them to your appointment or mail them to the clinic prior to your appointment. Pertinent medical records may include lab results, x-rays, MRI's, progress notes and other diagnostics.

TO SUMMARIZE YOUR FIRST VISIT, PLEASE BRING THE FOLLOWING ITEMS:

a. The enclosed forms completed the best you can
b. Written list of your medications & dosage, supplements, vitamins, etc.
c. A current insurance card (Please verify insurance coverage prior to your appointment)
d. Driver's license or some form of Photo ID

You will need to arrive **30 minutes early for a new patient appointment** so the front desk can process all of your information.

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NEW PATIENT INFORMATION SHEET

CONSULTATION FOR: ☐ **PRIMARY CARE**
☐ **INJECTION THERAPY** ☐ **NUTRITION/HEALTH** ☐ **SPORTS MEDICINE** ☐ **HORMONES** ☐ **SUBOXONE** ☐ **Pain Management**

PATIENT INFORMATION

Name: (First) ______________ (MI): ____ (Last): ______________
Date of Birth: ______________ Age: ________ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ W ☐ D ☐ S
Address: (Street) ______________
(City, State & Zip): ______________ SSN: ______________
Phone #: ______________ Employer: ______________ Occupation: ______________
Email Address: ______________ Referred By: ______________
Pharmacy: ______________ Pharmacy phone #: ______________

Primary Care Provider: ______________ **Phone #: _(____)** ______________

RESPONSIBLE PARTY OR SPOUSE INFORMATION

Name: ______________ Relationship to Patient: ______________
Address: (Street) ______________
(City, State & Zip): ______________
Phone #: ______________ Soc. Sec.: ______________ Driver License: ______________
Work #: ______________ Employer: ______________

INSURANCE INFORMATION *(Primary)*

Insurance Co. ______________ Phone: ______________
I.D. #: ______________ Group #: ______________
Insured's Name: ______________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent
Insured's Employer: ______________ Phone: ______________
Date of Birth: ______________ Sex: ☐ M ☐ F

If the patient is covered by another policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process our claim more quickly. Thank You!

INSURANCE INFORMATION *(Secondary)*

Insurance Co. ______________ Phone: ______________
I.D. #:: ______________ Group #: ______________
Insured's Name: ______________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Dependent
Insured's Employer: ______________ Phone: ______________
Date of Birth: ______________ Sex: ☐ M ☐ F

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize my physician to release any information acquired in the course of my treatment to process insurance issues including prior authorization.

Signature: ______________ Date: ______________

Please let us know how you heard about us: ☐ Family/Friend ☐ Radio ☐ Internet ☐ Newspaper

Event: ______________ Other: ______________

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PERSONAL HEALTH INFORMATION

NAME: ______________________________ DATE: ______________

1. **DO YOU HAVE ANY DRUG ALLERGIES?** ☐ NO ☐ YES (Explain)______________________
2. **PAST MEDICAL HISTORY:** Briefly Explain and date any medical conditions you have had or currently have

☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________

3. **OPERATIONS:** Have you had any surgeries? ☐ YES (if Yes, add year) ☐ NO

_____ Appendectomy _____ Hysterectomy: Full/Partial (if so, reason__________________)
_____ Gall Bladder _____ Joint Replacement _____Ovaries Removed
_____ OTHER (explain) ______________________________

- Do You Smoke? ☐ YES ☐ NO **If Yes, how many per day?** ______________
- Are you a former smoker? ☐ YES ☐ NO **If Yes, when did you quit?**
- Do you consume alcohol? ☐ YES ☐ NO **If yes, how many per day/week?** ______________
- Recreational Drug Use? ☐ YES ☐ NO **If yes, explain?**______________
- Exercise? ☐ YES ☐ NO **If yes, how often a week?** ______________
- Recent Hospitalization? ☐ YES ☐ NO **If yes, when and for what?** ______________
- Serious Injuries? ☐ YES ☐ NO **If yes, explain?**______________

4. **FAMILY HISTORY:**

CONDITIONS	**MOTHER** LIVING ☐ Yes ☐ No	**FATHER** LIVING ☐ Yes ☐ No	**SIBLING** LIVING ☐ Yes ☐ No
Heart Disease	☐	☐	☐
Respiratory Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Diabetes	☐	☐	☐
Blood Problems	☐	☐	☐
Asthma	☐	☐	☐
Stroke	☐	☐	☐
Mental Illness	☐	☐	☐
Other(explain)______________	☐	☐	☐

GYN HISTORY: Number of Pregnancies _______ Number of Children _______ Birth Control Method______________
Last Pap Test ______________ History of Abnormal Pap: YES / NO Last Mammogram ______________

HEALTH CARE MAINTENANCE: When was your last? Physical Exam _______ Blood Work _______ Tetanus ______

Hepatitis B. ________ Pneumovax _______Colonoscopy __________ DEXA ___________ PSA ___________

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CURRENT MEDICATION LIST

NAME: ______________________________________ DATE: ________________

☐ Check here if NOT on any medications or supplements

Please list below, your current medications including over the counter and herbal medications.

MEDICATION / SUPPLIMENT *Example: Lisinopril*	DOSAGE *Example: 25mg*	QTY *Per month*	DIRECTIONS *ex: 1 tablet once a day*

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CONSENT TO TREAT

The information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of Quality of Life Medical Center LLC to administer such procedures and treatment, as they deem necessary. The doctors have implied no guarantee of a cure.

Patient Signature: ______________________________ Date: ________________

CONSENT TO TREAT MINOR CHILD

The information I have given this office pertaining to ____________________is truthful and complete to the best of my knowledge. I authorize the doctors and staff of Quality of Life Medical Center LLC to administer such procedures and treatment (s), as they deem necessary for my child/ward in my legal custody. The doctors have implied no guarantee of a cure.

Parent or Guardian Signature: ______________________________ Date: ________________

PERMISSION TO RELEASE INFORMATION

I, ______________________________ hereby give my consent to release information to:
Name: ________________________ Relationship:______________ Phone:____________

ADDITIONAL CONTACTS:
Name: ________________________ Relationship:______________ Phone:____________
Name: ________________________ Relationship:______________ Phone:____________

CHECK ALL THAT APPLY:
_____ Contact in case of an emergency _____ Pick up referrals, prescriptions, or samples
_____ Leave message with ________________________ Phone: ____________________

PLEASE LIST ANY INFORMATION YOU WOULD NOT WISH TO BE RELEASED AND TO WHOM:

____

____

OK TO LEAVE MESSAGES ON:

Home phone: ______________________________ Mobile Phone: __________________
Work Voice Mail: ___________________________ Other: ______________________

This form will be kept in your medical file until you notify us of any changes you would like us to make

Signature: ______________________________________ Date: ________________

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NOTICE TO PATIENTS

State law, A.R.S. 32-1401(25)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. I support this law, because it helps patients make reasoned financial decision concerning their medical care.

In compliance with the requirements of this law, you are being advised that, John W. McGettigan, M.D. has a direct financial interest in the diagnostic or treatment agency or in non-routine goods or services named below. Further as indicated below, goods and services that I have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

Quality of Life Medical Centers' Lab, and ICON Labs

ARE THESE AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS?

YES

IF YES, WHICH ONES?

Sonora Quest Laboratory, LabCorp, TEN Healthcare, Vibrant America and CCL Labs

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. I will keep a signed original in your patient file; you will receive a copy.

ACKNOWLEDGEMENT

(I/We) read this Notice to Patients, and (I/We) understand the disclosures that it contains.

Dated this ____________________ Day of ______________ 20__________

____

Signature of Patient or Guardian

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AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

I HEREBY AUTHORIZE

☐ Quality of Life ☐ Facilities / Doctors Name: ______________________________

Address: ______________________________ City/State: ________________ Zip: __________

Phone: (_____) ________ - ________ Fax: (_____) ________ - ________

TO RELEASE

☐ **$25.00** for Complete Chart Record: *(If going to patient and to be paid at time of request).*

$0.00 if requested to be delivered to Physicians Office

☐ Chart Notes: ☐ ALL ☐ Specify: ______________________________

☐ Labs/Reports: ☐ ALL ☐ Specify: ______________________________

☐ Other: ☐ ALL ☐ Specify: ______________________________

FROM THE HEALTH RECORDS OF

Patient Name: ______________________________ D.O.B: ________________

Social Security: ________ - ________ - ________ Daytime Phone: (_____) ________ - ________

Are you authorizing the release of your own medical records? ☐ YES ☐ NO

If not, what is the name and relationship to the patient?

Name: ______________________________ Relationship: ________________

TO BE RELEASED TO

☐ Quality of Life ☐ Self *(please indicate mailing address below)*

☐ Facilities / Doctors Name: ______________________________

Address: ______________________________ City/State: ________________ Zip: __________

Phone No.: (_______) __________ - __________ Fax: (_______) __________ - __________

FOR THE PURPOSE OF:

☐ Concurrent Care ☐ Transfer of Care ☐ At My Request ☐ Other: ________________

MY RIGHTS

I understand that unless revoked, this authorization is valid for 1 year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent disclosure has already been made in accordance with this document. Also, I understand that I do not have to sign an authorization as a condition for receiving treatment or healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorized form to take part in a research study or to receive health care when the purpose is to create health care information for a 3rd party.

Unless specifically excluded, this authorization includes release of specially, protective information requiring my explicit authorization or release. This includes referrals, diagnosis and treatment information related to: (check the accompanying box(s) below to EXCLUDE the information authorization):

☐ Substance Abuse ☐ Mental Health Condition ☐ Sexually Transmitted Diseases ☐ HIV/AIDS ☐ Genetic Testing

I understand that once healthcare information is disclosed, the person or organization that receives it, may re-disclose it, and that it may no longer be protected by privacy law.

Patient Signature: ______________________________ Date: ________________

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Representative/Guardian Signature: ______________________ Date: ______________

FINANCIAL POLICY

Our goal is to offer our patients quality health care services at affordable rates. You can help us by providing us accurate, up-to-date information about your third-party health care payers each time you visit the clinic. Please bring your current ID and insurance card to each visit. Insurance Carriers are often changing ID numbers, scope of covered services and pre-authorization requirements. Maintaining accurate information on your account helps reduce the administrative costs of the Clinic.

- It is the patient's responsibility to verify that we are participants (in network) with his/her insurance plan.
- The patient is responsible for co-pays, coinsurances and any other portion of the bill not covered by their insurance plan.
- All elective procedures not covered by insurance must be paid in advance or on the day of service, unless payment arrangements have been agreed upon.
- Any unpaid balances on your account are due within 30 days of service. Please contact us to make payment arrangements if you are unable to pay the remaining balance in full.
- We reserve the right to add a $25 charge to your account for missed appointments or those cancelled less than 24 hours in advance.

STATEMENTS: Payments should be mailed to 5390 E. Erickson Dr., Tucson AZ, 85712, attention "Billing Department". If you have any questions please call 520.777.3819.
MEDICARE: You will be responsible for the "Patient Responsibility" portion of the fee, as outlined on your Medicare Explanation of Benefits. You are also responsible for any services deemed "non-covered" by Medicare. We will also bill secondary insurance for services as a courtesy to our patients.
INSURANCE: QLMC will submit claims to 'Primary' insurance plans according to the terms of the individual agreements with the insurance company when they exist. We will also bill secondary insurances as a courtesy to our patients. However, if payment is not made by the secondary insurance within 60 days of submission, you will be responsible for any balance due.

PLEASE NOTE:* *you will be responsible for non-covered services per your insurance contract.

PAYMENT ARRANGEMENTS AND COLLECTION: It is your responsibility to make payment for services rendered.
If you are unable to make payment in full, it is important that you contact our billing office to make payment arrangements on your account. Anyone who is making regular payments on their accounts via a "payment agreement" will continue to receive all services provided by the Clinic.

If NO payment is received, or if payments are untimely, a collection agency may be utilized. Only emergent care will be provided once your account is sent to the collection agency and your account remains unpaid. Once your account is paid in full, you again will have access to all of the services provided by the clinic as long as you continue to make your co-payments at the time of service and/or pay the entire cost of your self-pay appointment at the time of service.

***PLEASE NOTE:* Patients, who have not made regular payments in three (3) months, and who have not contacted our Billing Department to make payment arrangements, will be dismissed from the practice.**

SELF-PAYMENT ACCOUNTS: Self-pay account payments are due at the time of services. Self-pay patients will be asked to pay for a new patient visit, which ranges from $105 to $230, depending on the time and extent of the appointment. Discuss the fee at time of appointment scheduling. Payment is due at the time of appointment. Any additional services provided, as a courtesy, will be billed to you. It is the patient's responsibility to contact our Billing Department if unable to pay the account in full.

I have read and understand the financial policy of Quality of Life Medical Center. I understand that I am personally responsible and liable for payment of any balance on my account.

Patient Signature: ______________________________ Date: ______________

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Rep. /Guardian Signature: ______________________________ Date: ________________

RESEARCH PARTICIPANT - DATABASE CONSENT FORM

If you volunteer to participate in the clinical research database some of the information you have provided on this form such as name, contact information, address, date of birth, gender, medical diagnoses, and medications will be entered into a confidential, limited access, and password protected electronic database for the exclusive purpose of identifying potential clinical research subjects. This database is not used or accessed by any departments of QLMC other than the clinical research department. Private Healthcare Information about your care also is present in an electronic medical record system at QLMC for exclusive use of the Clinical Practice Department. This information is separate from and not accessed by the Clinical Research Department except in the case you sign a formal release of medical records to the research department as is usually required if you screen for one of our clinical research studies. Your information will not be shared, transferred, or sold without your express consent and this current consent does not grant us such permissions. By signing this consent you grant permission for the clinical research department to **contact** you from time to time regarding clinical trials we are conducting to assess your qualification for and interest in participating in a clinical research trial at QLMC. The contact may at times also be in the form of an email newsletter if this contact method was provided by you. If you receive such an email newsletter you will be offered an "opt out" if you no longer wish to receive the clinical research newsletter. You may also receive a written letter, postcard, flyer, and/or phone call. Your signature below attests that you have read and understood the above information, have had the opportunity to ask questions and these have been answered, and you freely choose to sign today. You may remove your information from the clinical research database anytime by verbally or in writing making this request to the clinical research department.

STATEMENT OF CONSENT

☐ **NO**, I do not give my consent to have my medical and/or personal information accessed for research purpose.

☐ I, ____ (PLEASE PRINT) hereby **CONSENT** to being contacted in future regarding potential involvement in future research at Quality of Life Medical Center.

Participant signature______________________________ Date ________________

Participant printed name: ____________________________

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HIPAA NOTICE OF PRIVACY PRACTICES POLICY

Effective as of April, 14 2003
Revised March 26, 2013

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to your, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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, 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 a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protect health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations may include: 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, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician's or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

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The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information complied in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to your or to another person, or information that was obtained under a promise of confidentiality.

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 healthcare 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. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for 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.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to receive notice of breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

HIPPA COMPLIANCE OFFICER: Kim Moon

PHONE: 520-733-2250 ext. 183

EMAIL: kim@qlmc.com

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of this notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Patient Signature: ______________________________ Date: ________________

Rep./Guardian Signature: __________________________ Date: ________________