Grand Medical Associates

Doctor of Choice (circle one) **Dr. Uppal** **Dr. Majhail** **Dr. Sandhu**

Patient Name _____ Gender ○ Male ○ Female

Street address _____ Phone _____

City State Zip

Cell _____

Age_ _ _ _ Date of Birth _____ Social Security#_ _ _ _ _ _ _ _ _ _ _ _

Employer _____ Occupation _____ How Long_ _ _ _ _

Street Address _____ Phone _ _ _ _ _ _ _ _

City State Zip

Marital Status ○ Single ○ Married ○ Widow/er ○ Divorce ○ Separated

Email Address : _____

All No Show Appointments and Cancellations Less than 24 hours will be charges a $25.00 Fee.

Emergency Contact_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Relationship _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Street Address _____ Phone _____

City State Zip

Primary Insurance Company _

Street Address_ Phone _ _ _ _ _ _ _ _ _ _ _ _ _ _

City State Zip

ID# _____ Group# _____

Policy Holder's Name _____ Relationship to Patient _____ Date of Birth _____

Policy Holder's Employer Phone _____ SS# _____

Street Address _____

City State Zip

Other Insurance Company _____

Street Address _____ Phone _____

City State Zip

ID# _____ Group#_ _ _ _ _ _ _ _ _ _ _ _ _ _

Policy Holder's Name_ _ _ _ _ _ _ _ _ _ Relationship to Patient _____ Date of Birth _____

Policy Holder's Employer Phone _____ SS#_ _ _ _ _ _ _ _ _ _

Street Address _____

City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OIF BENEFITS

I authorize payments of medical benefits to the provider for services rendered or to be rendered in the future without obtaining my signature on each claim submitted and this signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERESTAND I AM RESPONSIBLE FOR ALL CHARGES . If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees . I have read and understand the *office* policy and procedures. **PLEASE NOTE THERE WILL BE A 30% COLLECTIONS FEE IF YOUR BALANCE IS TURNED OVER TO A COLLECTION AGENCY.**

_____ _____

Responsible Party Signature Date

Name:_____ Date:_____

GRAND MEDICAL ASSOCIATES

Please answer the following questions. It will help the doctor to know not only about your health, but also about your family and relatives.

What is your main medical problem and how long have you had it?_____

_____

_____

Family History: Any cancers that run in you immediate family (colon, breast, prostate, etc.)

_____

_____

Please circle any illnesses which you have had:

Diabetes	Glaucoma	Heart Trouble	Vein Trouble	Arthritis
Cancer	Asthma	Tuberculosis	Bleeding Tendencies	Thyroid
Pneumonia	Hepatitis	Kidney Disease	High Blood Pressure	Other
Stroke	Jaundice	Rheumatic Fever	Nervous Disorders/Seizures	

Previous Surgeries/Hospitalization/Prolonged Illnesses:

_____ _____

_____ _____

_____ _____

_____ _____

Previous Vaccinations (with approximate year administered)

Vaccination	Date	Vaccination	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to Medications:

Medication	Reaction	Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please continue to next page

Please name or identify medications currently taking or recently used:

MEDICATION	DOSAGE & FREQUENCY

Please continue to next page

GRAND MEDICAL ASSOCIATES

Grand Medical Associates office will bill your insurance company as a courtesy to you . However, be aware that "insurance " was designated to be used as a reimbursement for payment , not as a substitute for payment. This means that the patient is ultimately responsible.

If Grand Medical Associates office participates with your insurance carrier or holds a contract with your insurance carrier, you will only be responsible for any patient portions or non-covered services. If our office does not participate with your insurance carrier or hold a contract with your insurance you will be responsible for all charges.

I understand that it is my responsibility to contact my insurance company (NOT THE OFFICE'S) to verify that the physician I am seeing is a contracted provider with my insurance company, I understand that if the physician I am seeing is not a contracted provider with my insurance I am responsible for al charges not paid by my insurance company.

If your insurance company requires you to change your PCP when seeing a new physician , it is your responsibility to contact your insurance company and change your PCP to a physician in our office prior to your appointments. I understand that I am responsible for all charges not paid by the insurance company if the physician I am seeing is not the PCP listed with my insurance company.

If your insurance company does not remit payment to Grand Medical Associates within 60 days from the date of service, the balance will be due in full from you .

If you fail to make any payments for which you are deemed responsible, in a timely manner, upon such default and upon referral to a collection agency or attorney by the Health Center, you will be responsible for all costs of collecting any and all monies owed, including but not limited to court costs, collection agencies and/or attorney fees.

ASSIGNMENT OF BENEFIT:

I authorize payment of medical benefits to the names provided for professional services rendered .

RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process this claim (including alcohol or drug abuse, HIV-related or communicable disease information) .

SIGNATURE:_____ **DATE:**_____

(Patient or Parent if Minor)

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician ' s ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan .

- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient ' s prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Grand Medical Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Grand Medical Associates to enroll me in thee-Prescribe Program . I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Print Patient Name Patient DOB

_____ _____

Signature of Patient or Guardian Date

_____

Relationship to Patient

NOTICE OF PRIVACY PRACTICES

PATIENT MAY RECEIVE A COPY OF OUR PRIVACY PRACTICE UPON THE PATIENT'S REQUEST

(Patient may refuse to sign this agreement.)

Grand Medical Associates

This Healthcare Practice recognizes that every patient has the Right of Privacy concerning their personal health information . We make every effort to protect and preserve patient records in a manner that secures this information.

By signing the acknowledgement:

You are only confirming that you understand our PRIVACY PRACTICES .

You do not give up any of your rights and you may choose at some point in the future to provide more specific instructions for us to follow regarding your personal health information.

I UNDERSTAND OR I HAVE REQUESTED A COPY OF THIS OFFICE'S **NOTICE OF PRIVACY PRACTICES** :

Print your name here: _____

Sign your name here: _____

Fill in today's date here: _____

GRAND MEDICAL ASSOCIATES

Amardeep Majhail, M.D.
Neena Uppal, M.D.
Pritpal Sandhu, M.D.

Joshua Kohl, PA
Taelyn Carrizales, PA
Danyelle Harbauer, PA
Nayla Mansoor, PA

AGREEMENT TO RECEIVE CHRONIC CARE AND CASE MANAGEMENT SERVICES

As of January 1, 2015, Medicare covers care management services provided by a physician per calendar month. Our physicians are dedicated to improving healthcare by closely managing your chronic conditions.

Your Care Team consists of Physician: Dr. _____and Care Manager:_____

I understand that my primary care physician, named above, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access or other non-face-to-face means **of communication.**
- The ability to get successive, routine appointments with my designated primary care physician or other members of **my care team.**
- **Care management of my chronic conditions, including timely scheduling of all recommended preventative care** services, medication reconciliation, and oversight of my medical management.
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my **choices and values.**
- Management of care as I move between and among health care providers and settings, including the following: Referrals to other health care providers, Follow-up after I visit the Emergency Department, Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility.)

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional. Medicare will only pay one physician or health care **professional to furnish me chronic care management services within a given calendar month.**

I understand these chronic care management services are subject to usual Medicare deductible and coinsurance.

I hereby indicate by singing this agreement that Dr. _____, is designated as my primary care physician for purposed of providing Medicare chronic management services to me and billing them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient Name(please print):_____DOB:_____

Patient or Guardian signature:_____Date:_____

Relationship to Patient if signed by guardian: _____

***(From time to time care team members may change, however we will always keep you informed and will transfer or forward patient information to new members of the team)**

GRAND MEDICAL ASSOCIATES

Wellness

Please take a few minutes to fill out this information so we may expedite the question portion and give complete attention to your wellness exam.

Personal Information

First Name	Last Name	Gender	DOB

Address	City	State	Zip

General Patient Information

In general, how would you rate your overall health?

☐Poor ☐Fair ☐Good ☐Very Good ☐Excellent

In the past 7 days, have you needed help from others to eat, dress, bathe, use the toilet, or do laundry?

☐Yes ☐No

Do you exercise or do moderate physical activity such as walking for at least ½ hour a day?

☐Yes ☐No

On a scale from 0 to 10 where 0 is none and 10 is the highest, what is your pain level today?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Where is the pain? _____

Living Will - Do you have a living will? ☐Yes ☐No

Do we have a copy of your living will on file? ☐Yes ☐No If no, please bring a copy so we can scan it into your record.

Decision Maker - Can we record the name & contact information of your Decision Maker in your record?

Name: _____ Relationship: _____ Phone Number: _____

Hearing – Do you use hearing aide?

☐Yes ☐No

Colon – When and where was your last colonoscopy?

Month _____ Year _____ Location _____

What were the results? ☐Normal ☐Polyps ☐Unknown

When is your next colon screening due?_____ **OR** ☐ Check box if no repeat is required.

Mammo – When and where was your last mammogram? Was it ☐ Normal OR ☐ Abnormal?

Month _____ Year _____ Location _____

DEXA – When and where was your last bone density/DEXA scan? Results?_____

Month _____ Year _____ Location _____

Eye – When and where was your last eye exam?

Month _____ Year _____ Location _____

Foot – When and where was your last foot exam?

Month _____ Year _____ Location _____

Incontinence – Do you have urinary incontinence? ☐Yes ☐No

Falls – Have you had any falls within the past year? ☐Yes ☐No

If you fell, how many times? _____ Did you injure yourself? _____

Immunizations – When and where was your last immunization received?

Flu vaccine:

Month _____ Year _____ Location _____

Pneumonia 23:

Month _____ Year _____ Location _____

Immunizations (cont.) – When and where was your last immunization received?

Prevnar 13:
Month _____ Year _____ Location _____

Zostavax:
Month _____ Year _____ Location _____

Shingrix Part 1:
Month _____ Year _____ Location _____

Shingrix Part 2:
Month _____ Year _____ Location _____

Covid-19 Vaccine Part 1:
Month_____ Year_____ Location_____

Covid-19 Vaccine Part 2:
Month_____ Year_____ Location_____

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

☐No ☐Yes If yes, how often did you have a drink and how many drinks do you typically have when drinking? _____

How often did you have 6 or more drinks on one occasion? _____

Nicotine – Do you use nicotine products?

☐No, I have never used nicotine

☐Former nicotine user. When did you quit? _____

☐Yes, I am a current nicotine user. ☐smoke ☐chew ☐vape ☐patch
How often do you use nicotine and how much?_____When did you start?_____

CBD/THC – Do you use CBD or THC products?

☐No, I have never used CBD/THC

☐Former CBD/THC user. When did you quit? _____

☐Yes, I am a current CBD/THC user. ☐smoke ☐vape ☐topical ☐oral
How often do you use CBD/THC and how much?_____When did you start?_____

Depression Screening:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things?	o	o	o	o
2. Feeling down, depressed or hopeless?	o	o	o	o
3. Trouble falling or staying asleep or sleeping too much?	o	o	o	o
4. Feeling tired or having little energy?	o	o	o	o
5. Poor appetite or overeating?	o	o	o	o
6. Feeling bad about yourself OR that you are a failure OR have let yourself or your family down?	o	o	o	o
7. Trouble concentrating on things such as reading newspapers or watching television?	o	o	o	o
8. Moving or speaking so slowly that other people have noticed or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?	o	o	o	o
9. Thoughts that you would be better off dead or of hurting yourself in some way?	o	o	o	o

Thank you for taking the time to fill out this information. It is greatly appreciated.

_____ _____

Signature Date

GRAND MEDICAL ASSOCIATES

Amardeep Majhail, M.D.
Neena Uppal, M.D.
Pritpal Sandhu, M.D.

Joshua Kohl, PA
Taelyn Carrizales, PA
Danyelle Harbauer, PA
Nayla Mansoor, PA

Health Information Exchange Consent Form

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

Print Patient Name _____ Patient DOB _____

Signature of Patient or Guardian _____ Date _____

Relationship to Patient _____

14674 W. Mountain View Blvd. Ste 200
Surprise, Arizona 85374

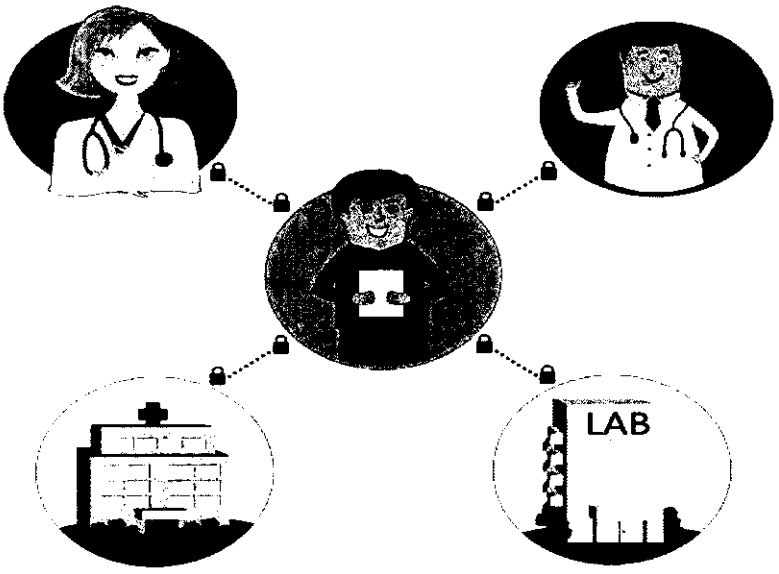
Tel. 623-544-6860
Fax 623-544-6861

grandmedicalassociates.com

healthcurrent

What You Need to Know About Secure Sharing of Your Health Information

Doctors and hospitals can give you better healthcare by sharing your health information electronically. This is very important in emergencies. This sharing is done electronically through Health Current, Arizona's health information exchange (HIE).



Many doctors' offices and hospitals are switching from paper medical records to electronic medical records. During your most recent doctor's visit, you may have noticed your doctor using a laptop or tablet to type in your health information. Now that your health information is stored safely in a computer, it can be shared more easily among your doctors' offices, hospitals, labs, and radiology centers. Your health information is shared securely through the HIE.

Secure sharing of your health information has many benefits:

- Better treatment in an emergency because your doctors will have information about your allergies and your previous problems.
- Prevention of errors and harmful drug interactions.
- Lower overall costs of healthcare by avoiding duplicate tests, procedures and prescriptions.

For details about how your health information will be shared and how it will be protected, please read the **Notice of Health Information Practices** you received at your doctor's office.

NOTE: If you do not want your health information shared through HIE, please ask your provider for an Opt Out Form. For more information, visit www.healthcurrent.org and click on the Patient Rights button.

healthcurrent

Summary of the Patient Rights Process for Healthcare Providers

Health Current, Arizona's health information exchange (HIE), makes patients' health information electronically available to participants. State and federal law give patients certain rights and protections concerning this information. This document describes the process for complying with these laws.

Implementing the Patient Notification Process and the Right to Opt Out

Healthcare providers who actively participate in the HIE are required to do the following:

1. Distribute the Notice of Health Information Practices (Notice) to patients. Obtain a signature from each patient acknowledging receipt of the Notice. This signature can be obtained on any form, including the healthcare provider's HIPAA Notice of Privacy Practices or conditions of admission or treatment form. The form must reference the healthcare provider's participation in the HIE and must state that the patient has received, read and understands the Notice. (See *FAQs for Healthcare Providers* for sample language.)

2. Provide the Opt Out Form to any patient who wants to opt out or the Opt Back In Form to change a previous opt out decision. A patient can opt out or opt back in at any time.

3. Provide the Health Information Request Form to any patient who wants to request a copy of his or her health information that is available through the HIE or who wants a list of persons who have accessed his or her health information through the HIE in the last three years.

Providers must complete the bottom section of the *Opt Out Form*, *Opt Back In Form* and *Health Information Request Form* before sending the forms through secure fax to Health Current at (602) 324-5596 or (520) 300-8364.

If a patient opts out of making some or all of his or her health information accessible through the HIE, then no one will have access to that information through the HIE, even in an emergency.

Implementing Consent or Emergency Access to Substance Abuse Treatment Information

Federal law (42 C.F.R. Part 2) gives special confidentiality protection for substance abuse treatment records from federally-assisted substance abuse treatment programs (Part 2 Data). Because a patient's substance abuse treatment information may be co-mingled with the patient's other health information from these programs, Health Current keeps all health information it receives from these healthcare providers separate from the rest of the patient's health information. A patient's health information from these participating healthcare providers is available through the HIE only if a patient gives written consent or in a medical emergency.

Healthcare providers may access Part 2 Data if a patient signs a Part 2 Consent Form. Healthcare providers also may access Part 2 Data without patient consent if the healthcare provider: (1) determines that access is necessary to meet a bona fide medical emergency; (2) determines that the patient's written

consent cannot be obtained; and (3) documents certain information. Health Current notifies the patient's federally-assisted substance abuse treatment program when the patient's Part 2 Data has been disclosed in a medical emergency. However, if a patient has opted out of the HIE, Part 2 Data may not be accessed through the HIE, even in a medical emergency.

Healthcare providers who access Part 2 Data through the HIE may not re-disclose it, unless expressly permitted by the patient's written consent or as otherwise permitted by law.

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing
You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.