Benson Healthcare - Patient Information Packet

Demographics

Name: _____ **Preferred Name:** _____
FIRST M.I. LAST

Sex: □ Male □ Female **Date of Birth:** _____ **Birth State:** _____

Social Security #: _____ **Status:** □ Married □ Single

Ethnicity: _____ **Race:** _____

Primary Phone: (_____)_____ Type: □ Home □ Work □ Mobile

Secondary Phone: (_____)_____ Type: □ Home □ Work □ Mobile

Email Address: _____

Mailing Address: Street Address: _____ Apt: _____

City: _____ State: _____ ZIP: _____

Permanent Address: Street Address: _____ Apt: _____
(If different from above)

City: _____ State: _____ ZIP: _____

Primary Care Provider: _____

Personal Contacts Please provide at least one Emergency Contact.

Name: _____ **Relationship**: _____

Phone: (_____)_____ This person is my Emergency Contact: □ Yes □ No

This person may do the following (check all that apply): □ Pick up referrals □ Pick up prescriptions/ medications

Name: _____ **Relationship**: _____

Phone: (_____)_____ This person is my Emergency Contact: □ Yes □ No

This person may do the following (check all that apply): □ Pick up referrals □ Pick up prescriptions/ medications

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Employment Information

Employment Status: □ Full-time □ Part-time □ Student – Full-time □ Student – Part-time

□ Self-employed □ Not employed □Active Military Duty □ Retired

Employer Name:_____ **Employer Phone:** (_____) _____

Employer Address: Street Address:_____ Suite: _____

City: _____ State: _____ ZIP: _____

Guarantor Information *Complete if individual financially responsible is anyone other than patient (e.g. patient is a minor).*

Name: _____ **Relationship to Patient:** _____
FIRST M.I. LAST

Sex: □ Male □ Female **Date of Birth:** _____ **Social Security #:** _____

Mailing Address: Street Address:_____ Apt: _____

City: _____ State: _____ ZIP: _____

Employer Name:_____ **Employer Phone:** (_____) _____

Employer Address: Street Address:_____ Suite: _____

City: _____ State: _____ ZIP: _____

Communication Preferences

Please identify your communication preferences. Benson Healthcare may use this information to provide you with timely notification regarding upcoming appointments, immunization and health exam due dates, and laboratory results. Your preferences indicated here will not affect how Benson Healthcare distributes billing statements.

□ I prefer that Benson Healthcare contact me via (check all that apply): □ Portal □ Mail □ Telephone

□ I prefer that Benson Healthcare not contact me to provide notifications.

Healthcare Directives: Healthcare Directives provide your healthcare providers with information about your preference of care related to life support issues (machines, drugs, & treatment) if you are unable to state your wishes at the time care is rendered due to catastrophic circumstances.

□ **I would** like to receive information at this time regarding Healthcare Directives such as living will and medical power of attorney authorizations.

□ **I would NOT** like to receive information at this time regarding Healthcare Directives such as living will and medical power of attorney authorizations.

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CONDITIONS OF TREATMENT
Benson HealthCare Primary Care Clinic

1. **Medical Consent:** The undersigned consents to receive comprehensive health services and medical treatment from Benson HealthCare including the provision of medical tests, procedures and treatments that are necessary or advisable for the medical evaluation and management of the patient's healthcare by any Benson HealthCare professional. The undersigned acknowledges that additional specific consent may be needed prior to performing any invasive procedure or a procedure that involves risk to the patient. The undersigned agrees to inform Benson HealthCare professionals of all medical history, medications and substances taken, and any changes in health. The undersigned agrees to allow Benson HealthCare to provide treatment or treatment options and maintain medical records regarding the patient.

2. **Release of Patient Information:** Demographic information, including patient name, age, address, sex, payer status, general condition and other similar information is collected by Benson HealthCare. This information is used for general business purposes of Benson HealthCare and its affiliates, as described in the Benson HealthCare Notice of Privacy Practices.

   Benson HealthCare also collects patient information of a clinical nature, including information relating to HIV, psychiatric, drug or alcohol treatment. Benson HealthCare may, subject to restrictions described in the Benson HealthCare Notice of Privacy Practices, disclose any information, including information relating to HIV, psychiatric, drug or alcohol treatment, for the provision of care, the advancement of medical science, education, research, the preservation of the Public health, accreditation, or in response to legal or statutory requirement(s).

3. **Assignment of Insurance and Similar Benefits:** In the event a patient is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, such benefits are hereby assigned to Benson Health Care for application to patient's bill. Patient is responsible for charges not covered by this assignment. The undersigned further understands that Benson HealthCare does not accept all assignments and that independent arrangement may need to be made for payment for services related to this visit. Patients eligible for Medicare hereby authorize Benson HealthCare to bill and collect from Medicare directly. Any charges not covered by Medicare or any supplementary insurance are the responsibility of patient. Benson HealthCare may disclose all or any part of patient's record pertaining to an episode of care, including information relating to HIV testing and treatment, psychiatric, alcohol and drug treatment records, to any person or corporation which is or may be liable under contract to Benson HealthCare or to patient or to a family member or employer of patient for all or part of Benson HealthCare's charge including, but not limited to, Benson HealthCare or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or patient's employer.

4. **Financial Agreement:** The undersigned agrees, whether signing as patient, parent of a minor child or legal guardian or conservator of patient, and whether or not undersigned is insured or is a member of a health maintenance organization, that in consideration of the services to be rendered to patient, undersigned is hereby obliged to pay the rates and charges Benson HealthCare has on file with the Arizona Department of Health Services. Should the account be referred to collection, the undersigned shall pay reasonable collection expenses, including attorney's fees.

5. **Methods of Contact:** The undersigned agrees, in order for Benson HealthCare to service Benson HealthCare's account or to collect any amounts the undersigned may owe, Benson HealthCare may contact the undersigned by telephone at any telephone number associated with the patient's account, including wireless telephone numbers, which could result in charges to the undersigned. Methods of contact may include text messages, using pre-recorded/artificial voice messages and/or use of any type of automatic telephone dialing system. This express authorization applies to any landline or cellular phone number the undersigned may acquire in the future. The undersigned also agrees to advise Benson HealthCare if the undersigned discontinues, transfers or otherwise changes the telephone number(s) provided to Benson HealthCare within five days of such change. The undersigned has read this disclosure and agrees that Benson HealthCare may contact the undersigned as described above.

The undersigned has read and understands the Conditions of Treatment, accepts its terms, and has received a copy of the Benson HealthCare Notice of Privacy Practices. This Conditions of Treatment may not be altered or amended. Any such changes will have no force or effect.

_____

Patient Name (Printed)

_____

Signature of Patient or Parent/Legal Guardian Date Time

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Benson Healthcare Insurance & Cancellation Policy

Thank you for choosing Benson Healthcare as your healthcare provider. Our mission is to provide exceptional healthcare with compassion. The information in this policy is important to ensure you are receiving quality healthcare while benefiting from Benson Healthcare and your health insurance.

Insurance: Benson Healthcare participates in most insurance plans, including Medicare. If you are not insured by a plan with which we contract, payment in full is expected at each visit. If you are insured by a plan with which we contract, but do not have an up-to-date medical insurance card, payment in full is required for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-covered services: Please be aware that your insurance may not cover every medical service. You must pay for these services in full at the time of visit.

Proof of insurance: All patients must complete our Patient Information form before seeing a Benson Healthcare provider. Benson Healthcare requires a copy of a government issued ID and up-to-date proof of medical insurance.

Claim submission: Benson Healthcare Care will submit your claims and assist you in any way reasonably possible to help get your claims paid. Your insurance company may need you to supply certain information directly to them; it is your responsibility to comply with their request. If your insurance company does not pay your claims in 45 days, the balance will automatically be billed to you. Your insurance benefit is a contract between you and your insurance company; Benson Healthcare is not party to that contract.

Coverage changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Nonpayment: Should your account become ninety (90) days delinquent, you will receive a letter advising you that your account needs to be paid within ten (10) days. Please be aware that if a balance remains unpaid, Benson Healthcare will refer your account to a collection agency. The patient or guarantor will be responsible for all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%. The contingency fees will be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

Minors: For all services rendered to minor patients, Benson Healthcare will rely on the Guarantor information provided unless payment is otherwise made.

Appointment Cancellation/No Show. When you schedule an appointment with Benson Healthcare, we set aside enough time to provide you with the highest quality care. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$25.00 fee**. If a **third** No Show or cancellation/reschedule without 24 hour notice should occur the patient may be **dismissed** from Benson Healthcare. Any **new patient** who fails to show for their initial visit may not be rescheduled.

Please note that this fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

We at Benson Healthcare understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

Benson Healthcare values your health and wellness and wants to ensure you receive the highest quality of care from our healthcare professionals. If you have questions or need further information regarding Benson Healthcare health services and policies, please ask a member of our team.

I,_____, have read and understand the Benson HealthCare Insurance & Cancellation Policy.
Name of Undersigned

I further understand that I may ask at any time for additional information regarding Benson HealthCare services and policies.

_____ _____
Signature of Patient or Patient Representative Date

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Patient Information Packet

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.

health current

BENSON PRIMARY CARE

Notice of Health Information Practices

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.

Patient Health Questionnaire (PHQ-9) Modified

Name:_____ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms in the past TWO WEEKS? For each symptom, put an "x" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half of Days	(3) Nearly Every Day
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, irritable, or hopeless?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Feeling tired, or having little energy?				
5. Poor appetite, weight loss, or overeating?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like schoolwork, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				
10. Do you feel safe at home?				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office Use Only: Severity Score:_____

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Allergies to Medications
Do not complete if you have a list of allergies with you.

Medication	Reaction

Medication List
Please list all medications you take daily including supplements.
Do not complete if you have a list of medications with you.

Medication	Dose	How Do You Take It?

Preferred Pharmacy

Pharmacy Name	Major Cross Street

MEDICAL HISTORY: Please circle all **current or past** medical problems or conditions.

Allergies	Depression	Liver Disease
Anemia	Diabetes	Meningitis
Anxiety	Emphysema	Nerve Muscle disease
Arthritis or Rheumatism	GERD (Heartburn)	Osteoporosis
Asthma	Glaucoma	Seizures
Blood Clots	Heart Attack	Sickle Cell
Blood Transfusion	Heart Disease	Sleep Apnea
Cancer	Heart Failure	Substance Abuse
Cataracts	Heart Murmur or Valve Problem	Thyroid Disease
Chronic Lung Disease	HIV/AIDS	Tuberculosis
CVA or TIA/Stroke	Kidney Disease	Ulcers
Other: _____		

SURGICAL HISTORY: Please circle **ALL** major operations or surgeries.

Appendectomy	Cosmetic Surgery	Joint Replacement
Brain Surgery	C-Section	Intestinal Surgery
Breast Surgery	Eye Surgery	Spine Surgery
Heart Surgery	Fracture Surgery	Tubes Tied
Gall Bladder Removal	Hernia Repair	Heart Valve Surgery
Colon Surgery	Hysterectomy	Tonsillectomy/Adenoidectomy
Other: _____		

FAMILY HISTORY: Please check **ALL** that apply.

	Alive	Deceased	Aneurysms	Arthritis	Asthma	Blood Clots	Cancer	Depression	Diabetes	Early Death	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Mental Illness	Miscarriage	Stroke	Substance Abuse
Mother																		
Father																		
Sister																		
Brother																		
Maternal Aunt																		
Maternal Uncle																		
Paternal Aunt																		
Paternal Uncle																		
Other																		

Patient Name:_____ MRN: _____

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SOCIAL HISTORY

Sexual History

1. What is your level of sexual activity?
   □ Never Sexually Active □ Currently Sexually Active □ Not Currently Sexually Active
2. Sexual Partners: □ Men □ Women □ Both
3. Birth Control Used: □ None □ Condom □ Diaphragm □ IUD □ Implant
   □ Patch □ Pill □ Pulling Out □ Other: _____

Alcohol Use

4. Do you drink alcohol? □ YES □ NO
   If you answered "NO", please skip to #11.
5. Glasses of wine per week:
   □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10+
6. Cans of beer per week:
   □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10+
7. Shots of liquor per week:
   □ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10+
8. How often do you have a drink containing alcohol?
   □ Never □ Monthly □ 2-4 Times/ Month □ 2-3 Times/ Week □ 4 or More Times/Week
9. How many standard drinks containing alcohol do you have on a typical day?
   □ 1-2 □ 3-4 □ 5-6 □ 7-9 □ 10 or more
10. How often do you have six or more drinks on one occasion?
    □ Never □ Less than monthly □ Monthly □ Weekly □ Almost Daily or More

Tobacco/Nicotine Use

11. Do you currently use tobacco/nicotine products? □ YES □ NO
    If you answered "NO", please skip to #15.
12. Which tobacco products do you use?
    □ Cigarettes □ Smokeless □ Cigars/Pipes □ E-Cig/Vape Pen
13. How many packs/units per day? _____
14. How long have you used tobacco/nicotine products?_____years
15. Have you used tobacco/nicotine products in the past? □ YES □ NO
    If you answered "NO", please skip to #18.
16. For how many years did you use tobacco/nicotine products?_____years
17. When did you quit using tobacco/nicotine products? Quit Date: _____

Drug Use

18. Do you use any recreational or illicit drugs? □ YES □ NO
19. Have you ever used needles to inject drugs? □ YES □ NO
20. Which recreational or illicit drugs have you used?
    □ Amphetamines □ Benzodiazepines □ Marijuana □ Opioids □ Other: _____

HEALTH MAINTENANCE

Screening

Have you had a colonoscopy?	□ YES, Date: _____	Facility:_____	□ NO	
Have you had a mammogram?	□ YES, Date: _____	Facility:_____	□ NO	□ N/A
Have you had a PAP smear?	□ YES, Date: _____	Facility: _____	□ NO	□ N/A

Immunizations

Hepatitis A	□ Unknown	□ No	□ Yes, Date: _____
Hepatitis B	□ Unknown	□ No	□ Yes, Date: _____
Human Papilloma Virus (HPV)	□ Unknown	□ No	□ Yes, Date: _____
Influenza (Flu shot)	□ Unknown	□ No	□ Yes, Date: _____
Measles, Mumps, Rubella (MMR)	□ Unknown	□ No	□ Yes, Date: _____
Meningitis	□ Unknown	□ No	□ Yes, Date: _____
Pneumococcal (Pneumonia shot)	□ Unknown	□ No	□ Yes, Date: _____
Tetanus/Diphtheria	□ Unknown	□ No	□ Yes, Date: _____
Varicella Zoster (Chicken Pox shot)	□ Unknown	□ No	□ Yes, Date: _____
Zoster (Shingles)	□ Unknown	□ No	□ Yes, Date: _____

Thank you for choosing Benson Healthcare!

Please note that Benson Healthcare primary care providers perform an individualized assessment of your health; however, not all providers manage chronic pain with long-term opioids (i.e. narcotics). Referrals to pain management and other specialists may be used, as appropriate, to best support treatment plans in individual patients.