Star Clinic®
Advanced Pelvic Health Institute for Women

14155 N. 83rd Ave. BLD 6, Suite 138
Peoria, AZ 85381
Phone: 623-271-8666
Fax: 623-271-9229
www.starclinic.org

Patient Information

Print Legibly (PLEASE FILL IN ALL BLANKS)

Patient Name (Last, First, Middle)	If patient is a minor: Parent/Guardian, Responsible Party		
Birth Date:	Social Security #:		
Ethnicity: (Required for certain labs)			
Street Address:	City:	State:	Zip:
Best daytime # ( ) [Hm]-[cell]-[wk]	Alternate# ( ) [Hm]-[cell]-[wk]		
Pharmacy Name/ Major Cross streets /City	E-Mail:	Marital status:	
Patient's Employer:	Employer's Phone #:		
Primary Care Physician:	Phone#:	Address:	
Emergency Contact: Name:	Home#:		
Relationship:	Other#:		

Primary Insurance

Insurance Name:	Policyholder's Name:	D.O.B:
Relationship to patient:	Policyholder's Employer:	
Policy ID number:	Group number:	Ins phone #:

Secondary Insurance

Insurance Name:	Policyholder's Name:	D.O.B:
Relationship to patient:	Policyholder's Employer:	
Policy ID number:	Group number:	Ins phone #:

SIGN:_____ DATE:_____

Minor Information

A parent or legal guardian must accompany a minor patient on her first visit to our office so that we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian, if we have the written permission. The adult accompanying the minor patient is responsible for payment of the services at the time of the visit.

Authorization To Treat A Minor

I, _____, being the parent or legal guardian of the minor child, _____ do hereby authorize the provider to treat the above mentioned minor.

IN OFFICE ONLY

Eff date:	Co-pay:	Contact/Ref#:

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DISCLOSING INFORMATION FOR FAMILY, FRIENDS, AND OTHERS

[ ] I authorize disclosure of my medical information to the following person(s)

_____ _____

_____ _____

[ ] DO NOT disclose my medical information to anyone (family member, other relatives, close personal friends or others)

Patient Name (Print) **Date**

_____ _____

Patient Signature **Date**

_____ _____

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HIPAA COMPLIANCE PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our ntice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1966) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations,
- The practice reserves the right to change the privacy policy as allowed by law,
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions,
- The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease,
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we leave a message on your answering machine at home or on your cell phone? **YES NO**

May we discuss your medical condition with any member of your family? **YES NO**

If **YES**, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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LAST NAME_____FIRSTNAME_____DOB_____DATE_____

MEDICAL HISTORY

Medical [ ] *None (High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)*

Pregnancy History

		YEAR	SEX	COMPLICATIONS

Last PAP: **Last Mammogram:** **LMP:**

Surgical [ ] *None (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc)*

Allergies to Medication [ ] *None (If YES, please explain type of reaction, i.e., hives, wheezing, upset stomach, swelling, etc.)*

Current prescription medicines [ ] *None*

Name of drug	mg dose	#tablets	#times/day

Current prescription medicines

Name of drug	mg dose	#tablets	#times/day

OTC medicines *(Aspirin, Tylenol, Ibuprofen, Aleve, Vitamins and Herbals)*

FAMILY HISTORY

Father: Living- Age: ____ Deceased, Age at Death _____ (Cause) _____
Mother: Living- Age: ____ Deceased, Age at Death _____ (Cause) _____
Siblings: Number Living ____ Number Deceased _____ (Cause) _____
List other illnesses in your family Example- Diabetes, Heart Disease, Colon Cancer, Breast Cancer, etc

Family Member	Illness	Family Member	Illness	Family Member	Illness

SOCIAL HISTORY

Smoke? YES NO If yes, how much? _____ # packs/day _____? # of years? When did you stop _____
Alcohol? YES NO If yes, how much?_____
Have you ever used recreational drugs? (i.e. marihuana, cocaine) If yes, what/when _____
Exercise regularly? YES NO If yes, what and how frequently _____

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Patient Financial Responsibility

Star Clinic Urogynecology accept cash, Visa, Master Card, Discover and American Express as forms of payment. **We DO NOT accept personal checks**. Please remember that it is the patient's responsibility to find what their insurance benefits are and if referral is required to see any of our providers. If you have concerns regarding your insurance coverage, please call the number on the back of your insurance card for a full explanation of coverage. Our financial policy is as follows:

Insurance Co-Payments: Must be paid at the time services are rendered.

Deductibles/Co-Insurance: If your deductible has not been met, full payment of the deductible will be required at the time of service along with any applicable co-insurance.

Private Pay/Non-Contracted Insurance Companies: If you do not have insurance coverage or have coverage with insurance we are not contracted with, you will be responsible for payment in full at time services are rendered.

Collection Policy: If your account is placed with a collection agency, all future visits will require payment in full at the time of service. You will be held fully accountable for any collection agency fees and/or attorney fees that are acquired in the recovery of the debt.

Laboratory Services: Laboratory services will be billed by the lab to which were sent. We bill your insurance for specimen collection only. You may receive a bill from the lab for any uncovered services, co-insurance or deductible that may be due. Not all laboratories tests are covered by the insurance company. It is patient's responsibility to see if a test is covered or not.

It is very important to stay well informed about your insurance coverage. If you have new insurance, it is your responsibility to provide us with an updated card. You will be held responsible for the total amount of any unpaid claims/denials for incorrect insurance information.

Signature of patient/guarantor _____

Print name of patient/guarantor _____