SUN CITIES MEDICAL GROUP, P.C.

GURVINDER SODHI, MD
PSYCHIATRY

AMARDEEP SODHI, MD
INFECTIOUS DISEASE

LAST: _____ FIRST: _____ MI: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BILLING ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

PHONE: _____ CELL: _____ WORK:_____

EMAIL: _____

DATE OF BIRTH: _____ SSN:_____ GENDER: M / F

MARITAL STATUS: _____

REFERRED BY: _____

PRIMARY CARE: _____ PHONE: _____

ADDRESS: _____

CITY: _____STATE:_____ZIP:_____

POLICY HOLDER: SELF / OTHER (CIRCLE)

HOLDER NAME AND RELATIONSHIP: _____

PRIMARY INS: _____

SECONDARY INS: _____

PHARMACY: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____PHONE:_____

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FINANCIAL AGREEMENT

REQUEST FOR MEDICAL RECORDS:

Due to the time required by the staff, it has become necessary for our office to implement a fee for the copying of any medical records requested. All forms and charts will be subject to a 25¢ per page copying fee. Required payment is due at the time forms are picked up. Please allow 24-72 hours for the completion of all forms and copying of charts. Fee will not be charged for any medical records requested by another physician's office.

LATE CANCELLATION/NO-SHOW POLICY:

A patient will be charged a late cancellation fee of $10.00 if an appointment is cancelled less than 24 hours of the scheduled appointment. If a patient fails to show for a scheduled appointment without cancellation or notice, a $25.00 fee will be charged. Notifying our office promptly allows us to schedule another patient who might be in need of medical services at the time.

COMPLIANCE

Frequent cancellations and No-Shows for appointments may be subject to discharge from services.

Signature: _____ Date Signed: _____

PLEASE INITIAL

_____ I understand that there will be a charge for the completion of forms and hereby consent to pay this fee at the time records are picked up.

_____ I understand that I am responsible for keeping all scheduled appointments and that reminder calls from Sun Cities Medical Group are ONLY courtesy reminder calls and should not be solely depended upon in order to keep my scheduled appointment.

_____ I understand that if I fail to show for a scheduled appointment, I will be charged a $25.00 No-Show Fee. If I cancel a scheduled appointment less than 24 hours, a $10.00 cancellation fee will be charged. I understand that this fee cannot be billed to my insurance company and is subject to change as Sun Cities Medical Group policies are updated.

_____ I understand that non-compliance may lead to discharge of services.

TEL: (623) 815-9733 9179 W. Thunderbird Rd., Suite B105 FAX: (623) 815-9755
Peoria, AZ 85381

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MEDICAL QUESTIONAIRE

LAST NAME: _____FIRST: _____DOB:_____

CHIEF COMPLAINT/REASON FOR VISIT: _____

HEIGHT: _____ WEIGHT: _____

PATIENT HISTORY OF MAJOR ILLNESSES:

___HEART DISEASE ___DIABETES ___VALLEY FEVER ___ARTHRITIS

___COPD/EMPHYSEMA ___STROKE ___H/O MRSA ___HEPATITIS

___HIGH BLOOD PRESSURE ___EPILEPSY/SEIZURES ___ANXIETY

___DEPRESSION ___DEMENTIA ___SCHIZOPHRENIA ___INSOMNIA

___LIVER/KIDNEY DISEASE (SPECIFY:_____) ___CANCER (SPECIFY: _____)

OTHER: _____

FAMILY MEDICAL HISTORY:

MOTHER: _____FATHER: _____

SIBLINGS: _____

PAST OPERATIONS:

YEAR: _____ YEAR: _____

YEAR: _____ YEAR: _____

SOCIAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

CAFFEINE: _____CUPS TOBACCO: ____PACKS/WK ALCOHOL: ____GLASS/WK

OTHER SUBSTANCE ABUSE: _____

PAST OCCUPATIONAL EXPOSURES: _____

ALLERGIES: _____

_____

MEDICATIONS: _____

_____

MISC. INFORMATION: _____

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

LAST: _____ FIRST: _____MI: _____ DOB: _____

I authorize **SUN CITIES MEDICAL GROUP** to request and/or disclose medical health records on my behalf.

INFORMATION TO BE RECEIVED:

_____Discharge Summary

_____History & Physical

_____Lab Test Results

_____X-Ray Reports

_____Other Reports: _____

Specific description of the purposes of the disclosure:

_____Continuation of Patient Care

_____Insurance Claims/Payment/Coverage

_____State/Federal Disability Application

_____Legal Action (Court/Law Office)

_____Other: _____

I authorize the provider to use or disclose information related to: (Please circle all that apply)

YES NO AIDS/HIV and other communicable disease

YES NO Behavioral Health Care/Psychiatry Care

YES NO Alcohol and/or Drug Abuse Treatment

YES NO Lab Work

I understand that I may revoke this authorization at any time. To revoke my authorization, I must submit a written request to the doctor.

Signature of Patient or Legal Representative: _____

Date Signed: _____

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NOTICE OF PRIVACY PRACTICES

This notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

1. A statement that this practice is required by law to maintain the privacy of the protected health information, HIPAA.
2. A statement that this practice is required to abide by the terms of the notice currently in effect.
3. The types of uses and disclosures that this practice is permitted to make for each of the following purposes:
    a. Treatment
    b. Payment
    c. Health Care Options
4. A description of each of the other purposes for which this practice is permitted or required to use or disclose protected healthcare information without my written consent or authorization.
5. A description of other disclosures that will be made only with my written authorization and that I may revoke such authorization.
6. My individual right with respect to protect health information and a brief description of how I may exercise these rights.
7. The right to complain to this practice and the Secretary of Health and Human Services if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such complaint.

    The U.S. Department of Health and Human Services
    200 Independence Avenue, S.W.
    Washington, D.C. 20201
    Toll Free: 1-877-696-6775
8. The right to request restriction on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
9. The right to receive confidential communication of protected health information.
10. The right to inspect and copy protected health information.
11. The right to amend protected health information
12. The right to receive an accounting of disclosures of protected health information.
13. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

    This practice reserves the right to change the term of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient if signed by Guardian or Legal Representative: _____

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