IYA Medical

PLC Dr. Ayad Agha, DO, DABR – Dr. Yazan Al-Hasan, MD – Dr. Ahmed Agha, MD

Patient Information

Today's Date: _____

Name(Last)_____ (First) _____ (Middle) _____

DOB:_____ Sex:_____ Marital Status:_____ Social Security #:_____

Home Phone:_____ Cell Phone: _____

☐ I would like to receive text reminders of my upcoming appointments.

Email: _____

Address: _____

City/State/Zip: _____

Primary Language:_____ Race:_____ Ethnicity:_____

Employer:_____ Phone:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Pharmacy:_____ Phone: _____

Primary Insurance

Name of Insurance: _____

ID#:_____ Group#:_____

Policy Holder's Name:_____ DOB:_____

Relation to Patient:_____ Social Security #:_____

Secondary Insurance

Name of Insurance: _____

ID#:_____ Group#: _____

Policy Holder's Name:_____ DOB:_____

Relation to Patient:_____ Social Security #:_____

Workman's Comp : _____ DOI : _____ Claim # _____

Adjusters Telephone # _____ Adjusters Name : _____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office, IYA Medical, PLC. to use and disclose protected health Information(PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

(The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of IYA Medical, PLC reserves the right to revise Its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of IYA Medical, PLC may call my home or other alternative location and leave a message on voicemail or in-person, In reference to any Items that may assist the practice In carrying out TPO, such as appointment reminders, Insurance items and any calls pertaining to my clinical care, Including testing and laboratory results.

With this consent, the office of IYA Medical, PLC may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of IYA Medical, PLC may e-mail to my home or other alternative location on any occasion that assists the practice in carrying out TPO, such as, appointment reminder cards and patient statements. I have the right to request that the office of IYA Medical, PLC restrict how It uses or discloses my PHI to carry out TPO. However, the practice Is not required to agree to my requested restrictions, but If It does, It Is bound by this agreement.

By signing this form, I am consenting to the office of IYA Medical, PLC use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except for services already rendered, according to my prior consent. If I do not sign this consent, or later revoke It, the office of IYA Medical, PLC may decline to provide treatment to me.

Patient’s Printed Name: _____

Legal Guardian Printed Name: _____

_____

Signature of Patient or Legal Guardian Date

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Permission of Release of Records

Date: _____

I _____, give permission for the
(Name of Patient)

following individuals to obtain copies of my medical records and/or any medical information pertaining to my care at IYA Medical, PLC.

Name	Relationship	Phone Number

Patient's Printed Name: _____ DOB: _____

Patient's Signature: _____

Guardian's Signature: _____

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Payment Policy
Assignment and Release

- **Insurance:** We participate in most insurance plans, including Medicare. If you do not have insurance or are not insured by a plan we are contracted with, payment in full is due at the time services are provided unless prior arrangements have been made and agreed to in advance. You authorize the physician to release any medical information required to process any claims.

- **Proof of Insurance/Referral Forms:** We may require that you provide us with a copy of your driver's license and valid insurance card to provide proof of insurance. If we are not provided with the correct information, you may be held responsible for payment. Once we obtain your insurance information, we will bill the insurance company and refund any overpayments once the claim has been paid by your insurance plan. Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full.

- **Co-Payments, Deductibles, & Coinsurance:** You agree to pay all co-payments, deductibles, and co-insurance at the time your exams are performed as required by your insurance plan. A time of service payment is an estimate of the amount due. The final amount due cannot be calculated until the claim is processed by your insurance company. Additionally, the estimate of the amount due at time of service may change over time due to deductible charges processed for other medical services rendered.

- **Non-Covered Services:** In some instances, the services you receive may not be covered or considered medically necessary by Medicare or other insurance plans. In these instances, you will be required to pay for these services in full at the time of your exam. Medicare patients may be required to complete a separate Advance Beneficiary Notice form in order for services to be rendered.

- **Collections:** Once an account is placed in collection status, all future services must be paid in full at the time of service. Patient payment policies may not be applicable in certain cases, including but not limited to workers compensation cases.

- **Communication:** You authorize IYA Medical staff to contact you via telephone to remind you of appointments and financial obligations

Printed: _____ Date: _____

Signed: _____

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Additional Policies and Agreements

- **No Show/ Cancellation Policy:** Any time that you miss an appointment in our office or cancel an appointment without giving us 24 hours notice, you will be assessed a $35 - $250 fee for no-show/ late cancellation. This fee will be your responsibility and must be paid in full prior to your next visit. Dismissal from our practice may result following three No Shows. The fees associated for the most common appointments are as follows:
  - ***Office Visit - $50***
  - ***Surgery- Hospital Procedure & Nuclear Testing - $250***

- **Application/ Form Completion Fees:** A prepayment fee up to $35 must be paid in full for forms and applications completion such as school physical, sport physical, disability application, and others that do not require you to come to the office.

- **Medical Records Fees:** Charges for copies of medical records will be determined in accordance with the current State of Arizona Office of Planning and Budget published rates. Minimum costs are approximately $25 as a base fee in addition to a cost of $0.10 per page.

- **Check Policy:** We are happy to accept your personal check for payment toward your account balance. However, if funds are not available in your account and your check is returned to us as a NSF (or for any other reason), you will be assessed a $35 service fee plus amount of the original check. You may be required to make future payments using cash, credit card, or money order.

- **Outside Services:** For services rendered in our offices and outpatient facilities please note that you may also receive bills from other non-IYA medical entities for services rendered in conjunction with your care (i.e, **laboratory services, anesthesia services, hospital services**).

_____
Initials

Printed: _____ Date: _____

Signed: _____

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No Surprises Act Consent

YOU HAVE THE RIGHT TO RECEIVE A "GOOD FAITH ESTIMATE" EXPLAINING HOW MUCH YOUR MEDICAL CARE WILL COST.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items or services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, and equipment.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider and any other provider you choose for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill of at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure you save a copy or picture of the Good Faith Estimate.

For questions or more information, visit www.cms.gov/nosurprises or call 1-800-985-3059

Reviewed With _____

Relation to Patient _____

Patient Signature _____ Date _____

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New Patient Health Questionnaire

Today's Date: _____

Name: _____ Date of Birth: _____

Primary Care Physician(PCP): _____Phone#: _____

Referring Physician: _____Phone#: _____

Please answer the questions below that pertain to your problem:

Why are you here today? _____

What causes it? _____

When did it start? _____ Severity: _____

Location: _____ Character: _____

Duration: _____ How Often: _____

Modifying Factors: _____

Other Symptoms: (Please Check if Present)

☐	☐	High Blood Pressure	☐	☐	Cancer	☐	☐	Swelling of Ankles	☐	☐	Heart Disease
☐	☐	Blood Clots	☐	☐	Diabetes	☐	☐	Swelling of Legs	☐	☐	Liver Disease
☐	☐	TIA / CVA	☐	☐	Kidney Disease	☐	☐	Calf/ Leg Pain			

Have you seen another Physician regarding this problem? If Yes, When? _____

Whom? _____

Do you have any medical records that may assist us? ☐ Y ☐ N

Do you have any recent lab work in past 6 months? ☐ Y ☐ N

Medications: List *ALL* medications that you are currently taking including non-prescription medications & Herbal Remedies.

Medication	Dose	How Often?	Approximate Start Date (Month & Year)

Allergies or Sensitivity to Medications

Allergic to	

General Past Medical History:

Please Check box on left if Yes.

☐	ASTHMA	☐	ANEMIA	☐	ANXIETY	☐	ARTHRITIS
☐	AUTOIMMUNE DISORDER	☐	BLEEDING PROBLEMS	☐	CANCER	☐	COPD
☐	DEPRESSION	☐	GALLBLADDER STONES/ DISEASE	☐	GI BLEED	☐	AVM
☐	GOUT	☐	HEMORRHOIDS	☐	HEPATITIS (A, B, OR C)	☐	HIV/ AIDS
☐	THYROID DISEASE	☐	KIDNEY DISEASE	☐	LIVER DISEASE	☐	LUNG DISEASE
☐	NEUROPATHY	☐	OBESITY	☐	OSTEOPOROSIS	☐	PEPTIC ULCER DISEASE
☐	SEIZURES	☐	SLEEP APNEA	☐	SMOKING (TOBACCO)	☐	VARICOSE VEINS
			FEMALES ONLY:				
☐	GESTATIONAL DIABETES	☐	MENOPAUSE	☐	PREGNANCY INDUCED HYPERTENSION	☐	PREECLAMPSIA / ECLAMPSIA
			MALES ONLY:				
☐	ERECTILE DYSFUNCTION(ED)	☐	ENLARGED PROSTATE	☐	REDUCED URINE FLOW	☐	BENIGN PROSTATIC HYPERPLASIA

PAST SURGICAL HISTORY (MAJOR ONLY: CARDIOVASCULAR & GENERAL)

Year	Major Surgery

If Female:

Hysterectomy? ☐ Y ☐ N	Ovaries Removed? ☐ Y ☐ N	# of Pregnancies:

Family History: Questions will **only** pertain to first-degree relatives(i.e. parents, siblings, and children) in your family. Questions will also pertain to age limits: Males 55 or younger and females 65 or younger. Do any of your first-degree relatives have any of the following? Please check Y or N to the questions listed below, and if yes please explain.

1. Cancer? ☐ Y ☐ N _____
2. Peripheral Artery Disease? ☐ Y ☐ N _____
3. Stroke or TIA? ☐ Y ☐ N _____
4. Deep Vein Thrombosis or Pulmonary Embolism? ☐ Y ☐ N _____
5. Any vascular disease not mentioned? ☐ Y ☐ N _____
6. Is your father alive? ☐ Y ☐ N Age:_____
   If Deceased, at what age?_____ Cause if known? _____
7. Is your mother alive? ☐ Y ☐ N Age: _____
   If deceased, at what age? _____ Cause if known? _____

SOCIAL HISTORY:

1. What is your occupation? _____
2. Marital Status: _____ If Children, How Many? _____
3. Do you or have you ever smoked (cigarette, cigar, pipe)? ☐ Y ☐ N
   If so, how long (yrs)? ____ How many per day? _____ Currently Smoke? ☐ Y ☐ N
   If you quit, when? _____ Non-smoking tobacco (Chew/Snuff)? ☐ Y ☐ N
4. Do you use Alcohol? ☐ Y ☐ N If yes, type?_____
   How many drinks per week? ☐ 0-5 ☐ 6-10 ☐ >10

Social History (continued)

5. Have you ever used illicit drugs (Type/ How Long?) ☐ Y ☐ N

   _____

6. Do You Exercise? ☐ Y ☐ N Type: _____
   How Often (Sessions/ Week)? _____ For how long (per session)? _____Mins.
7. Any special diet? (i.e. Adkins, Paleo, Keto, low sodium, etc)_____
8. Do you add salt to food? ☐ Y ☐ N Daily Caffeine? ☐ Y ☐ N
   Daily Soft Drinks/Soda? ☐ Y ☐ N

Review Of Systems: Please check the following symptoms that have occurred in the *Last 30 Days only.* (Leave blank if negative)

☐ Abdominal Pain	☐ Anxiety	☐ Balance Problems/ Falls
☐ Blood in Stool/ Black Stool	☐ Blood in Urine	☐ Blurred Vision/ Double Vision
☐ Clotting Disorder	☐ Depression	☐ Excessive Bruising
☐ Fatigue	☐ Fevers/ Chills	☐ Heartburn
☐ Muscle Pain/ Weakness	☐ Nausea	☐ Nose/ Gum Bleeding
☐ Poor Dental Health	☐ Rash	☐ Recent Weight Loss or Gain
☐ Recurrent Headaches	☐ Ringing in Ear/ Tinnitus	☐ Seizures
☐ Sinus Problems	☐ Slurred Speech	☐ Snoring
☐ Urination at Night	☐ Wheezing	☐ Pregnant