BioClinic
An Innovative & Cost Effective Healthcare System

11468 N Frontage Rd. Suite A
Yuma, AZ 86367
Tel (928) 342-6500
Email: info@biofamilyclinic.com
www.biofamilyclinic.com

Personal Information

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other:_____

Last Name:_____ First Name:_____ Middle Name:_____

Suffix:☐ Jr. ☐ Sr. ☐ II ☐ Other:_____ Date of Birth:_____ Last 4 of SS#:_____

Sex: ☐ M ☐ F ☐ Other:_____ Email: _____

Address:_____ City:_____

State:_____ Zip:_____ Country:_____

House Phone:_____ Cell:_____ Work Phone:_____

Preferred method of contact: ☐ House Phone ☐ Cell ☐ Work

IF A WINTER VISITOR, WE NEED YOUR SUMMER ADDRESS AS WELL

Address:_____ City:_____

State:_____ Zip:_____ Country:_____

From _____ to _____ (month to month)

PLEASE CHECK ONE BOX

Race:
- ☐ American Indian
- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic/Latino/Spanish Origin of any race
- ☐ Native Hawaiian/Pacific Islander
- ☐ Non-Resident Alien
- ☐ Race & Ethnicity Unknown
- ☐ White
- ☐ Two or More Races
- ☐ Other:_____

Language:
- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ French Creole
- ☐ German
- ☐ Greek
- ☐ Gujarati
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Urdu
- ☐ Vietnamese
- ☐ Other: _____

Ethnicity:
- ☐ Hispanic/Latino/Spanish Origin
- ☐ NON Hispanic/Latino/ Spanish Origin

Communication Preference: ☐ In Person ☐ Mail ☐ Other:_____
☐ Telephone ☐ Email

Do you want to receive our newsletter & other promotional information via email: ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other:_____

Do you need information on a durable will? ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Self-Employed ☐ Retired
☐ Other:_____

Occupation:_____

Student: ☐ Full Time ☐ Part Time ☐ None

Name of School:_____

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Emergency Contact

Last Name:_____ First Name:_____

Patient Relationship:_____

Address:_____ City:_____

State:_____ Zip:_____ Country:_____

House Phone:_____ Cell:_____ Work Phone:_____

Insurance Information

Primary Insurance

Plan Name:_____ Insurance ID:_____

If AHCCCS (State Medicaid): ☐ United Healthcare Community Plan ☐ Other:_____
☐ University Family Care

Effective Date:_____ Co-Pay Amount:_____

Relationship with Insured

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Last Name:_____ First:_____ Middle:_____

Date of Birth:_____

Address:_____ City:_____

State:_____ Zip:_____ Country:_____

House Phone:_____ Cell:_____ Work Phone:_____

Secondary Insurance

Plan Name:_____ Insurance ID:_____

Effective Date:_____ Co-Pay Amount:_____

Relationship with Insured

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Last Name:_____ First:_____ Middle:_____

Date of Birth:_____

Address:_____ City:_____

State:_____ Zip:_____ Country:_____

House Phone:_____ Cell:_____ Work Phone:_____

Signature:_____ Date:_____

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Medical History Questionnaire

Name:_____ Date of Birth:_____

THIS IS A FORM TO OBTAIN A PORTION OF YOUR MEDICAL HISTORY. PLEASE FILL OUT COMPLETELY.

PAST MEDICAL HISTORY AS DETERMINED BY A PHYSICIAN: (CHECK ALL THAT APPLY TO YOU)

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Chronic Bronchitis
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Angina
- ☐ High Cholesterol
- ☐ Decreased Hearing
- ☐ Non-Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Disease
- ☐ Stroke
- ☐ Ulcers
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Fibrocystic Breast Disease
- ☐ Hiatal Hernia
- ☐ Diverticulitis
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Kidney Infections
- ☐ Decreased Vision
- ☐ Kidney Stones
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Seizures
- ☐ Depression
- ☐ Migraines
- ☐ Headaches
- ☐ GOUT
- ☐ Pancreatic Disease
- ☐ Kidney Disease
- ☐ Cancer: ☐ Lung ☐ Breast ☐ Colon ☐ Stomach ☐ Uterus ☐ Other:_____

IODINE ALLERGY: ☐ Yes ☐ No

List all the medications you are allergic to: _____

_____

_____

List the medications you are currently taking:

Name Of Medication	Dosage	When Is Medication Taken

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List **ALL** Types of Surgeries that you have had:

Type of Surgery	Year

List Hospitalizations other than surgeries and childbirth:

_____

_____

_____

Have you had any blood transfusions? ☐ Yes ☐ No

When: _____

FAMILY HISTORY

(Place an "M" for Mother's side of the family and "F" for Father's side of the family)

- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ High Blood Pressure_____
- ☐ Lung Disease _____
- ☐ Stomach Disorders _____
- ☐ Thyroid Problems _____
- ☐ Cancer _____
- ☐ Kidney Disease _____
- ☐ Stroke _____
- ☐ Bone Disorders _____

Others not listed: _____

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BIO CLINIC AUTHORIZATION FOR TREATMENT

CONSENT FOR MEDICAL TREATMENT / PROCEDURE

____ I authorize my doctor at Bio Family Clinic to administer treatment, anesthetics, and perform procedures as he/she deems necessary or advisable in my diagnosis and treatment. I am aware the practice of medicine and surgery is not an exact science and acknowledge no warranty, guarantee or assurance has been made by the doctor. If accidental exposure of a healthcare worker to my blood or body fluids occur, I authorize and consent to testing of a sample of my blood for certain infectious diseases, such as hepatitis and the virus associated with AIDS. I understand I will not be billed for these tests if performed because of exposure of a healthcare worker. I realize the importance of such testing for my own sake as well as for healthcare personnel.

AUTHORIZATION FOR RELEASE OF INFORMATION

____ The doctor is authorized to furnish from the patients record requested information or excerpts to the primary care or referring physician, if any, and to any insurance company or third party payor for the purpose of obtaining payment of the account of the physician for services provided to the patient. The doctor is authorized to release information from my medical record to any healthcare facility or provider for continuum of care.

ASSIGNMENT OF INSURANCE BENEFITS

____ In the event the patient is entitled to medical benefits arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to the doctor for application on the patients bill. It is agreed that the doctor may accept any such payment and such payment shall discharge the said insurance of any and all obligations under the policy to the extent of such payment. I am responsible for charges not covered by this assignment.

FINANCIAL RESPONSIBILITY

____ I agree (as the patient or responsible party) that in consideration of the services to be rendered to the patient, I obligate myself to pay all charges by the physician incurred in connection with treatment of the patient or costs related thereto. It is further agreed that the undersigned shall be liable for actual charges billed. Any charges estimated at the time of treatment are subject to change.

CONSENT FOR PHOTOGRAPH TO BE TAKEN

____ I *do consent* to my picture being taken to become a part of my medical records as felt appropriate by my doctor and give him/her permission to include my picture when releasing my medical records to my referring physician, primary care physician, and insurance company for processing a claim or any other entity that I may give permission to in the future.

CONSENT FOR RANDOM DRUG TESTING

____ I hereby consent to the submission of random urine drug screening as a patient of Bio Family Clinic. I understand that I may be tested at any time during my relationship with Bio Family Clinic and failure to abide by these rules will result in the termination of my relationship with Bio Family Clinic.

This form has been fully explained to me and I certify that I understand its contents.

Signature of Patient Date

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Bio Family Clinic, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bio Family Clinic. I understand that diagnosis of treatment of me by Bio Family Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice Bio Family Clinic is not required to any restrictions that I request, however, if Bio Family Clinic agrees to a restriction that I request, the restriction is binding on Bio Family Clinic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Bio Family Clinic has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from means created or received by my physician, another health care provider, a health plan, and my employer or health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Bio Family Clinic's "Notice of Privacy Practices" prior to signing this document. The Bio Family Clinic Notice of Privacy Practices has been provided to me. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bio Family Clinic.

This "Notice of Privacy Practices" also describes my rights and MD duties with respect to my protected health information.

Bio Family Clinic reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices". I may obtain a revised notice of "Privacy Practices" by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient Date

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CONSENT TO RELEASE INFORMATION ORALLY TO FAMILY OR FRIENDS FOR PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Patient Name: _____ Date of Birth: _____

Bio Family Clinic has my permission to release my confidential health information to the following individuals who are involved in my care:

Name	Relationship

I understand that I have the right to revoke this permission, in writing, at any time and that disclosures made in good faith may have already occurred and that the withdrawal of permission cannot be applied retroactively.

_____

Signature of Patient Date

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Acknowledgement of Bio Family Clinic No-Show Policy

Due to the increasing number of patients who do not show up for their scheduled appointments or fail to cancel within a 24 hour period before your appointment, the practice has established the **NO SHOW** policy with a fee of **$25.00**. Exceptions for emergencies will be considered on an individual basis. Please remember that the confirmation calls we do prior to you appointment are a courtesy. We provide appointment cards with your appointments on them. It is your responsibility to know when you appointment is scheduled. Missing your appointment because we didn't call you is not an excuse for missed appointment. If you misplace your appointment card, please call the office to verify the date and time.

Please be considerate and keep your appointments or call 24 hours in advance to reschedule. This new policy is effective 03/01/2014.

Patient Name DOB

Signature of Patient/Guardian Date

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Acknowledgement of Prescription Refill Policy

Please contact your pharmacy regarding medication refill requests. Your pharmacy will notify our office of your request. Please be advised that we require 72 hour notice to process medication refill requests.

Patient Name DOB

Signature of Patient/Guardian Date

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Acknowledge of Receipt of Notice of Privacy Practices

Bio Family Clinic is committed to protecting the confidentiality of your medical information. This notice describes how we may use your medical information within our facility and how we may disclose your medical information to others. Please review it and let us know if you have any questions.

Signing this form is an acknowledgement that you have received a copy of **HIPPA Practices.**

_____
Patient Name

_____
Signature of Patient/Guardian Date

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HIPAA Policies and Procedures

Introduction

BIO FAMILY CLINIC (BFC) has adopted this HIPAA Policies and Procedures Policy in order to recognize the requirement to comply with the Health Insurance Portability and Accountability Act ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health ("HITECH") Act of 2009 (Title XIII of division A and Title IV of division B of the American Recovery and Reinvestment Act "ARRA") and the HIPAA Omnibus Final Rule (Effective Date: March 26, 2013). We acknowledge that full compliance with the HIPAA Final Rule is required by or before September 23, 2013.

We hereby acknowledge our duty and responsibility to protect the privacy and security of Individually Identifiable Health Information ("IIHI") generally, and Protected Health Information ("PHI") as defined in the HIPAA Regulations, under the regulations implementing HIPAA, other federal and state laws protecting the confidentiality of personal information, and under principles of general and professional ethics. We also acknowledge our duty and responsibility to support and facilitate the timely and unimpeded flow of health information for lawful and appropriate purposes.

Scope of Policy

This policy governs the establishment and maintenance of policies and procedures for **BIO FAMILY CLINIC (BFC)**. All personnel of **BIO FAMILY CLINIC (BFC)** must comply with this policy. Demonstrated competence in the requirements of this policy is an important part of the responsibilities of every member of the workforce.

Officers, agents, employees, Business Associates, contractors, affected vendors, temporary workers, and volunteers must read, understand, and comply with this policy in full and at all times.

Assumptions

- BIO FAMILY CLINIC (BFC) hereby recognizes its status as a Covered Entity under the definitions contained in the HIPAA Regulations.
- BIO FAMILY CLINIC (BFC) must comply with HIPAA and the HIPAA implementing regulations, in accordance with the requirements at 45 CFR Parts 160 and 164, as amended.
- Full compliance with HIPAA is mandatory and failure to comply can bring severe sanctions and penalties. Possible sanctions and penalties include, but are not limited to: civil monetary penalties, criminal penalties including prison sentences, and loss of revenue and reputation from negative publicity.
- Full compliance with HIPAA strengthens our ability to meet other compliance obligations, and will support and strengthen our non-HIPAA compliance requirements and efforts.
- Full compliance with HIPAA reduces the overall risk of inappropriate uses and disclosures of Protected Health Information (PHI), and reduces the risk of breaches of confidential health data.
- The requirements of the HIPAA Administrative Simplification Regulations (including the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules) implement sections 1171-1180 of the Social Security Act (the Act), sections 262 and 264 of Public Law 104-191, section 105 of 492

Public Law 110-233, sections 13400-13424 of Public Law 111-5, and section 1104 of Public Law 111-148.

- Entities subject to HIPAA Rules are also subject to other federal statutes and regulations. For example, federal programs must comply with the statutes and regulations that govern them. Pursuant to their contracts, Medicare providers must comply with the requirements of the Privacy Act of 1974. Substance abuse treatment facilities are subject to the Substance Abuse Confidentiality provisions of the Public Health Service Act, section 543 and its regulations. And, health care providers in schools, colleges, and universities may come within the purview of the Family Educational Rights and Privacy Act.

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Policy Statement

- It is the Policy of BIO FAMILY CLINIC (BFC) to create and implement appropriate policies and procedures as required by law and as suggested by good business practices and general business ethics.
- All policies and procedures shall be updated and amended as needed or as required by law.
- All policies and procedures shall be distributed to, or made otherwise available to, the entire workforce.
- All policies and procedures shall be regularly maintained and secured, and copies shall be stored offsite with other important business records for safekeeping.
- All members of the workforce are required to read, understand, and comply with this and all other policies and procedures created and implemented by BIO FAMILY CLINIC (BFC).

Procedures

- **BIO FAMILY CLINIC (BFC)** shall create or revise its own HIPAA policies and procedures, consistent with all applicable HIPAA Rules and Regulations as well as with applicable State laws and statutes.
- **BIO FAMILY CLINIC (BFC)** shall designate a qualified individual to assume control of the policies and procedures process. This individual shall report to IRFAN FAZIL, M.D. and shall execute the creation or revision process in a timely manner, in order to meet the current HIPAA Compliance Deadline of September 23, 2013.
- **BIO FAMILY CLINIC (BFC)** shall engage its qualified legal counsel to guide or review the policies and procedures creation/revision process, and to intercede where necessary, to ensure **BIO FAMILY CLINIC (BFC)**'s policies and procedures meet all applicable HIPAA (and other) standards.
- **BIO FAMILY CLINIC (BFC)** shall internally publish its HIPAA policies and procedures, when complete, to its workforce members, and shall provide appropriate training to members of its workforce on the interpretation and implementation of its policies and procedures.
- **BIO FAMILY CLINIC (BFC)** will have appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information.
- **BIO FAMILY CLINIC (BFC)** must reasonably safeguard protected health information from any intentional or unintentional use or disclosure that is in violation of the standards, implementation specifications or other requirements of this subpart.
- **BIO FAMILY CLINIC (BFC)** must reasonably safeguard protected health information to limit incidental uses or disclosures made pursuant to an otherwise permitted or required use or disclosure.

Compliance and Enforcement

All managers and supervisors are responsible for enforcing this policy. Employees who violate this policy are subject to discipline up to and including termination in accordance with **BIO FAMILY CLINIC (BFC)**'s Sanction Policy.