SWGeriatrics

Welcome,

Thank you for choosing **SWGeriatrics**.

We are so glad you have chosen us! Our goal is to provide you with the highest quality and compassionate care. If you have questions about our admission process, please call our Admissions Direct Line: **520-314-3412,** then press option **0**.

We accept most insurance plans. If you have questions about your insurance coverage, please contact your insurance carrier.

To process patient admission, we require the registration packet to be filled out completely. This includes the signature of the patient. If a Power of Attorney is signing for the patient, then the proper documents are required.

In addition, please attach:

1. A copy of the front and back of the insurance cards

2. A list of medications

3. Medical records, including lab tests, recent hospitalization, and the most recent physical exam from your previous medical provider

4. Any end-of-life decision paperwork, including Power of Attorney, Do Not Resuscitate, or Full Code documents

Please fax completed documents to **(520) 314-3413**.

Sincerely,

The **SWGeriatrics** Team

MAILING ADDRESS ONLY: 6890 E Sunrise Drive, Suite 120-176, Tucson, AZ 85750
OFFICE: (520) 314-3412 • FAX: (520) 314-3413 • EMAIL: info@swgeriatrics.com
www.SWGeriatrics.com

SWGeriatrics

(520) 314-3412

This form must be filled out completely prior to admission.

How did you hear about us?

Primary contact email address:

Patient Information

Patient Name: SS#: - - DOB: / /

Address: Phone:

City/State/Zip: Facility:

Marital Status: S M W D Sex: M F Height: Weight:

Preferred Pharmacy: Phone: Fax:

Financially Responsible Party (please print)

Name:

Phone:

Address:

City/State/Zip:

Medical Power of Attorney*

Name:

Phone:

**IMPORTANT: Include the Medical Power of Attorney documents when submitting this form.*

Billing Information

Primary: ID# Group#

Secondary: ID# Group#

Authorization to Treat, Release Information, Photo & Assignment of Benefits

I hereby authorize Linda Wroten, PC, dba, SWGeriatrics and any Nurse Practitioner legally contracted with SWGeriatrics to treat, release medical information, bill my insurance and take my photo for use in the Electronic Medical Record (EMR). I permit a copy of this authorization to be used in place of the original. I request that payment from my insurance company be made directly to SWGeriatrics. I understand that services not covered by my insurance are my financial responsibility. I certify that the information I have provided regarding my insurance coverage is correct. I may revoke this authorization at any time by written notification to SWGeriatrics.

PATIENT

Signature: Date:

FINANCIALLY RESPONSIBLE PARTY

Signature: Date:

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Credit Card on File Authorization

SW Geriatrics is now keeping a credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to your account.

Information to be completed by the card holder

Patient Name:

Cardholder's Name:

Card Number:

Card Type: ☐ VISA ☐ MasterCard ☐ American Express ☐ Discover

Expiration Date:

Security Code:

Billing Address:

Email:

I, , authorize SW Geriatrics to charge the above credit card account for payments owed to my account for services rendered at their office. This authorization relates to all payments not covered by my insurance company for services provided to me by SW Geriatrics. This authorization will remain in effect until I (we) cancel this authorization. To cancel I (we) agree to give a 30 day notification in writing and the account must be in good standing. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder's Name:

Cardholder's Signature: Date:

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Arizona HIPAA Medical Release Form

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize _____ to disclose the following information
(Name of clinic, individual, etc.)

from the health records of:

_____ ___/___/___
Name (Please print first/last name) Date of Birth (MM/DD/YY)

( )
Phone Number

Street Address

City / State / Zip E-mail Address

I authorize the following persons (or class of persons) to receive my Protected Health Information (PHI):

Name (Please print)

Address

( )
City / State / Zip Phone Number

E-mail Address

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Form B: HIPAA Privacy Program

HIPAA Authorization

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

Signature: _____ Date: _____

Description of Authority to sign if personal/legal representative:

_____

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Current Medications List

Patient Information

Name: DOB: Phone:

Emergency Contact

Name: Phone:

Allergies

Prescription Medications*

Name of Medication	Strength and Frequency

**If you are unsure, most of this information can be found on your prescription bottle.*

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