Durbin Family Internal Medicine Date: ________

Dr. Drew A. Durbin D.O.

*****PLEASE PRINT AND COMPLETE EVERYTHING*****

Whom may we thank for referring you? ☐ Dr. ___________________, ☐ Friend/ Relative, ☐ Insurance Plan, ☐ Yellow Pages, ☐ Hospital, ☐ Other: _______________

Patient Name: ____
(First) (MI) (Last)

Address: ____

E-mail address:____

Home Phone: _____________ Work Phone: _____________ Cell Phone: ______________

Date of Birth: ____________ Social Security #: ____________ Marital Status: S M Sep W D

Employer: ________________________________ Occupation: ____________________

Spouse/Partner's Name: ____________________________ Work Phone: _____________

Emergency Contact: ____

Phone: ______________________________ Relationship to Patient: _________________

Primary Physician: _______________________________ Phone: __________________

Insurance Information

Primary Insurance: ___________________________ Effective Date: ________________

Address: ____ Phone: _________________

Subscriber's Name: ______________________________ Date of Birth: ______________

Subscriber's SS#: ____________________________ Relationship to Patient: __________

Policy Number: _____________ Group Number: ______________ Co-pay: ____________

Secondary Insurance: ___________________________ Effective Date: _______________

Address: ____ Phone: _____________

Subscriber's Name: __________________________ Date of Birth: _________________

Subscriber's SS#: __________________________ Relationship to Patient: ____________

Policy Number: _______________ Group Number: ___________ Co-pay: ____________

EMERGENCY CONTACT AND CURRENT MEDICATION INFORMATION

PATIENT INFORMATION			
Name:	Date of Birth:	Social Security Number:	
Home Address: Mailing Address:			Home: Cell:
Physician(s):	Physician's Phone Number:	Pharmacy:	Pharmacy's Phone Number:

EMERGENCY CONTACTS				
NAME	RELATIONSHIP	HOME PHONE	MOBILE PHONE	WORK PHONE

MEDICAL CONDITIONS		
1.	2.	3.
4.	5.	6.

ALLERGIES TO MEDICATIONS	
MEDICATION	REACTION

CURRENT MEDICATION REGIMEN			
MEDICATION	DOSAGE	FREQUENCY	CONDITION / SPECIAL NOTES

RELEASE OF INFORMATION FOR Dr. DREW A. DURBIN

Durbin Family Internal Medicine

16601 N 40TH ST. #119

PHOENIX, AZ 85032

P: 480-779-4999

F: 480-779-4998

I ___________________________ hereby grant the permission for

__________________ (spouse or family member)to obtain any and/or all medical information or results from my medical chart from Dr. Drew Durbin at the practice of Durbin Family Internal Medicine 16601 N. 40th St. #119, Phoenix, AZ 85032

Patient signature ___________________________________ Date: _______________

Printed name ___________________________________

Authorized printed name ____

Relationship to patient ___________________________

Durbin Family Internal Medicine, PLLC

FINANCIAL POLICY / RECEIPT OF PRIVACY PRACTICES / LEGAL ASSIGNMENT

All patients / legal representatives /guarantors are responsible for payment at the time of service. We accept cash, checks and most major credit cards.

If your insurance deductible is not met, we will collect a portion of it at the time of service until met. Thereafter, we will collect your co-payment only. Insurance co-payments are due at the time of service. We will bill for co-insurance payments. If you have no insurance, full payment is due at the time of service.

Supplements or medications prescribed, dispensed or suggested by our doctors must be paid for on receipt unless prior arrangements have been made. As a service to you we will bill your insurance for you, or print out a claim form for you to turn into your insurance for reimbursement.

If your account is placed in collection status, all future services must be paid in full at the time of service. Any balance assigned to a collection agency will be assessed a 30%-40% fee to offset the recovery expense.

LEGAL ASSIGNMENT: I, the undersigned, have health insurance and/or employee healthcare benefits coverage and hereby assign and convey directly to Durbin Family Internal Medicine, PLLC all medical benefits and/or insurance reimbursement otherwise payable to me for services rendered to me by Durbin Family Internal Medicine, PLLC, its officers, directors and/or employees. Notwithstanding the above, I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize Durbin Family Internal Medicine, PLLC to release any and all of my medical information as necessary to process my medical claims. Further, I agree to fully cooperate with Durbin Family Internal Medicine, PLLC in its attempts to pursue my medical claims against my insurers and/or health care benefit plan as necessary, including bringing suit against any such insurer and/or health care benefit plan. This assignment will remain in effect until revoked by me (or by patient's legal representative or guardian) in writing.

MISSED APPOINTMENT POLICY: If you are not able to keep your appointment, a 24 hour notice is requested. A $25.00 fee will be charged to you for all missed appointments not cancelled within the 24 hour time period.

I have read and agree to abide by the above Financial Policy, Missed Appointment Policy and Legal Assignment. I have also received a copy of the Notice of Privacy Practices:

Patient Signature: ___________________________________ Date: ________________________
If a minor or incapacitated, name and signature of legal representative or guardian:

Signature: ____ Date: _______________________

Durbin Family Internal Medicine, PLLC

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your Privacy…

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

Use and Disclosure of Your Health Information

We may be required to use or disclose your health information:

1. if public health authorities and/or health oversight agencies authorized by law to collect information make a request for information;

2. with respect to lawsuits or similar proceedings in response to a court or administrative order;

3. when docketing a medical provider lien;

4. when your or a third party's insurance company and/or attorney submits a request for information;

5. if required to do so by a law enforcement official;

6. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to reduce or prevent the threat;

7. if you are a member of U.S. or foreign military forces (including veterans) and we are required to disclose by the appropriate authorities;

8. to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official;

9. to Workers' Compensation or similar programs; and

10. To companies performing diagnostic testing services on your behalf.

You’re Rights Regarding Your Health Information

1. You may request that our practice communicate with you about your health and related issues in a particular manner or location. We will accommodate reasonable requests (i.e. home vs. work);

2. you have the right to request we do not leave information regarding your care and treatment, including but not limited to appointments, insurance and billing matters, with a particular individual or on a telephone answering or voice-mail system. However, **please note that we may leave messages for you with alternative sources regarding the above unless and until specifically directed by you in writing not to do so;**

3. You have the right to obtain a copy of your health information, including your medical and billing records, but not including psychotherapy notes. You must submit your request in writing to us at 16601 N. 40th St., Ste. 119, Phoenix, AZ 85032;

4. if you believe your privacy rights have been violated, you may file a written complaint that clearly outlines the nature of the violation with our office or with the Secretary of the Department of Health and Human Services; and

5. Our office will obtain your written authorization for uses and disclosures not identified by this notice.

If you have any questions regarding this notice, please contact us at 480-779-4999; Durbin Family Internal Medicine, PLLC, 16601 N. 40th St., Ste. 119, Phoenix, AZ 85032