SKYLINE MEDICINE POLICIES

(Please read and initial each line and sign and date below.)

Initial

_____*As a patient paying for today's office visit (**SELF PAY PATIENTS**), I understand that* ***payment of cash or credit card is due at time of service.***

_____I have insurance and have provided that information to Skyline Medicine. I realize that it is ***my responsibility*** to notify Skyline Medicine of any insurance or address changes.

_____I understand that ***co-pays are due at the time of service*** and that this is a contract between me and my insurance company.

_____I understand that some services recommended by Skyline Medicine may or may not be covered by my insurance company and that ***non-covered services are still my responsibility. Failure to provide accurate insurance information will result in all charges being assigned directly to patient/guardian.***

_____I understand that it is my responsibility to contact my insurance to find out what procedures will or will not be covered in my office visits (i.e, immunizations).

_____I understand that the estimate of benefits by my insurance is not a guarantee of payment and may not be accurate at the time of my visit. I will be responsible to pay for those procedures not covered by my policy. It is the patient/guardian responsibility to know what their benefits are.

_____I understand that after **45 days from date of service if my insurance company has not made a payment on my claim it will be my responsibility to pay Skyline Medicine and follow up with my insurance company.**

_____I understand that a ***$25.00 late fee*** will be added to my account on any unpaid patient balances and after 60 days my account will be turned over to a collection agency.

_____I understand that a ***$50.00 no show fee*** will be added to my account for any appointments that I do not call to cancel or reschedule.

_____I understand that a ***$25.00 fee will be added for all returned checks.***

_____ I understand that **refills on medications must be written in an appointment setting.** *Please have medications and refill expiration dates available to discuss with the doctor. Depending on the medication will determine how often a prescription needs to be refilled.*

_____ Of late we've had patients request medical services for themselves (refills, evaluation, opinions) while accompanying their loved one(s) during their appointment. ***While minimal commentary from the physician may be appropriate and deemed "pro bono" (i.e.—Tylenol dosing), I understand that, at the discretion of the Skyline provider, I may be billed for an appointment while requesting the aforementioned services. I understand, too, however, that while accompanying a loved one to an appointment I may request an appointment for myself at the front desk and oftentimes be accommodated for such a request.***

_____ _____ _____

Signature Print Name Date

If you would like a copy of this form please ask the receptionist at the front desk. Updated 11/11

SKYLINE MEDICINE-PEDIATRIC
(Please Print)

PATIENT'S NAME:_____
Last Name, First Name Middle Initial

ADDRESS:_____ APT#_____

CITY:_____ STATE_____ ZIP_____

PARENT/ GUARDIAN e-mail address _____

PHONE #:(_____)_____-_____ DATE OF BIRTH: _____ SEX: (---
Month day year

Mothers Name _____

Address ***(if different from above)*** _____

Telephone number ***(if different from above)*** _____ Cell # _____

Employer_____ Work # _____

Fathers Name _____

Address ***(if different from above)*** _____

Telephone number ***(if different from above)*** _____ Cell # _____

Employer_____ Work # _____

Ethnicity (please circle) Hispanic ◯ Not Hispanic ◯

Race (please circle) Asian ◯ Black or African American ◯ Hispanic ◯ White ◯

Other (please specify) _____

Language (please circle) ◯English ◯Spanish ◯Other (please specify) _____

Primary Insurance

Insurance Company Name: _____

Insurance Company Claims Address: _____

Policy #:_____ Group #:_____

Insured's name:_____ Insured's Date of Birth: _____ ---

Insured's Employer: _____ Insured's SS# _____

Relationship to Patient:_____

Secondary Insurance

Insurance Company Name: _____

Insurance Company Claims Address: _____

Policy #:_____ Group #:_____

Insured's name:_____ Insured's Date of Birth: _____ ---

Insured's Employer: _____ Insured's SS# _____

Relationship to Patient:_____

PHARMACY NAME & TELEPHONE _____

Emergency Contact

Name/Number/Relationship_____

Who may receive information regarding your Protected Health Information? (Check all that apply)

Parent/Guardian ☐ Name: _____ Date of Birth:_____
Name: _____ Date of Birth:_____
Other ☐ Name: _____ Date of Birth:_____
Name: _____ Date of Birth:_____

May we leave messages regarding test results and appointments on your answering machine? ◯ Yes ◯ No

Whom may we thank for referring you to our office? _____

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

I also give permission to Skyline Medicine to forward my (or my dependent's) medical records to my insurance company. I recognize that my insurance company may request these records to verify eligibility and medical claims Skyline Family Medicine submits thereto. I also recognize that payment to Skyline Medicine is my responsibility and that my insurance company may or may not cover services provided during this or any other visit.

Date:_____ Signature_____
Circle One (PATIENT/ PARENT/ GUARDIAN)

Pediatric History

Patient Name _____ Date _____

- Regarding the patient's birth, please circle any of the following that apply AND provide details as to severity, treatment of condition, etc:

Abnormal hearing test-

Metabolic or endocrine disorder (PKU, galactosemia, hypothyroidism, etc)-

Premature birth-

Newborn jaundice-

Prolonged hospitalization for newborn sepsis (infection), prematurity, respiratory distress, or any other reason-

Genetic abnormalities apparent at birth OR genetic concerns (Down's syndrome, cystic fibrosis, etc.)-

- Has patient ever been diagnosed with Failure to Thrive-i.e-difficulty with growing, gaining weight, or reaching developmental milestones (walking, rolling over, learning alphabet, acquiring vocabulary, etc.)?

- Are the patient's immunizations up to date? --- ***Please provide an immunization record that we can copy for our records.***

- Does the patient have any food or drug allergies of which Skyline Medicine should be aware?

- Please indicate in which grade and school the patient participates. If patient is not currently in school, simply write N/A.

- Any concerns regarding patient's inattentiveness and or hyperactivity at school, home or elsewhere? ---

- Where applicable, does the patient have any history of substance abuse of which you're aware? ---

- Please list any pertinent family medical history (diabetes, rheumatoid arthritis, depression, hypothyroidism, etc) that affects either the patient's parents or grandparents:

- Please list all over the counter and prescription medications this patient takes routinely:

PEDIATRIC

Patient Name_____ Date of Birth_____

Please Check Any Of The Following Symptoms That *Currently* or *Recently* Apply To You.

Seasonal Allergies

Respiratory

- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Chest Congestion
- ☐ Cough

Cardiac

- ☐ Dizziness
- ☐ Chest Pain
- ☐ Fast Heart Rate

Constitutional

- ☐ Night Sweats
- ☐ Heat/Cold Intolerance
- ☐ Fever
- ☐ Weakness
- ☐ Weight Gain/Loss
- ☐ Loss of Appetite
- ☐ Fatigue

Skin

- ☐ Rash
- ☐ Mole
- ☐ Lumps
- ☐ Hives

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

ENT

- ☐ Hearing Loss
- ☐ Cough
- ☐ Sore Throat

Gynecology

- ☐ Pelvic Pain
- ☐ Breast Pain/Mass

Gastroenterology

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool

Blood Disorders

- ☐ Anemia
- ☐ Swollen Glands
- ☐ Easy Bruising

Musculoskeletal

- ☐ Joint Stiffness/Pain/Swelling

Neurology

- ☐ Migraine Headache
- ☐ Tension Headache
- ☐ Numbness
- ☐ Seizures
- ☐ Insomnia
- ☐ Dizziness

Ophthalmology

- ☐ Diminished Vision
- ☐ Eye Irritation
- ☐ Blurring of Vision

Psychiatry

- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Abuse Mental or Physical

Urology

- ☐ Difficulty Urinating
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urinary Incontinence

Skyline Medicine recommends that all patients get an annual physical in order to deliver excellent, comprehensive primary care. Often during this appointment new or established problems are also addressed in order to not create the need for a second appointment on a separate day. **Please contact your insurance company to understand your coverage and costs.** Thank you for entrusting us with your care.

Patient Name _____

HAVE ANY OF YOUR BLOOD RELATIVES EVER HAD:	Yes	List Relative Relation
Anemia	☐	
Bleeding tendency	☐	
Cancer	☐	
Diabetes mellitus	☐	
Epilepsy/seizures	☐	
Heart attack or heart disease	☐	
High blood pressure	☐	
Mental or emotional problems	☐	
Stroke	☐	

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS (WHERE POSSIBLE):

	Name		Date of Birth	Deceased	Living
Father				○	○
Mother				○	○

Number of SISTERS _____ Number of BROTHERS _____

Skyline Medicine

MAIN OFFICE *PATIENT INFORMATION*
(480) 924-4422 *(480) 481-6487*

To our patients:
In our continuing effort to provide the very best care possible for you, our valued patient, we have added an additional service.

This service will enable you to quickly access information such as laboratory test results, Doctor's instructions and other pertinent information by calling our private patient information line. We have implemented new technology that will help make us more effective in providing you with timely information. Please review this information and feel free to ask the nurse if you have questions.

It is also very important that you notify us with any changes in your home phone number, as this will affect our success in contacting you.

Lab: When you have lab work done or tests performed in our office, your results will be called in to a private mail box on our patient information line. We will then contact you, to let you know you have a message to retrieve. You can call the Patient Information Line at **(480) 481-6487** and follow the easy instructions to retrieve your message. The information you will be given will be very specific and you should listen to the entire message for further instructions or information regarding medication changes. ***Please listen to the entire message to ensure you receive all the information that our staff has left on the Patient Information Line.***

At the end of your message you will be given three options:

- Press 1 to repeat the message,
- Press 2 to delete the message,
- Press 3 to save the message.

The maximum amount you can save a message is two days from the time you first listen to the message. At the end of the two days, the message will be automatically deleted from the system.

If you have any questions after receiving your results you may call our main office phone at (480) 924-4422 during normal business hours. You may need to leave a message with the receptionist as to the nature of your questions and the phone number where you can be reached so we can have your chart available when we call you back.

Just follow this simple guide to retrieve your information:

- Using a "Touch-Tone" telephone (a phone that beeps when you dial) call **(480) 481-6487.**
- Listen to the prompts in English, press 1.
- Dial your **identification number** (your **social security number** unless otherwise specified).
- Record your name. End your recording by pressing 1.

BE SURE TO LISTEN TO YOUR ENTIRE MESSAGE

After listening to your message, press 1 to repeat, 2 to delete or 3 to save.

You can now hang up your phone! That's all there is to it!

Skyline Medicine

6112 E. Brown Rd. Mesa, AZ 85205
(480) 924-4422

Patient Information

Sick Visits vs. Well visits or BOTH?

- **Sick Visit** – This is an office visit for an acute problem or flare-up of a chronic problem. This could also be an office visit to follow-up on chronic problems (Diabetes, Cholesterol, Blood Pressure, etc.).

- **Well Visit** – This is an office visit for a routine physical exam or yearly health maintenance exam.

- **Sick/Well Visit** – This is a ***combination visit*** of a routine physical exam where an acute or chronic issue is addressed as well. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a ***combination visit*** and must be billed differently than just a well visit or just a sick visit.

- **Why is it billed differently?** - It is billed differently to account for the additional work, expertise and time required for a combination visit (additional lab work, x-ray, referrals, and/or prescription medications). It involves additional documentation as well. For example, think about taking your vehicle in for an oil change (routine maintenance), and mentioning to the mechanic that your brakes are squeaking and your windshield wipers were not working well. In addition to the oil change, you might require additional brake work if a problem was found and replacement windshield wipers. Since additional services were provided, you would be charged more than just for the oil change.

- **How does this affect me?** Although many insurance companies acknowledge the sick/well visit combination, some of them still require the patient to pay two co-pays or have additional costs applied to his/her annual deductible.

We realize this can be confusing and if you have ANY questions or concerns after reviewing this material, please ask.