NALLY FAMILY PRACTICE

Welcome. Why choose Nally Family Practice?
We would like to be your nearby Surprise, Arizona, family physician office. Our office is made up of three practitioners, Dr. Adam Nally and physician assistants, Brad Hall PA-C, and Jenna Lightfoot PA-C. They work closely together to provide the best care for you and your family.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office. The Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

Participating patients are given secure User IDs and passwords, enabling them to access the Portal to view their personal and private documents, including lab and diagnostic test results, educational information, billing statements, and other health information.
Through the Patient Portal, you are able to:

- ask questions of doctors, nurses, and staff members
- request prescription refills and referrals
- set up appointments
- view your personal health record
- examine your current and past statements

You must fill out all of the enclosed forms completely prior to your first appointment. Incomplete paperwork will affect your visit with the doctor. As a patient of our practice it will be **required** for you to provide your SSN for identification purposes and prescriptions, please talk to our office staff with any questions or concerns.
Please check that you have received, filled out, and signed these forms included in this packet:

Print Name:_____ _____ _____

Signature:_____ Date:_____

NALLY FAMILY PRACTICE

Patient:_____ _____ _ _ D.O.B:_ _____ _

Demographics

Please Complete prior to your first office visit, so we can better assist you with your health during that visit.
Please print all written information.

Patient Information

First:_____ MI:___ Last:_____ _____ Suffix:____ Sex: ☐Female ☐Male

Preferred name:_____ _____ DOB:_____ Age:____ **SSN**:_____

Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed Primary Language: ☐English ☐Spanish ☐Other:_____

Ethnicity: ☐Caucasian ☐Black ☐Hispanic ☐Asian ☐Other:_____

Primary Address:_____ _____ City:_____ State:____ Zip:_____

Mailing Address:_____ City:_____ State:____ Zip:_____

Primary Telephone:_____ Leave VM? ☐Yes ☐No Secondary Telephone:_____

Occupation:_____ Employer:_____ Employer phone:_____

Employer's Address:_____ _____ City:_____ State:____ Zip:_____

Preferred Pharmacy (name & cross streets)_____ _____

E-mail:_____ _____

**E-mail authorization is a separate form that specifies what we can send you, for example; electronic statements, forms to update your chart, and login information about your portal account.*

Family Information

Spouse's name:_____ _____ Telephone:_____ Leave VM? ☐Yes ☐No

Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Employer:_____ Employer phone:_____

Number of children:____ Child 1:_____ Child 2:_____ Child 3:_____ Child 4:_____ Child 5:_____ Child 6:_____

Other children:_____ _____

Are your children covered under your insurance Policy?☐Yes ☐No Spouse's? ☐Yes ☐No

Emergency Contacts

Name:_____ Relationship:_____ Phone:_____

Primary Address:_____ _____ City:_____ State:____ Zip:_____

Name:_____ Relationship:_____ Phone:_____

Primary Address:_____ _____ City:_____ State:____ Zip:_____

Name:_____ Relationship:_____ Phone:_____

Primary Address:_____ _____ City:_____ State:____ Zip:_____

NALLY FAMILY PRACTICE

Patient:_____ _____ _ _ D.O.B:_____

Insurance information

Please Complete prior to your first office visit, so we can better assist you with your health during that visit.
**Please make sure to inform the office whenever any of your insurances change.*

Primary Insurance

Insurance Name:_____ Effective Date start:_____ End:_____

ID-Policy-Subscriber Number:_____ _ Group Number:_____ _

Insurance Address to submit Claims:_____ _____

City:_____ _____ State:_____ Zip Code:_____

Policy Holder's Full Name:_____ _____ *Same as on insurance Card*

Policy Holder's SSN:_____ Policy Holder's Date of Birth:_____

Relationship to patient: □Self □Other:_____

Employer of Policy Holder:_____ Telephone:_____

Secondary Insurance

Insurance Name:_____ Effective Date start:_____ End:_____

ID-Policy-Subscriber Number:_____ _ Group Number:_____ _

Insurance Address to submit Claims:_____ _____

City:_____ _____ State:_____ Zip Code:_____

Policy Holder's Full Name:_____ _____ *Same as on insurance Card*

Policy Holder's SSN:_____ Policy Holder's Date of Birth:_____

Relationship to patient: □Self □Other:_____

Employer of Policy Holder:_____ Telephone:_____

Tertiary Insurance

Insurance Name:_____ Effective Date start:_____ End:_____

ID-Policy-Subscriber Number:_____ _ Group Number:_____ _

Insurance Address to submit Claims:_____

City:_____ _____ State:_____ Zip Code:_____

Policy Holder's Full Name:_____ _____ *Same as on insurance Card*

Policy Holder's SSN:_____ Policy Holder's Date of Birth:_____

Relationship to patient: □Self □Other:_____

Employer of Policy Holder:_____ Telephone:_____

(The above information must be filled out completely or patient will be considered a cash pay and be billed for services rendered)

I _____hereby authorize Adam S. Nally, DO. Office to release any information acquired in the course of my examination or treatment to the referring physician or insurance carriers listed above.

Signature:_____ _____ Date:_____

NALLY FAMILY PRACTICE

Patient:_____ D.O.B:_____

Disclosure of Health Information to Family, Friends or Others

The HIPAA Privacy Rule prohibits the disclosure of Protected Health Information (PHI) without the authorization of the patient. Examples of PHI would be test results, medication information, payment information, or anything considered patient condition, treatment, or payment related. Please choose one of the following disclosure options:

□ **No, do not** allow disclosure of my PHI to anyone, including family members, other relatives, close personal friends, etc.

□ **Yes, please allow** disclosure of my PHI (including detailed messages by phone, fax, e-mail, voice mail, or any other means) to my contact info and to the following person(s):

Full Name:_____

Relationship:_____ Phone#:_____

Full Name:_____

Relationship:_____ Phone#:_____

Full Name:_____

Relationship:_____ Phone#:_____

Signature: _____ Date: _____

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, to my personal contact information or with the above-named persons. I understand that it is my responsibility to keep the office informed of any changes to this information and agree to hold the office harmless if my PHI is disclosed due to my failure to notify the office of changes or updates.

E-mail Authorization

Our office now has a notification program for our patients who have e-mail. If interested, you would receive notification on your laboratory, radiological or other diagnostic data via e-mail instead of by phone.

This program will be for normal studies only. If your diagnostic data is normal, you will receive an e-mail including a copy in "PDF" format of your study as an attachment to your e-mail. Any abnormal labs will not be e-mailed and you will be notified via the phone regarding instructions that Dr. Nally would like you to follow.

Our office also offers an E-statement option. You have the choice of receiving your billing statements via e-mail, or regular mail. It is a secure 256 bit encryption and SSL protected way to receive your statements.

By checking yes and signing this form, you are giving Nally Family Practice (Adam S. Nally, D.O., P.C.) permission to send diagnostic studies and E-statements for your review to the e-mail address below. It is your responsibility to ensure that the address below is secure and protected. It is also your responsibility to immediately notify our office when changes to your e-mail address occur. It is our intent to help you receive information about your medical care in a more efficient manner.

Electronic Diagnostic Results

□ Yes – I would like to receive my results via e-mail

□ No – I do not want my results via e-mail

Electronic Billing Statements

□ Yes – I would like to receive e-statements.

□ No – I do not want my billing statements via e-mail

Electronic Forms

□ Yes – I would like to receive my annual update forms via e-mail

□ No – I do not want my forms via e-mail

Patient Full Name:_____

E-mail Address (please print):_____

Signature:_____ Date:_____

We do not create individual profiles with the information you provide. If information is collected, it will be used solely in connection with Nally Family Practice. We do not give, sell, or transfer any personal information to a third party. All information is securely stored with 256-bit encryption and SSL protection.

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Patient:_____ _____ _ _ D.O.B:_____ _

ERISA Authorization

For good and valuable consideration, I _____ , do hereby designate, authorize, and convey to Dr. Adam S. Nally, D.O. to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan:

a) the right and ability to act on my behalf in connection with any claim, right or chose in action that I may have under such insurance policy and/or any employee Health care benefit plan; and

b) The right and ability to act on my behalf to pursue such claim, right or chose in action in connection with said insurance policy and/or employee health care benefit plan (including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the provisions of the Employee Retirement Income Security Act of 1974 as provided in 29 CFR §2560.503-1(b)(4)) with respect to any medical or other health care expense incurred as a result of the service I received from the above-named doctor and, to the extent permissible under law, to claim on my behalf, such medical or other health care service benefits, insurance or health care benefit plan reimbursement and any other applicable remedy.

I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authorize the office of Adam S. Nally, D.O. to obtain, on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) files. I further agree to pay all collection on costs, attorney fees, and any other collection costs that may be incurred to enforce collections of any amounts outstanding. A late fee of $10 per statement cycle for accounts over 30 days will be applied. Collections fees are 50% of balance and all balances over 120 days past due will be submitted to collection agency TSI. I authorize payment of medical benefits to the provider for services of these insurance companies listed on Insurance Information form.

Signature: _____ Date: _____

ADVANCED BENEFICIARY NOTICE (ABN) – ___

This notice is to inform you that periodically your doctor may order testing or perform an examination that is not a covered item or service under your insurance plan. Your insurance only pays for covered items and services when certain rules are met. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There are legitimate reasons your doctor may recommend particular items or services that are not covered. It is ultimately your responsibility, as the insured, to know what your individual insurance plan will and will not cover. By signing this form, you are agreeing to pay for services rendered that are not covered by your insurance company. The most common items or services not covered but frequently recommended by your doctor are:

For Medicare Advantage plans and For Commercial Payers

Complete yearly physical (99397)

Annual Wellness Visit (AWV) initial G0438 and subsequent G0439 is a covered Medicare Benefit; *an AWV is not a complete or partial physical.*

Pap smear collection (Q0091)/Breast/pelvic exam (G0101) is paid 100% during complete yearly physical

Preventative or Screening ekg (93000) is not a covered benefit

Hepatitis A injection (90632 – 90634)

TDaP – (90715), Tetanus vaccine (90703), B12 injection (J3420)

Dietary counseling for BMI 29 and lower

Any patient requesting to schedule a preventive service such as a physical that wishes to discuss any other health problems with the doctor needs to ask their insurance carrier if they bundle a problem-oriented visit with preventive service. It is our recommendation to schedule the problem-oriented visit first and the preventive service another day. If two different appointments is an inconvenience and lost work time for a patient they are encouraged to contact their insurance company and his or her employer and state that the consequences of the insurer's payment policy is an inconvenience. It takes many voices to make a change for the better.

By signing this form, I understand that my insurance may not cover the above items or services and that I may have to pay the bill while my insurance makes its decision. If my insurance does pay, I will be refunded any payment that is due to me. If my insurance denies payment, I agree to personal and full responsibility for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my insurance's decision.

Signature: _____ _____ Date: _____ ____

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Patient:_____ _ D.O.B:_____

Explanation of Physical Exam versus Problem Focused Visit

Terms you should know when scheduling your appointment:

- Physical (Complete physical)
- IPPE (Welcome to Medicare physical)
- AWV (Annual wellness visit) for those 65 and older

We want you to receive wellness care – health care that may lower your risk of illness or injury. Most commercial plans cover wellness care. For those that qualify for Medicare or Medicare advantage insurance plans, it is important to note that you plan pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medical benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare and Medicare advantage plans does not pay for a traditional, head-to-toe physical. Some secondary and tertiary payers will cover the cost of your "physical" it is important for you to contact your insurance providers and know your coverage benefits prior to your visit. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment and during, our staff will ask you some questions about your health and may ask you to fill out a form. A physical, IPPE, and AWV **DOES NOT** include addressing specific new or existing health problems or refilling medication. That would be a separate service and may require a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, a refill or something else. A separate charge applies to these services, whether provided on the same date or a different date than the physical, IPPE, or AWV.

We hope to help you get the most from your wellness benefits. Please contact us with any questions.

Sincerely,

Nally Family Practice

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Patient:_____ D.O.B:_____

Health History

Please Check those conditions you have been diagnosed with and write any that are not listed below.

Vision:	□ Cataracts	□ Glaucoma	□ Macular Degeneration	
Hearing:	□ Hearing loss	□ Dizziness	□ Vertigo	
	□ Tinnitus (ringing in ears)			
Allergies : (Environmental)	□ Chronic (sinus infection)		□ Allergic rhinitis (runny nose)	
Lungs:	□ Asthma	□ Emphysema	□ Valley fever	□ COPD
	□ Pulmonary Embolism			
Cardiovascular:	□ Hypertension (Elevated blood Pressure)		□ Dyslipidemia (High cholesterol)	
	□ Myocardial Infarction (Heart Attack)		□ Dysrhythmia (Abnormal heart rhythm)	
	□ Atrial fibrillation		□ Heart murmur	
	□ CHF (heart Failure)		□ CAD (heart disease)	
Vascular Disease:	□ Use of Anti-Coagulant (Blood thinner daily)		□ DVT (blood clot in extremity)	
	□ Hemophilia (bleeding Disorder)		□ Coagulopathy (clotting disorder)	
	□ CVA (Stroke)	□ TIA (mini-stroke)	□ Peripheral Vascular Disease (PVD)	
Endocrine:	□ Hashimoto's disease	□ Graves' disease	□ Anemia	□ Thyroid cancer
	□ Hyperthyroidism	□ Hypothyroidism	□ CKD (chronic kidney Disease)	
	□ Iron deficiency	□ Vitamin D deficiency	□ Vitamin B12 deficiency	
	□ Diabetes Mellitus (DM) *Type I* (insulin use)		□ Diabetes Mellitus (DM) *Type II*	
Cancer:	□ Previous Type:		□ Current Type:	
Neurologic:	□ Encephalopathy:		□ Neuropathy:	
	□ Concussion/head trauma (date):		□ Sciatica Location:	
	□ Parkinson's disease	□ Tremor	□ Alzheimer's disease	□ Neuritis
	□ Seizure disorder	□		
Rheumatologic:	□ Rheumatoid arthritis	□ Osteopenia	□ Herniated Disk	□ Lupus
	□ Fibromyalgia	□ Osteoporosis	□ Chronic Fatigue syndrome	
	□ Connective tissue disorder			
	□ Osteoarthritis: □ *Spine* □ *Hips* □ *Knees* □ *Ankles/Feet* □ *Shoulders* □ *Hands*			
	□ Chronic back problems: □ *Neck* □ *Mid-Back* □ *Low-Back*			
Gastrointestinal	□ Hemorrhoids	□ Hiatal hernia	□ Diverticulosis	
	□ GERD (acid reflux)	□ Diverticulitis	□ PUD (Peptic Ulcer Disease)	
	□ Cholecystitis (Gallstones/Gall bladder)			
	□ Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis)			
Genitourinary:	□ Overactive bladder	□ Kidney stones	□ Recurrent UTI	
	□ Incontinence: □ Stress or □ Urge		□ Chronic Hematuria (blood in urine)	
	□ Sexually Transmitted Disease (STD): □ *Herpes* □ *Gonorrhea* □ *Trichomonas* □ *HPV*			
Male:	□ Erectile dysfunction	□ Prostate Cancer	□ BPH (prostate enlargement)	
Female:	□ Uterine fibroid	□ Ovarian Cysts	□ Abnormal menses	
	□ Fibrocystic breast disease			
Skin:	□ Psoriasis	□ Eczema	□ Fungal skin infection	
	□ Actinic Keratosis (pre-cancers)			
Psychiatric:	□ Depression	□ Anxiety	□ Mood disorder	□ Alcoholism
	□ Drug abuse			

Previous Fractures: _____

Other: _____

NALLY FAMILY PRACTICE

Patient:_____ D.O.B:_____

Health History: Surgical History

Please check all that apply and year done (approximate) and write in any that are not listed below.

ENT:	□ Cataract	□ Retina	□ Sinus surgery	□ Tonsillectomy
GI:	□ Colostomy	□ Bowel surgery	□ Appendectomy	□ Laparoscopy
	□ Cholecystectomy (Gall bladder)		□ Hernia Repair: □L □R (location):	
Cardio:	□ CABG (heart bypass)	□ Heart transplant	□ PTCA (Cardiac Stent)	□ Valve replacement
	□ Pacemaker	□ Cardiac Ablation		
GU:	□ C-section#:_____	□ Hysterectomy	□ Bladder surgery	
	L R		L R	
Extremities:	□ □ TKA (Total Knee Replacement)		□ □ THA (Total Hip Replacement)	
	□ □ Shoulder Surgery		□ □ Joint Arthroscopy (location):	
Pregnancy/ Menstrual History:	#Pregnancies:_____ #Birth(s):_____		#Still birth(s):_____	#Miscarriage(s):_____
	#Elective abortion(s):_____		Abnormal PAP History: □ yes □ no	
	Menstruation regularity: □ Monthly □ Irregular □ Menopausal			
	Date of last menstrual period:_____		Date of last PAP:_____	
	Date of last Mammogram:_____		Date of last DEXA (bone density) Scan:_____	

Other screening exams: *(year)* EKG:_____ EGD:_____ Chest X-ray (CXR):_____ Colonoscopy:_____

Drug allergies/ intolerances

Please list all medications that you have had an allergy to or side effects from plus the type of reaction.

Medications/vitamins/supplements *Please list all medications including herbal products and supplements.*

Medication & Strength i.e. Lisinopril 10mg	Dosing i.e. 1 tablet/capsule	Frequency i.e. once a day

IMMUNIZATIONS *Please give the last date of the immunizations below.*

Hepatitis A:_____ Hepatitis B:_____ Pneumonia:_____ Typhoid:_____

Yellow Fever:_____ Small Pox:_____ Tetanus:_____ Influenza:_____

TB Skin Test:_____ □ Positive □ Negative

Family History

Please check for which side (Maternal, Paternal) all those that apply and write in any that are not listed.

YOUR father: □Adopted / □Unknown **YOUR mother:** □Adopted / □Unknown

	M P	M P
Cardiovascular	□ □ Hypertension (Elevated blood pressure)	□ □ Atrial fibrillation
	□ □ Dyslipidemia (High cholesterol)	□ □ Heart murmur
	□ □ Myocardial Infarction (Heart Attack)	□ □ CAD (Heart disease)
	□ □ Dysrhythmia (Abnormal heart rhythm)	□ □ CHF (heart failure)
Lungs:	□ □ Pulmonary embolism	□ □ Emphysema
	□ □ COPD	□ □ Asthma
	□ □ Valley Fever	□ □ Other:
Vascular disease:	□ □ DVT (blood clot in extremity)	□ □ Hemophilia (bleeding Disorder)
	□ □ CVA (Stroke)	□ □ Coagulopathy (clotting disorder)
	□ □ Peripheral Vascular Disease (PVD)	□ □ other:

NALLY FAMILY PRACTICE

Patient:_____ D.O.B:_____

Health History: Family History continued

Please check for which side (Maternal, Paternal) all those that apply and write in any that are not listed.

	M P	M P
Neurologic:	□ □ Encephalopathy:_____	□ □ Alzheimer's disease
	□ □ Sciatica Location:_____	□ □ Seizure disorder
	□ □ Neuropathy:_____	□ □ Tremor
	□ □ Neuritis:_____	□ □ Parkinson's disease
Endocrine:	□ □ Hashimoto's Disease	□ □ Graves' disease
	□ □ Thyroid cancer	□ □ Anemia
	□ □ Hyperthyroidism	□ □ Hypothyroidism
	□ □ CKD (chronic kidney Disease)	□ □ Vitamin B12 deficiency
	□ □ Iron deficiency	□ □ Vitamin D deficiency
	□ □ Diabetes Mellitus(DM); *Type I* (insulin use)	□ □ Diabetes Mellitus(DM); *Type II*
Gastrointestinal	□ □ GERD (acid reflux)	□ □ Cholecystitis (Gallstones/Gall bladder)
	□ □ Hiatal hernia	□ □ PUD (Peptic Ulcer Disease
	□ □ Irritable or Inflammatory bowel disease (IBS, Crohn's Disease, Colitis)	
Rheumatologic	□ □ Rheumatoid arthritis	□ □ Osteoporosis
	□ □ Osteopenia	□ □ Osteoarthritis
	□ □ Herniated Disk	□ □ Lupus
	□ □ Fibromyalgia	□ □ Chronic Fatigue syndrome
	□ □ Connective tissue disorder	□ □ Other:
Psychiatric:	□ □ Depression	□ □ Alcoholism
	□ □ Drug abuse	□ □ Anxiety Mood disorder
Cancer:	□ □ Colon	□ □ Pancreatic
	□ □ Prostate	□ □ Bone
	□ □ Leukemia	□ □ Lung
	□ □ Gastric	□ □ Other:

YOUR Siblings:_____ Paternal family:_____ Maternal Family:_____

Social history

Circle or check all those that apply.

Marital Status: □ Single □ Married □ Divorced □ Remarried □ Widowed

Who do you live with? _____ Number of Children: _____

Occupation:_____ Religious Preference:_____

Sexual Activity: □Inactive □Active-Single Partner □Active-Multiple partners □Active-Same gender partner

Tobacco Use: □ *Never* □Quit (year___) □Current*:(□Cigarette □Cigar □Chew)Packs per day*:____ for___years

Alcohol Use: □ *None* □ Number of beers/ glasses of wine #___, per day / week/ month: _____

Illicit Drug Use: □ *Never* □ Quit □Current:(□*Marijuana* □*Methamphetamines* □*Cocaine* □*Heroin* □*Ecstasy*)

Advanced directives

If you have any of the below documents, please bring a copy in for your medical record.

Do you have an Advanced Medical Directive? □ *Yes* □ *No* Do you have a Living Will? □ *Yes* □ *No*

Do you have a medical Power of Attorney? □ *Yes* □ *No*

What are we seeing you for today?_____

What are your main symptoms?_____

Please list any other concerns:_____

How did you find us? _____

Thank you and Welcome to the practice.