ARIZONA LIVER HEALTH™

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

ACCOUNT # _____

Today's Date: [Date]		PCP:	
Patient's last name:	First:	Middle:	Marital status:
Maiden Name:	Date of Birth:	Age:	Select: Male ☐ Female ☐
Address: [Address/ P.O Box, City, ST ZIP Code]		Email:	
Social Security no.:	Home phone no.:		Cell phone no.:
Occupation:	Employer:		Employer phone no.:

Ethnicity: Non-Hispanic or Latino ◯ Hispanic/Latino ◯ Race: White ◯ Hispanic ◯ African American ◯ Asian ◯

Referred to clinic by:

PREFERRED PHARMACY: PHONE:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Emergency contact #1:	Relationship to patient:	Home phone no.:	Work phone no.:
Emergency contact #2:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ARIZONA LIVER HEALTH or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

Patient's name:

ARIZONA LIVER HEALTH™

Allergies

Medical Conditions

Prior Surgeries & Hospitalizations

Medications	**For**	**Dose**	**Frequency**

Patient's name: _____

ARIZONA LIVER HEALTH™

HIPAA Protected Health Information Form

Name:_____ DOB:_____

I_____authorize Arizona Liver Health to release and/or discuss protected health information pertaining to my care to the below listed individuals. I realize that if I've listed an emergency contact on my registration paperwork, and I want them to have access to my protected health information, I must list them below. I also understand I may revoke access to the listed individuals at any time. I also understand the withdrawal must be in writing.

Name/ Relationship/ Telephone Number

1. _____
2. _____
3. _____
4. _____

☐ I **do not** authorize my medical records to be released or discussed with anyone.

_____ _____

Signature of Patient or Legal Representative Date

Patient's name: _____

ARIZONA LIVER HEALTH™

Medical Records Release- TO ALH

I **authorize** the provider listed below to provide medical records to Arizona LiverHealth, formerly *The Institute for Liver Health*.

Provider(s) Name: _____

_____

Address:_____City:_____State:_____Zip Code:_____

Phone: _____Fax: _____

Medical records may include confidential information related to HIV, communicable disease, alcohol, drug abuse and mental health diagnosis and treatment.

___Yes, I authorize ___I **do not** Authorize

Records Requested:

Complete Medical Records	Operative/ Discharge
Pathology and Procedures	Progress Notes
Hospital Reports	Radiology Reports
Labs and Reports	Other_____

I understand that:

- I may revoke this authorization at any time, except to the extent that it has already been acted upon
- Treatment will not be conditioned on my providing this authorization, unless the provision of healthcare is solely for the purpose of created protected health information for disclosure to a third party
- Once this information is released, it may be re-disclosed by the recipient and may nolonger be protected information

I authorize Arizona Liver Health to access the Health Information Exchange to retrieve records related to my the above listed history and records.

_____ _____

Signature of Patient or Legal Representative Date

Patient's name: _____

healthcurrent

Notice of Health Information Practices

Arizona Liver Health participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information.

I acknowledge I have received and read the Notice of Health Information Practices. I understand my healthcare provider participates in Health Current, Arizona's health information exchange (HIE}. I understand my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Signature Date

Aviso de Practicas de Informaci6n de Salud

Salud del hígado de Arizona participa en una organizaci6n sin animo de lucro, organizaci6n no gubernamental de intercambio de informacion sobre la salud (HIE-por sus siglas en ingles) llamada Health Current. Esto no le generara ningun costo y puede ayudar a su medico, proveedores de salud y planes de salud a coordinar mejor su cuidado compartiendo de forma segura su informacion medica. Este aviso explica c6mo funciona el programa HIE y le ayudara a entender sus derechos con repesto al mismo bajo las leyes estatales y federales.

Yo reconosco que he recibido y leido el Aviso de Pr<icticas de Informaci6n de la Salud. Yo estoy consiente que mi proveedor participa en el HIE (Arizona's Health Information Exchange). Yo estoy consiente que mi informaci6n de la salud sera compartida de manera segura atravez de/ sistema HIE, al menos de que llene una forma de Optar Par No.

Firma Fecha