Ashwini Ammunje, MD
Ana Ciszek, MD
Hamidullah Fala, MD
Roberto Lopez, MD
Pedro Rodriguez-Guggiari, MD
Breezy Doling, NP
Jenniffer Ramirez, NP

14420 W Meeker Blvd., #201 Sun City West, AZ 85375
9139 W Thunderbird Rd., #265 Peoria, AZ 85375
926 E McDowell Rd. #208 Phoenix, AZ 85006
P-(623)777-4567 F-(623)777-4497

Patient Registration:

Name: _____ Date of Birth: _____

Address: _____ City/ZIP: _____

Home phone: _____ Cell: _____

Social Security Number: _____ E-mail: _____

Gender: Female Male

Marital Status: Married Single Widowed Divorced

Race: Caucasian Hispanic African American Asian American Indian/Alaskan Native Hawaiian/Other Other_____

Ethnicity: Hispanic Origin Not of Hispanic Origin Refused by Patient

Preferred Language: _____

Employment Status: Retired Disabled
Employed/Employer: _____ Work phone: _____

Preferred Pharmacy: (Phone Number and Location)

_____

Emergency Contact:

Name: _____Relationship: _____Telephone: _____

Who Referred you?

_____

Primary: Insurance Company _____

ID# _____ Group# _____ Policy Holder Name: _____

DOB: _____ Relationship to Insured: _____

Secondary: Insurance Company _____

ID# _____ Group# _____ Policy Holder Name: _____

DOB: _____ Relationship to Insured: _____

INSURANCE PAYMENT/FINANCIAL RESPONSIBILITY RELEASE

I request that payment of authorized Medicare benefits, or any other insurance benefits be made to either me or on my behalf to Guggiari Medical PC (DBA: True Care MD) for any services furnished to me by the Physician/Provider. I authorize any holder of medical information concerning me to be released to my insurance carrier or Health Care Financing, its agents; any information needed to determine these benefits or the benefits payable for related services. A photocopy of this authorization shall be considered effective and valid as the original.
I understand that I am financially responsible for all charges not covered by my insurance company.

Signature: _____ Date: _____

Notice of Privacy

To Our Patients: 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

□ we realize that these laws are complicated, but we must provide you with the following important information
□ 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 in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.

2. Lawsuits and similar proceedings in response to a court or administrative order.

3. If required by a law enforcement official.

4. 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 help prevent the threat.

5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.

7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

8. For workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests

2. You can request a restriction of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.

4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing.

5. Right to copy this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

I hereby acknowledge that I have been presented with a copy of Notice of Privacy

Signature _____ Print Name: _____ Date: _____

Notice to Patients:

- ALL insurance copays are due at the time of service.

PERSONAL MEDICAL HISTORY

GENERAL MEDICAL HISTORY

❑Yes ❑No Alcoholism
❑Yes ❑No Allergies/Hay fever
❑Yes ❑No Anemia
❑Yes ❑No Anxiety
❑Yes ❑No Asthma
❑Yes ❑No Atrial Fibrillation
❑Yes ❑No Blood Transfusions
❑Yes ❑No CAD
❑Yes ❑No Cancer
❑Yes ❑No Cardiac Pacer
❑Yes ❑No Cardiovascular Disease
❑Yes ❑No CHF
❑Yes ❑No Cirrhosis
❑Yes ❑No Colitis
❑Yes ❑No COPD
❑Yes ❑No CRF
❑Yes ❑No Crohn's Disease
❑Yes ❑No CVA
❑Yes ❑No DVT
❑Yes ❑No Depression
❑Yes ❑No Diabetes Type 1
❑Yes ❑No Diabetes Type 2
❑Yes ❑No Epilepsy
❑Yes ❑No Fracture
❑Yes ❑No Gastric Ulcer
❑Yes ❑No Gastrointestinal Disease
❑Yes ❑No GERD
❑Yes ❑No Gestational Diabetes
❑Yes ❑No Glaucoma
❑Yes ❑No Heart Murmur
❑Yes ❑No Hepatitis
❑Yes ❑No High Cholesterol
❑Yes ❑No Hyperlipidemia
❑Yes ❑No Hypertension
❑Yes ❑No Hyperthyroidism
❑Yes ❑No Hypothyroidism
❑Yes ❑No Insulin Pump
❑Yes ❑No Joint Pain
❑Yes ❑No Kidney Infections
❑Yes ❑No Kidney Stone
❑Yes ❑No Migraine
❑Yes ❑No Multiple Sclerosis
❑Yes ❑No Obesity
❑Yes ❑No Old MI
❑Yes ❑No Osteoarthritis
❑Yes ❑No Osteoporosis
❑Yes ❑No Pneumonia
❑Yes ❑No Progressive Neurological Disorder
❑Yes ❑No Pulmonary Disease
❑Yes ❑No Rheumatic Fever
❑Yes ❑No Rheumatoid Arthritis
❑Yes ❑No STD
❑Yes ❑No Terminal Illness
❑Yes ❑No Thyroid Disease
❑Yes ❑No TIA
❑Yes ❑No Tuberculosis
❑Yes ❑No Valvular Problems

HOSPITALIZATIONS

_____

_____

Social History

Smoking Status (Circle below)

1. Current Every day Smoker
2. Former Smoker
3. Heavy tobacco Smoker
4. Light tobacco Smoker
5. Smoker current status unknown
6. Unknown if ever smoked.
7. Never smoked

❑Yes ❑No counseling on tobacco cessation ❑Yes ❑No Tobacco User

❑Yes ❑No RX therapy for tobacco cessation

# of packs per days/ for how many years_____
Smoked for how long_____
Date Quit Smoking_____

Alcohol use

1. Non-Drinker
2. Occasional
3. Social Drinker
4. Moderate alcohol consumption
5. Heavy alcohol consumption
6. Recovering alcoholic
7. Beer drinker
8. Wine drinker
9. Never Drank
10. Alcohol Discontinued

Caffeine Use: servings per day (circle one) 0 1 2 3 4+ occasional

Drug use: Type _____ **Status**: 1.Ocassional 2. Daily 3. Prior use

SURGICAL / PROCEDURES

- ❑ No prior surgical history
- ❑ Appendectomy
- ❑ Breast Lumpectomy
- ❑ Cataract Surgery
- ❑ Colectomy
- ❑ Cone Biopsy
- ❑ D&C
- ❑ Endometrial Ablation
- ❑ Gall Bladder
- ❑ Heart Surgery
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Joint Replacement
- ❑ Laparoscopy
- ❑ Mastectomy
- ❑ Myomectomy
- ❑ Oophorectomy
- ❑ Ostomy
- ❑ Splenectomy
- ❑ Tonsil/ Adenoidectomy
- ❑ Tubal Ligation

Other Surgical History _____

_____

HISTORY OF MOTHER

❑ Living ❑ Deceased ❑ Age _____ ❑ In good health
❑ Adopted

❑Yes ❑No Alcoholism
❑Yes ❑No Anemia
❑Yes ❑No Anxiety
❑Yes ❑No Asthma
❑Yes ❑No Birth Defects
❑Yes ❑No CAD
❑Yes ❑No Cardiovascular Disease
❑Yes ❑No CHF
❑Yes ❑No Cancer
❑Yes ❑No Congenital Anomaly
❑Yes ❑No COPD
❑Yes ❑No Crohn's Disease
❑Yes ❑No Depression
❑Yes ❑No Diabetes
❑Yes ❑No Epilepsy
❑Yes ❑No GERD
❑Yes ❑No High Cholesterol
❑Yes ❑No Hyperlipidemia
❑Yes ❑No Hypertension
❑Yes ❑No Hypothyroidism
❑Yes ❑No Kidney Disease
❑Yes ❑No Liver Disease
❑Yes ❑No Multiple Births
❑Yes ❑No Osteoarthritis
❑Yes ❑No Osteoporosis
❑Yes ❑No Pulmonary Disease
❑Yes ❑No Stroke

Type of Cancer _____
Other Conditions _____

FAMILY HISTORY OF FATHER

❑ Living ❑ Deceased ❑ Age _____ ❑ In good health
❑ Adopted

❑Yes ❑No Alcoholism
❑Yes ❑No Anemia
❑Yes ❑No Anxiety
❑Yes ❑No Asthma
❑Yes ❑No Birth Defects
❑Yes ❑No CAD
❑Yes ❑No Cardiovascular Disease
❑Yes ❑No CHF
❑Yes ❑No Cancer
❑Yes ❑No Congenital Anomaly
❑Yes ❑No COPD
❑Yes ❑No Crohn's Disease
❑Yes ❑No Depression
❑Yes ❑No Diabetes
❑Yes ❑No Epilepsy
❑Yes ❑No GERD
❑Yes ❑No High Cholesterol
❑Yes ❑No Hyperlipidemia
❑Yes ❑No Hypertension
❑Yes ❑No Hypothyroidism
❑Yes ❑No Kidney Disease
❑Yes ❑No Liver Disease
❑Yes ❑No Multiple Births
❑Yes ❑No Osteoarthritis
❑Yes ❑No Osteoporosis
❑Yes ❑No Pulmonary Disease
❑Yes ❑No Stroke

Type of Cancer _____
Other Conditions _____

Please List Medications Below

Medication	Dose	Directions	Quantity (30 day or 90 day supply)

Allergies

Please list anything that you are allergic to (Medications, food, Bee Stings, Etc.) and how it affects you.

Allergies and Reactions	Reaction
1.	
2.	
3.	
4. NO KNOWN DRUG ALLERGIES	

TRUE CARE MD
14420 West Meeker Blvd. Suite 105, Sun City West, AZ 85375
13634 N. 93rd Ave. Suite 200, Peoria, AZ 85381
P (623)777-4567 Fax (Sun City West) (623)777-4497 Fax (Peoria) (623)777-4797

FINANCIAL POLICY TRUE CARE MD

At **True Care MD** we believe in delivering exceptional patient care. However, our professional services are rendered to you, not your insurance company; therefore, payment for treatment is your responsibility. We are committed to navigating with you to get you your best allowed coverage.

Please notify us of any change in your insurance, address, place of employment, phone number, etc. when you arrive and before you see your physician or have any testing. Failure to notify us of these changes will result in you being responsible for the bill.

You may use cash, check, Master Card, Visa, Discover to charge current services or any outstanding balance on your account.

Payment Responsibility: The patient or his legal representative is ultimately responsible for all charges incurred. We do not have a contract with your insurance company. It is your responsibility to know and understand your insurance. We will do the best job we can to help you understand or direct you to the information, however we are not responsible for verifying that your insurance is an "in-network "participant.

Self-Pay Patients: For patients that do not have insurance, payment in full is due at the time of service. We offer discount for all self-pay patients who pay at the time of service.

Co-Pays/Patient Balance: Your balance and co-pay is due at time of service. You may be asked to reschedule your appointments if you are not prepared to pay your co-pay.

Physicals: We recommend that you have a physical once a year, but it is your responsibility to clarify with your insurance if these services are covered with your health plan.

Non-covered Services: Payment for all charges which are not covered by insurance is due and payable at the time of service

Prior Unpaid Accounts: Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements be approved by the Practice Administrator.

Collection Agency: Accounts which cannot be collected by True Care MD after normal in-house collection procedures may be referred to a collection agency, for further collection action. Any fees incurred will be patient's responsibility. If your account has been sent to collection, we will not be able to see you in the office until your balance is paid in full.

Forms: There will be a $10.00 fee due, at the time of request, associated with simple/one page forms that need to be completed by the physician or office staff. For longer/complex forms, the fee charged will be $25 and will be due at the time of request. Allow 5-7 business days for the forms to be completed. All forms will be filled at the discretion of the provider

Lab Orders: It is your responsibility to check with your insurance company to confirm the coverage for your lab work. Physicians will order lab work but not guarantee that your insurance company will cover them.

Auto Insurance: We will bill your Attorney for auto-accident or other liability or lawsuit related case. You are responsible for payment if you do not have any of the above stated coverage. We will need all information associated with the claim to bill your carrier.

Worker's Compensation: If your injury is work related, we will need the case number and carrier name prior to your visits in order to bill the Worker's compensation insurance company.

Patient Acknowledgement: I have read, understand and agree to the above financial policy.

Patient Signature: _____ **Date:** _____

Consent for release of Protected Health Information

True Care MD

Name_____DOB:_____

Social Security Number _____

I consent to the release of protected health information that is required to carry out treatment, or for payment of healthcare operations on my behalf.

I have received a copy of the Notice of Privacy practices and am aware of the following:

- I have the right to place restrictions on the way my PHI is used or disclosed.
- I understand that once True Care MD agrees to my restrictions, it must comply with these restrictions.
- I have a right to revoke my consent for use and disclosure of my PHI at any time. I understand that, if I chose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that True Care MD must immediately comply with my request to revoke consent, except to the extent that it has already taken some action based on my original consent.
- True Care MD has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the notice accordingly; and we will inform you, placing the amendment date at the bottom of the posted notice.

I understand that on occasion True Care MD may need to contact me concerning health matters.

On these occasions I give permission to speak to another Authorized party

YES ☐ NO ☐

Name of Authorized Entity or Person(s) to Receive Information:

_____ _____

Name Date of Birth

_____ _____

Name Date of Birth

_____

Name of patient or Personal Representative (Type/Print)

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

Chart Update

Choose a Year: 1 2 3 4 5

True Care MD
9139 W. Thunderbird Rd. #265
Peoria, AZ. 85381

Patient's Name: _____ DOB: ____/____/____ ID# _____

1. I suffer from allergies ☐ Airborne ☐ Food
2. My allergies are seasonal ☐ Spring ☐ Summer ☐ Fall ☐ Winter

CHECK BOX IF ANSWER IS "YES"

3. I suffer from watery, itchy eyes ☐
4. I often suffer from a stuffy or runny nose ☐
5. I suffer from nose bleeds ☐
6. I often suffer from wheezing or other asthma like systems ☐
7. I am often "short of breath" or "out of breath" ☐
8. I have sore throat or hoarseness ☐
9. I have recurring headaches ☐
10. I suffer from sinus pressure, pain or infections ☐
11. I have been told I snore ☐
12. I experience "mouth breathing" and have difficulty sleeping ☐
13. I suffer from ear pain/aches, pressure, or infections ☐
14. I have a persistent cough, even when not sick ☐
15. I often suffer from rashes and/or hives ☐
16. I have other skin problems like eczema ☐
17. I have known allergies to animals or stinging insects ☐
18. If I could be desensitized to allergies, I would like to be tested ☐

Please check if the following are true:

☐ I am or may be pregnant
☐ I currently take heart medication:
Name: _____
☐ I am currently taking blood pressure medicine
Name: _____
☐ I am currently taking sleep aids
Name: _____
☐ I am currently taking antidepressants
Name: _____
☐ I have been tested for allergies in the past
☐ I have an allergy to latex
☐ I have had an anaphylactic reaction in the past
When: _____
Cause: _____

Weight: _____ **Age:** _____

Diagnosis Code:

J30.1 Allergic Rhinitis Due to Pollen
J30.9 Allergic Rhinitis
J30.2 Other Seasonal Allergic Rhinitis
R05 Cough
J45.909 Asthma, Unspecified
J45.998 Other Asthma
J30.81 Allergic Rhinitis due to Animal Hair/Dander
Other: _____ Other: _____

Patient/Parent Signature: _____
Date: ____/____/____

Patient recommended for allergy testing and/or treatment

Provider Signature: _____

Checklist for Wellness and Annual Physical

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Please enter the most recent date that you had the following, please be as specific as possible noting a minimum of month and year.

Mammogram _____ Completed at: _____

Colonoscopy _____ Completed at: _____

Bone Density Scan _____ Completed at: _____

Pap Smear _____ Completed at: _____

Pneumovax 23 _____ Completed at: _____

Prevnar 13 _____ Completed at: _____

Shingles (Zostovax) Vaccine _____ Completed at: _____

DTAP Vaccine _____ Completed at: _____

Flu Shot _____ Completed at: _____

Diabetic Eye Exam _____ Completed at: _____

Routine Eye Exam _____ Completed at: _____

Hearing Test _____ Completed at: _____

Please list the following and provide any supporting documentation.

Healthcare Proxy _____

Advanced Directives _____

Power of Attorney _____