TrueCareMD
Helping You Achieve Your Best Health

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Internal Medicine
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Specialists
Julio Marcolini, MD
Infectious Disease

Patient Registration:
Name: _____ Date of Birth: _____
Address: _____ City/Zip: _____
Home phone: _____ Cell: _____
Social Security Number: _____ E-mail: _____
Ok to leave detailed voice messages? Yes ☐ No ☐ Ok to use email to enroll in patient portal? Yes ☐ No ☐

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
If 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 TESAI PLC (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 and that all copays are due at the time of service.

Signature: _____ Date: _____

Notice of Privacy Practices

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

1. We realize that these laws are complicated, but we must provide you with the following important information.
2. 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: _____

Personal Medical History

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

Hospitalizations

_____

_____

Social History

Smoking Status (Circle Below)

1. Current everyday Smoker
2. Former Smoker - Date Quit Smoking _____
3. Heavy tobacco Smoker
4. Light tobacco Smoker
5. Never Smoked

□ Yes □ No □ N/A Counseling on Tobacco Cessation

□ Yes □ No □ N/A Prescription Therapy for Tobacco Cessation

Smoked for how many years _____ Number of Packs per day _____

Alcohol Use (circle one)

1. Non-Drinker
2. Occasional
3. Social Drinker
4. Moderate consumption
5. Heavy Consumption
6. Beer Drinker
7. Wine Drinker
8. Recovering Alcoholic
9. Never Drank

Caffeine Use

Servings per day (circle one) 0 1 2 3 4+ Occasional

Street Drug Use

Type: _____ Status: 1. Occasional 2. Daily 3. Prior Use

Surgical/Procedures

☐ No Prior surgical history

☐ Appendectomy	☐ Gall Bladder	☐ Myomectomy
☐ Breast Lumpectomy	☐ Heart Surgery	☐ Oophorectomy
☐ Cataract Surgery	☐ Hemorrhoids	☐ Ostomy
☐ Colectomy	☐ Hernia	☐ Splenectomy
☐ Cone Biopsy	☐ Joint Replacement	☐ Tonsil/Adenoidectomy
☐ D&C	☐ Laparoscopy	☐ Tubal Ligation
☐ Endometrial Ablation	☐ Mastectomy	

Other Surgical History: _____

Gyn History : Pregnancies: Live Births: _____

History of Mother

☐ Living ☐ Deceased ☐ Age: _____ ☐ In Good Health
☐ Adopted

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

Type of Cancer _____

Other Conditions _____

History of Father

☐ Living ☐ Deceased ☐ Age: _____ ☐ In Good Health
☐ Adopted

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

Type of Cancer _____

Other Conditions _____

Please List ALL Medications Below

Medication	Dose/Directions	Quantity

Allergies

Please list anything you are allergic to (medications, food, bee stings, etc.) and how it affects you.

Allergies	Reaction
1.	
2.	
3.	

4. No Known Allergies

FINANCIAL POLICY FOR 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; therefor, payment for treatment is your responsibility. We are committed to navigating with you to get 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 or Visa to charge current services or any outstanding balance on our account.
Payment Responsibility: The patient or his legal representative is ultimately responsible for all charges incurred. 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 in an "In Network" participant.

Self-Pay Patients: For patients that do not have insurance, payment in full is dur at the time of service.

Co-pays/Balances: Your co-pays and/or balances are due at the time of service. You may be asked to reschedule your appointment if you are not prepared to pay your co-pay.

Physicals/Wellness: We recommend that you have a Physical/Wellness exam 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.

Medical Records Copies: There will be a fee of $1.00 for the first 25 pages and $0.50 per page thereafter. We also provide CD Disc's with a flat fee of $35.00. If patients are just requesting a copy of, i.e., labs, please provide this with no charge.
WE DO NOT CHARGE DOCTOR TO DOCTOR-TRANSFER OF CARE

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 Manager.

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 the 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, more 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 cannot 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-mentioned 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 visit 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: _____

True Care MD
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Annual Wellness Form

Patient Name: _____Date of Birth:_____ Date: _____

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

Mammogram _____ Completed at _____

Colonoscopy _____ Completed at _____

Bone Density (DEXA) 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 Poxy _____

Advanced Directives _____

Power of Attorney _____

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

FOR TRUE CARE MD

Patient's 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 I am aware of the following:

- I have the right to place restrictions on the way my PHI is used or disclosed.
- I understand the 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 posed 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 DOB

_____ _____

Name DOB

_____

Print Name of Patient or Representative

_____ _____

Signature of Patient or Representative Date

_____

Description of Representative

Notice of Health Information Practices

You are receiving this notice because your healthcare provider 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. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors can access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of heath information may be available:

- Hospital records
- Medical History Clinic and Doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment
- Medication
- Allergies
- Lab results
- Radiology results

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care of case management, transition of care planning, payment for your treatment, conducting quality assessments and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal Law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPPA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the health information request form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the health information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed information who should not have.

You have the right under article 27, section2 of the Arizona Constitution and Arizona revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the opt out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving you opt out form from your healthcare provider Caution: If you opt out, your health information will NOT be available to your healthcare providers- even in an emergency.
2. If you opt out today, you can change your mind at any time by completing an Opt Back in Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT

Acknowledgement

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's Health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an opt out form to my health care provider.

Patient Signature: _____ Date: _____