

PATIENT INFORMATION

NAME:	M □ F □ · DOB:			
ADDRESS:				
IS ARIZONA YOUR PERMANENT RESIDENCE:	YES / NO			
ALT ADDRESS:				
SOCIAL SECURITY:	MARITAL STATUS:			
CONTACT	PREFERRED METHOD OF CONTACT			
НОМЕ:	OK TO LEAVE MESSAGE? YES / NO			
CELL:				
WORK:	HOME CELL WORK OTHER EMAIL			
OTHER:	EMAIL:			
ARE YOU CURRENTLY WORKING? YES / NO	DISABLED? YES / NO RETIRED? YES / NO			
CURRENT/FORMER OCCUPATION or EMPLOYE	ER:			
RESPONSIBLE PARTY				
OTHER THAN PATIENT				
NAME: RELATION	ISHIP: PHONE:			
ADDRESS:				
PRIMARY CARE PHYSICIAN:	PHONE:			
REFERRING PHYSICIAN:	PHONE:			
INSURANCE INFORMATION				
PRIMARY INSURANCE:	PHONE:			
INSURED NAME:	DOB:			
GROUP#	POLICY#			
SECONDARY INSURANCE:	PHONE:			
INSURED NAME:	DOB:			
GROUP#	POLICY#			





1495 W. Chandler Bivd, Suite 8-8, Chandler, AZ 88224



Phone: 400 899 1696 Fax: 480 963 6227



(ii) Uhasz.com

Advar	nce Directive	Name	Number
		Name	Number
Print name	Signature		
I have a health care pow	er of attorney 1 have an advance directive	Name	Number
	family and my doctor about the care to speak for myself, please contact:	You	r life. Your terms.
Name	Number (Additional names on back)		

Anthony J. Dyer, MD Shaw Mahre, PA-C



Consent to Release Protected Health Information Contact List

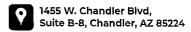
Patient Name:		DOB:	Date:	
Initials	l authorize Ironwood Physicians, PC to ulisted on this form.	ise/disclose my perso	onal health information to the individuals	
Initials				
Contact Name: (Emergency Contact)				
Phone:		Phone (other):		
Address:				
Relationship: Spouse	Family (Describe)	Friend [Other (Describe)	
2. Contact Name:				
Phone:		Phone (other):		
Address:				
Relationship: 🗌 Spouse	Family (Describe)	Friend [Other (Describe)	
3. Contact Name:				
Phone:		Phone (other):		
Address:	·			
Relationship: Spouse	Family (Describe)	Friend [Other (Describe)	
	d Physicians, PC to use and disclose mon does not expire unless written notice		ormation <i>to</i> the individuals identified on this form. x 6423 Chandler AZ, 85245.	
	de information relating to communicable abuse treatment, and genetic testing in		VIAJDS, sexually transmitted diseases, behavioral or ords exist.	
	ns, PC will be allowed to release my per		ans PC as individuals involved directly in my care and on to these individuals for the purposes of treatment,	
I understand that I have a	ight to request and receive a Notice of F	Privacy Practices fron	n Ironwood Physicians, PC.	
	is authorization, and I understand that		licate of the statement is considered the same as the lealth care from Ironwood Physicians PC will not be	
Patient Signature: _	MARKANIA STATE OF THE STATE OF	·	Date:	
Personal Representa	ative Signature:		Date:	
Relationship to Patie	ent:			

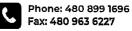


FINANCIAL POLICY/ASSIGNMENT OF BENEFITS FOR PATIENTS

	visits and treatment charges initials
•	I will inform Ironwood Physicians, PC or Ironwood Cancer and Research Centers of a change in my insurance coverageinitials
•	I understand the billing process may take 4-6 weeks at which time my insurance company will determine and pay for services per my contract initials
•	I understand that it is my responsibility to pay all co-pay, deductible and estimated co-insurance amounts at the time of service rendered and remaining balance as determined by my insurance company initials
•	I understand that I will leave my credit card information to be kept on file and that if I do not pay within 60 days after my insurance has paid, I acknowledge that Ironwood Physicians, PC and Ironwood Cancer and Research Centers will charge the balance to the credit card on file initials
•	I understand that if for any reason my insurance company does not pay for the covered services within 90 days of the services provided, I shall assume responsibility for the total amount owed, which may be charged to the credit card on file initials
•	I thereby assign all medical benefits directly to Ironwood Physicians, PC and Ironwood Cancer and Research Centers for services rendered at their facilities initials
•	I understand if a CT or PET/CT scan is completed it will be necessary for a licensed Radiologist to interpret or read your scan results. You will be receiving two statements for your CT or PET/CT scan for their professional interpretation of the CT or PET/CT scan separate of Ironwood initials
•	We may request proof of insurance premium payment initials
•	I have read and received a copy, if desired, of this document initials
⊃a	itient Printed Name: DOB:
⊃ອ	itient Signature: Date:









Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Ironwood Physicians may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at PO Box 6423, Chandler, AZ 85246

With your consent, Ironwood Physicians may mail to your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Ironwood Physicians may mail to your home or office any items that assist the practice in carrying out any TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your Pill to carry out treatment, payment and healthcare operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound to our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment payment and healthcare operations. This consent may be revoked inwriting except to the extent that we may have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Patient Name:	
Signature of Patient or Legal Guardian	
Print Legal Guardian Name (Ifapplicable)	
Date:	



Authorization to Release Protected Health Information (PHI) To: Urologic Health Associates

Fax: (480) 963-6227
For the purpose of continuing patient care

rime Telephone Number reby authorize the hospital or medical facility in receipt of this wing Protected Health Information pertaining to the above refective of the Protected Health Information pertaining to the above refective of the Protected Health Information pertaining to the above refective of the Protected Health Information pertaining to the above refective of the Protected Health Information: Please release all pertinent records from the dates of Please release the following Information: Inderstand that this authorization covers records relating to communiodeficiency Syndrome ("AIDS"), Human Immunodeficience and the protected of the authorization and the stream of the protected that the recover of the protected that the revocation only applies to records that the protected by Federal Privacy Regulations of the authorization may not be protected by Federal Privacy Regulations disclosed by the third party or entity that has the received this derstand that Urologic Health Associates will not re-disclose normation without my written consent. Inderstand that this authorization does; and will expire one (1) ining unless an earlier date is specified in writing.	Birth	_!_	_/
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Please release all pertinent records from the dates of R Please release the following Information: Inderstand that this authorization covers records relating to communodeficiency Syndrome ("AIDS"), Human Immunodeficience that health, alcohol and/or drug abuse treatment genetic testing inderstand that at any time I have the right to revoke on this authorization I must do so in writing, and ser less understand that the revocation only applies to records that sponse to the authorization. Inderstand that, once this information has been disclosed to a sponse to the authorization. Inderstand that Unlogic Health Associates will not re-disclose in derstand that Unlogic Health Associates will not re-disclose in ormation without my written consent. Inderstand that this authorization does; and will expire one (1) ining unless an earlier date is specified in writing.	form to d	lisclose patient t	the to:
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nature Date	year fron	n the da	te of
nature Date	Expirat	ion Date	•
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Code of Conduct for Patients and Visitors

In an effort to provide a safe and healthy environment for staff and patients, fronwood Physicians PC expects patients, parents and accompanying family and friends to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited and may result in your immediate dismissal from the practice:

- Physical assault or threatening to inflict bodily harm.
- Rude behaviors in person or through written, verbal or electronic communication, including but not limited to the following: Profanity, harassment, offensive or intimidating statements or gestures and threats of violence.
- Racial or cultural slurs or other derogatory remarks associated with race, language, or sexual orientation.
- Requests that would constitute illegal or unethical behavior on the part of Ironwood.
- Possessing firearms or any weapon
- Making verbal threats to harm another individual or destroy property

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or are unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your
 appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do
 this in advance, another visit may be necessary so that the doctor can give all patients the time
 and quality of care they deserve.
- Questions about your billing can be addressed with our patient accounts team @ 480-245-6285.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When
 interacting with any of our staff, please put your devices away. Set the ringer to vibrate before
 storing away.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Patient's Name Date of Birth

Caregiver's Name/Relationship to patient Date

I agree to the Ironwood Physicians "Code of Conduct for Patients and Visitors"



IRST NAME: LAST NAME:		NAME:	<u>DOB:</u>			OB:	
POA/LEGAL SIGNER (if	not patient):				!	PHONE:	
REFERRED BY:			PRIMARY CARE DOCTOR:				
PHARMACY: (Name, Add	dress/Phone)			· ·			
ALLERGIES: None	□ PCN □ Sulfa □ Cip	pro 🗆	Iodine/Contrast	Other			
MEDICAL HISTORY: H	eight:		Weight:				
Influenza Vaccine Date:			Pneumonia Vaccir	ne Date:			
Colonoscopy/Cologuard Da							— ·□ Menopause
☐ Diabetes (Onset Date: ☐ Cancer (List Type): ☐ Other:			☐ Emphysema ☐ Parkinson's	☐ Hei	nia 🗆	l Hepatitis	_
MY MAIN PROBLEMS	SYMPTOMS:						
Is condition result of Wo MEDICATIONS: □ Nor			••	•	-	t) 	
FAMILY HISTORY: Family Members: Most Social History: Marital Status: Surgical History:	Other Cancer Unknother Father Grandr Retired Occupation Married Divorced	own mother: ion: \[\square\] Wid	(Maternal / P	Paternal) cco Use:	☐ Gra	andfather:(□ Ma ne □ Smoking	iternal / 🗆 Paternal)
☐ Cystoscopy	☐ Kidney Stone Surgery						der Tack
☐ Appendectomy ☐ Other:	☐ Back/Hip/Knee	☐ Gallb	ladder	☐ Hear	t Bypass	□ Sling	; (TVT)
SYSTEMS REVIEW:							
General/Constitutional Eyes Ears, Nose, Mouth, Throat Cardiovascular Respiratory Gastrointestinal Genitourinary Musculoskeletal Integumentary/Skin Neurologic Hematologic/Lymphatic	☐ Chest Pains ☐ Wheezing ☐ Abdominal Pai ☐ Incontinence ☐ Chronic Back P ☐ Rash ☐ Numbness ☐ Swollen Glands	Pain	☐ Weight Loss ☐ Double Vision ☐ Nasal Stuffines ☐ Swollen Ankles ☐ Chronic Cough ☐ Nausea/Vomit ☐ Painful Urinati ☐ Chronic Neck S ☐ Persistent Itch ☐ Tingling ☐ Abnormal Blee	ss s ing ion Pain ing	So So Sh	nills ataracts are Throat regular Heartbea nortness of Breat nange in Bowels ood in Urine are Muscles in Cancer History zziness ansfusion History	h Y
URINARY SYMPTOM(1		[C4=a!=;	_	C abdance
☐ Frequency ☐ Bladder pain	☐ Urgency ☐ Pain in side: R / L	☐ Leak	age emptying bladder		Strainin Urinatir	g ng at nìght (#	☐ Abdominal pain