A New Creation Clinic & Medi-Spa

1801 W. Ina Rd
Tucson, AZ 85704
Phone: (520) 293-1117 Fax: (520) 293-7701

Patient Information			
First Name:	Last Name:		Middle Initial:
Date of Birth:	Preferred Name:	Soc. Sec. Number:	
Address:			
City:		State:	Zip:
Cell Phone:	Home Phone:		Alt Phone:
Email:	Alt Email:		
Emergency Contact:	Number:		Relationship:

Insurance Information		
Primary Insurance Information		
Insurance Carrier:		
Subscriber ID:	Group:	
Insurance Address:		
City:	State:	Zip:
Insurance Phone #:	Effective Plan Date:	
Name of Policy Holder:	Date of Birth	
Relationship to Patient:	Phone Number:	
Secondary Insurance Information		
Insurance Carrier:		
Subscriber ID:	Group:	
Insurance Address:		
City:	State:	Zip:
Insurance Phone #:	Effective Plan Date:	
Name of Policy Holder:	Date of Birth	
Relationship to Patient:	Phone Number:	

Concerns & Goals
How would you rate your health? Excellent Good Fair Poor
What are your health goals for this year:
Main things you would like us to help you with:
Is there anything about yourself you think we should know?

By signing this form, I agree and consent to A New Creation Clinic and Medi-Spa to use and disclosure of my protected health information to conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, and to conduct normal healthcare operations such as quality assessment and healthcare provider certifications as stated in the notice of privacy practice and that I have been provided a copy of if I so wish.

I agree that all the above demographic and insurance information is accurate and up to date. If there is an error in the information above I understand that I am responsible for the charges related to the errors. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for changes insured if my account is sent to a collections agency and any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services and procedures and I may receive a statement for these charges. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services. I hereby assign all medical and/or treatment benefits including major medical benefits to A New Creation Clinic and Medi-Spa for services rendered.

Print Name: _____ Signature: _____ Date: _____

Pharmacy Information

Preferred Pharmacy	Compound Pharmacy
Name:	Name:
Address:	Address:
Phone:	Phone:

Medications: Prescription and Non Prescription

☐ I Do Not Take Any Medication

Medication Name	Doseage & Amount Taken

Allergies: Drug, Food & Enviromental

☐ No Known Drug Allergies ☐ No Known Allergies

Other Healthcare Providers Who Participate in Your Care

Name:	Number:	Specialty:
Name:	Number:	Specialty:
Name:	Number:	Specialty:
Name:	Number:	Specialty:
Name:	Number:	Specialty:
Name:	Number:	Specialty:

Past Surgical & Procedure History

Procedure:	Date: ___/___/_____	Procedure:	Date: ___/___/_____
Procedure:	Date: ___/___/_____	Procedure:	Date: ___/___/_____
Procedure:	Date: ___/___/_____	Procedure:	Date: ___/___/_____

Social History				
Occupation:		Employer:		
Married	Single	Significant Other	Divorced	Widowed
Spouses Name:			Number:	
Emergancy Contact:			Number:	
Tobacco Use: ___ Never ___ Current (# of cigarettes per day ___) ___ Former (Quit at Age ___)				
Alcohol use: _____ Yes _____ No		If yes, Your average # of drinks per week:		
Do You Use Recreational Drugs? _____ Yes _____ No		If yes, type & last used:		
How many times per week do you exercise?			Time Per Workout:	
Type of Diet: _____ Regular _____ Vegetarian _____ Vegan _____ Gluten Free Other _____				
Do you take an aspirin daily:	Do you drink cafeine:		General Stress Level:	
Do you wear your seatbelt:	Do you keep firearms in the house:		Smoke Detectors:	
Does a partner or anyone in your house hurt, hit or threaten you?				
Would you like more information about Domestic Violence and a Safe Place to Go?				

Medical History - Please circle any that apply			
Abdominal Pain	Difficulty Hearing	Hyperlipidemia	Plantar Fasciitis
Abnormal Liver Function	Diverticulitis	Hyperparathyroidism	Pneumonia
ADHD	Dizziness & Giddiness	Hypertension	Polycystic Ovaries
Alcohol Dependence	DVT	Hypothyroidism	Postmenopausal
Allergic Rhinitis	Ear Aches	Impacted Cerumen	Postmenopausal Bleeding
Alopecia	Edema	Infertility	Prolapsed Bladder
Aneurysm	Endocrine Disorder	Insomnia	Psoriasis
Anemia	Endometrial Disorder	Irregular Periods	Raynaud's Phenomenon
Anxiety	Epilepsy	Joint Pain	Rectal Bleeding
Aortic Valve Disorder	Epstein Bar Virus	Leg Length Inequality	Reduced Libido
Arthritis	Exhaustion	Loss of Hair	Sciatica
Asthma	Fecal Occult Blood	Lupus	Scoliosis
Autoimmune Disease	Fibroids	Lyme Disease	Seizures
Bacteria Vaginosis	Fibromyalgia	Malignant Tumor of _____	Severe Migraines
Balance Problems	Foot-Mouth Disease	Memory Loss	Shingles
Bipolar Disorder	Frequent Urination	Meniere Disease	Shortness of Breath
Blood Sugar Problems	Frequent Yeast Infections	Menopausal	Sinus Infections
Bloody Stool	Genital Pain	Migraine	Sleep Apnea
Breakthrough Bleeding	Genital Discharge	Mood Swings	STD
Breast Lump	Genital Itching	Murmur	Stroke
Bulimia	Gerd	Muscle Spasms	Substance Abuse
Candidiasis of Vagina	Glaucoma	Nausea	Suicidal Attempts
Cataracts	Goiter	Nerve Pain	Suicidal Ideation
Celiac Disease	Gout	Numbness of _____	Swollen Glands
Cellulitis	Hashimotos	Obesity	Swollen Tonsils
Change in Libido	Headaches	Osteoarthritis	Tachycardia
Chronic Fatigue	Hearing Aids	Osteopenia	Thyroid Nodule
Chronic Pain	Heart Attack	Osteoporosis	Tobacco Dependence
Cirrhosis	Heartburn	Otitis Media	Tremor
Constipation	Heart Palpitations	Ovarian Cyst	Tuberculosis
COPD	Heavy Periods	Overactive Bladder	Vaginal Bleeding
Cough	Hemorrhoids	Overweight	Vaginal Discharge
Crones	Hepatitis	Painful Urination	Vaginal Dryness

Cyst of: _____	Hernia	Palpitations	Vaginal Itching
Decreased Appetite	HIV	Panic Disorder	Vertigo
Decreased Hearing	Hormone Replacement	Parkinson's Disease	Visual Change
Dentures	Hot Flashes	PCOS	Vitamin D Deficient
Depression	HPV	Pelvic Pain	Vomiting
Diabetes Type _____	Hypercalcemia	Perimenopausal	Wears Glasses/Contacts
Diarrhea	Hyperglycemia	Phlegm Production	Wheezing
Other: _____	Other: _____	Other: _____	Other: _____

Family History

Family Member	Health Status	Major Health Concerns

Surgies & Medical Procedures- Mark all that apply

Ablation	Ceasarean Surgery	Gallbladder	Oophorectomy
Abortion	Colonoscopy	Gastric Bypass	Open Heart
Ankle Surgery	Colposcopy	Hand Surgery	Ovarian Cyst
Appendectomy	Crones	Hemorrhoid	Pacemaker
Back Surgery	Cystoscopy	Hernia Repair	Pap/GYN Exam
Bariatric	D & C	Hysterectomy Full	Physical
Bladder Suspension	Dexa	Hysterectomy Partial	Pneumonia Shot
Breast Biopsy	Discectomy	Joint Replacement	Prostate Surgery
Breast Enlargement	Ear Tubes	Knee Surgery	Pulmonary Function
Breast Reduction	Echocardiogram	Laminectomy	Shoulder Surgery
Bunionectomy	Ectopic Pregnancy	LASIK	Skin Cancer Excision
CABG	EKG	Ligament Surgery	Spinal Fusion
Cardiac Stress Test	Endometrial Ablation	Lumpectomy	TDAP
Carotid Stent	Endoscopy	Mammogram	Thyroid Surgery
Carpel Tunnel	Eye Exam	Mastectomy	Tonsillectomy
Cataract	Flu Shot	Mastectomy- Double	Tubes Tied
Cervix Surgery	Foot Surgery	Nasal Surgery	Tummy Tuck
Other:		Other:	Other:
Other:		Other:	Other:
Other:		Other:	Other:

OB & Pregnancy History

Age of Menses:	Total Pregnancy:	HRT Use:
Age of Menopause:	Full Term:	Abnormal Pap:
Last Menstruation:	Pre-Term:	Use of Fertility Drugs:
	Miscarriages:	Irregular Menses:
		Cervical Biopsy:

Hospitalizations

Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:
Date:	Reason:

HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
Gender (M/F): _____ Today's Date(MM/DD/YY): _____ Healthcare Provider: _____
Reason for Today's Visit: _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	----	---	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLORECTAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	o <u>2 or more</u>: breast / ovarian / prostate / pancreatic cancer o <u>2 or more</u>: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) o <u>2 or more</u>: melanoma / pancreatic
☐	**Young** Any 1 of the following at age <u>50 or younger</u>:	o Breast cancer o Colorectal cancer o Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at <u>any age</u>:	o Ovarian cancer o Breast: Male breast cancer or Triple negative breast cancer o Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† o Endometrial cancer with abnormal MSI/IHC o 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

RESOURCE SUPPLIED BY MYRIAD GENETIC LABORATORIES, INC. MYRIAD myRisk

Sexual Distressed Scale

Name: _____ DOB: ____ / ____ / _____

Below is a list of feelings that patients can often experience regarding the sexual aspect of their life. Please read each question and check the box that best describes how often that feeling has occurred **over the last 4 weeks, including today**. Please make sure to not skip any questions. **Please check one box per question.**

1. How often do you feel **distressed about your sex life**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

2. How often do you feel **unhappy about your sexual relationship(s)**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

3. How often do you feel **guilty about your sexual difficulties**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

4. How often do you feel **frustrated by your sexual problems**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

5. How often do you feel **stressed about sex**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

6. How often do you feel **inferior because of sexual problems**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

7. How often do you feel **worried about sex**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

8. How often do you feel **sexually inadequate**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

9. How often do you feel **regrets about your sexual experiences**?
   - ☐ 0 Never
   - ☐ 1 Rarely
   - ☐ 2 Occasionally
   - ☐ 3 Frequently
   - ☐ 4 Always

10. How often do you feel **embarrassed about sexual desires and/or problems**?
    - ☐ 0 Never
    - ☐ 1 Rarely
    - ☐ 2 Occasionally
    - ☐ 3 Frequently
    - ☐ 4 Always

11. How often do you feel **dissatisfied with your sex life**?
    - ☐ 0 Never
    - ☐ 1 Rarely
    - ☐ 2 Occasionally
    - ☐ 3 Frequently
    - ☐ 4 Always

12. How often do you feel **angry about your sex life**?
    - ☐ 0 Never
    - ☐ 1 Rarely
    - ☐ 2 Occasionally
    - ☐ 3 Frequently
    - ☐ 4 Always

Hormone Symptoms Questionnaire

Hormones play an essential part in our daily lives. Having inadequate hormone levels can lead to many health concerns such as: fatigue severe enough to be debilitating, foggy thinking, excessive intolerance to exercise, lethargic depression and anxious depression. Please answer the following questions to see if you have any of the following symptoms.

Fatigue ○ Never ○ Mild ○ Moderate ○ Severe

Mood Changes ○ Never ○ Mild ○ Moderate ○ Severe

Decreased Mental Ability ○ Never ○ Mild ○ Moderate ○ Severe

Excessive Sweating ○ Never ○ Mild ○ Moderate ○ Severe

Weight Gain ○ Never ○ Mild ○ Moderate ○ Severe

Decreased Sex Drive ○ Never ○ Mild ○ Moderate ○ Severe

Sleep Problems ○ Never ○ Mild ○ Moderate ○ Severe

Decreased Muscle Strength ○ Never ○ Mild ○ Moderate ○ Severe

Hair Loss / Breakage ○ Never ○ Mild ○ Moderate ○ Severe

Joint Pain / Muscle Aches ○ Never ○ Mild ○ Moderate ○ Severe

Mood Changes ○ Never ○ Mild ○ Moderate ○ Severe

Decreased Mental Ability ○ Never ○ Mild ○ Moderate ○ Severe

Hot Flashes / Night Sweats ○ Never ○ Mild ○ Moderate ○ Severe

Always Cold ○ Never ○ Mild ○ Moderate ○ Severe

Dry Wrinkled Skin ○ Never ○ Mild ○ Moderate ○ Severe

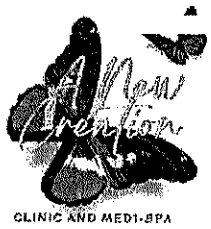
Do you have any of the following?

Name:			DOB:	
Symptoms	No	Mild	Moderate	Severe
Do you have areas where you'd like to have hair reduced?				
Do you have Spider Veins?				
Do you have fine line wrinkles?				
Do you have large pores?				
Do you have uneven skin texture?				
Do you have scars you'd like to reduce?				
Do you have redness or rosacea?				
Do you have Cherry hemangiomas?				
Do you have nail fungus?				
Do you have acne scars?				
Do you have photodamage?				
Would you like your skin tightened?				
Would you like to get rid of pigmented skin lesions (freckles)?				
Would you like to build up your collagen?				
Would you like to learn more about proper skin care?				
Do you have chronic fatigue?				
Are you looking to lose weight?				
Do you have low libido?				
Do you have vaginal dryness?				
Do you have urine incontinence?				
Are you interested in restoring your vagina/penis?				
Are you interested in Bio-Identical Hormones?				

Financial Agreement

I understand and agree, whether signing as an agent or as a patient and whether insured or a member of a health insurance group, that in consideration of the services to be rendered, that I hereby individually obligate myself to pay the account of the medical facility in accordance with the regular rates, terms and interest on the unpaid balance set out by A New Creation Clinic and Medi-Spa. I understand that payment is due at the time of billing. I also understand and agree that if payment is not received in the billing office within thirty days of initial billing, that I may be charged 18% per annual interest on the past due balance. In the event that it becomes necessary to place the account with a collection agency to collect the balance due, an additional 40% of the principal balance due will be added to help defray the cost of collection. In addition, should legal action become necessary to collect the balance due, I understand that I will be responsible for reasonable attorney's fees, interest, and court costs. Should the account be placed with a collection agency (General Business Recoveries) or attorney I understand that a credit report may be pulled for the sole purpose of collecting the delinquent balance.

Name	Signature	Date
Parent or Guardian Name, if applicable	Parent or Guardian Signature, if applicable	Date



HIPAA Guidelines

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our notice that is currently in effect.

1. **Uses and Disclosures:** We may make without written authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following: Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.
   Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.
   Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.
   Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:
   • To avoid a serious threat to your health or safety or the health or safety of others. • As required by state or federal law such as reporting abuse, neglect, and/or certain other events. • As allowed by workers compensation laws for use in workers compensation proceedings. • For certain public health activities such as reporting certain diseases. • For certain public health oversight activities such as audits, investigations, or licensure actions. • In response to a court order, warrant or subpoena in judicial or administrative proceedings. • For certain specialized government functions such as the military or correctional institutions. • For research purposes if certain conditions are satisfied. • In response to certain requests by law enforcement to locate a fugitive, victim, or witness, or to report deaths or certain crimes. • To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosures We May Make Unless You Object**. Unless you instruct us otherwise, we may disclose your information as described below. • To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
   People allowed to release my information to:
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____
   Name: _____ Relationship: _____

3. **Uses and Disclosures with Your Written Authorization**. Other uses and disclosures not described in this Notice will be made only with your written authorization.

4. **Your Rights Concerning Your Protected Health Information**. You have the following rights concerning your health information. To exercise any of these rights

• You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer. • We normally contact you by telephone, mail at your home address and possibly by e-mail (if you have given your email address.) You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

It is ok to contact me by:

Phone: _____ E-Mail: _____

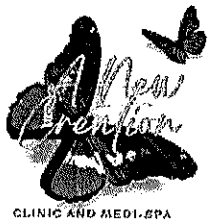
You may leave message pertaining to my health: ___ Yes ___ No

• You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. • You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete. • You may obtain a paper copy of this notice upon request. You have this right even if you have agreed to receive the notice electronically.

5. **Changes to This Notice.** We reserve the right to change the terms of this notice at anytime, and to make the new notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website.

6. **Effective Date**. This Notice is effective September 27, 2022

_____	_____	_____
Name	Signature	Date
_____	_____	_____
Parent or Guardian Name, if applicable	Parent or Guardian Signature, if applicable	Date



No Show & Cancellation Policy:

A No Show is an appointment you do not arrive to with prior cancellation. It is our policy to charge a **$50.00 fee** for a No-Show to an appointment. If an emergency arises and you are unable to make the appointment and you call or notify us, it will be reviewed with the Clinical Coordinator and the fee may be waived in some circumstance. Non-notification of a missed appointment results in a charge. **Cancellations must be made 24 hours in advance**. If the appointment is canceled the same day, there will also be a $50.00 fee for the late cancellation.

A patient who arrives more than 15 minutes late for an appointment will need to be reschedule.

Name	Signature	Date

Parent or Guardian Name, if applicable	Parent or Guardian Signature, if applicable	Date

Insurance Disclaimer:

Although we make every attempt to verify coverage prior to your appointment, you may have a deductible to pay and/or your insurance may not completely cover your office visit or other fees associated with your care including procedures, supplies and/or phone consultations. Fees are charged based on time and level of service. I understand that this is my responsibility to pay for all fees associate with my visit and/or procedures.

Name	Signature	Date
Parent of Guardian Name, if applicable	Parent or Guardian Signature, if applicable	Date

Medicare Waiver (Sign only if you have Medicare):

Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862 (1)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. I believe that in your case Medicare is likely to deny payment for:

1. Annual exam with Pap once every two years
2. Medicare does not cover Birth control
3. Medicare does not cover most preventative services. Preventative services are rendered when you have already received your annual exam with Pap smear in the last two years. For patients receiving these services advanced beneficiary notices are not required. According to Medicare guidelines, patients can be billed directly. Preventive services include an annual exam with pap smear.
4. Medicare only covers physical within the first six months of signing up with Medicare, otherwise it is the patient's responsibility.

Name	Signature	Date

Patient's Bill of Rights and Responsibilities

As a patient you have the right to:
• Considerate and respectful care • Knowledge of the name of the healthcare providers who have primary responsibility for coordinating the care, and the names and professional relationships of any other healthcare providers who may see you. • Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternative course of treatment or non-treatment and the risks involved in each and know the name of the provider who will carry out the procedure or treatment. • Participate actively in any decisions regarding your medical care; to the extent permitted by law, this includes the right to refuse treatment.
• Full consideration of privacy concerning your medical care. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual. • Confidential treatment of all communication and records pertaining to your care. • Reasonable continuity of care and to know, in advance, the time and location of the appointment as well as the identity of the persons providing the care. • Be advised if the healthcare provider proposes to engage in or perform human experimentation affecting care or treatment, you have the right to refute to participate in such research projects. • Have all your rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient. • Have complaints forwarded to administrative personnel for appropriate response. • Know that all the Clinic/Office personal will observer your rights.

The care a patient receives depends partially on the patient. Therefore, in addition to patient rights, you as a patient have certain responsibilities. You are responsible for:
• Providing accurate and complete information conceding your present complains, past medical history, and other matters relating to your health. • You are responsible for making it known whether you clearly comprehend the course of your medical treatment and what is expected of you. • You are responsible for following the treatment plan established for you by your healthcare provider, including the instructions of Medical Assistants and other health professionals as they carry out the healthcare providers orders. • You are responsible for keeping appointments and for notifying the office within 24 hours to cancel your appointment. We understand emergency situations occur; however, we reserve the right to initiate a $50.00 missed appointment fee per occurrence, with the possibility of dismissal after three occurrences. • You are responsible for your actions should you refuse treatment or not follow the healthcare providers orders/recommendations. • You are responsible for assuring that the financial obligations of your care are fulfilled. • You are responsible for being considerate of the rights of other patients and office personnel.

Name	Signature	Date
Parent or Guardian Name, if applicable	Parent or Guardian Signature, if applicable	Date

CLINIC AND MEDI-SPA

A New Creation Clinic and Medi-Spa
2001 W. Orange Grove Rd. Suite 308
Tucson, AZ 85704
O: 520.293.1117
F: 5202937701
Email: ANewCreationClinicandMediSpa@outlook.com
Website: WWW.ANewCreatioClinicandMediSpa.com
Cheryl Abraham, FNP

Medical Record Request

Patient Name: _____ DOB: _____ / _____ / _____

Patient Signature: _____ Date: _____ / _____ / _____

I authorize _____
(Releasing Physician/Facility)

_____
(Address)

_____
(Phone Number & Fax Number)

To release my medical information, including the diagnosis and records of any treatment and/or examination rendered to me during the period:

From: _____ / _____ / _____ To: _____ / _____ / _____

* Excluding: Office Notes [ ] Labs/Radiology [ ] Mental Health/Alcohol/Drug/Communicable Diseases Tx [ ]

* No Exclusions: [ ]

These records are to be release to:
Cheryl Abraham, FNP
A New Creation Clinic and Medi-Spa
**** **Please Send Records Via email if over 10 pages to our secure line** ****

This authorization will expire 12 months from the signature date or when the signer withdraws authorization.