Thompson Peak Internal Medicine - Gary A. Betz,II MD PC- Please complete in ink.

Name	Date of Birth	Gender (circle one) Male · Female
Address City State Zip Code		
Home Phone	Cell Phone	Social Security #
Marital Status (circle one) Single · Married · Divorced · Widow · Legally separated · Partner	E-mail Address*	
Employer	Work Phone	
Emergency Contact Relationship	Emergency Contact Phone	
Referral Source (circle one) Family/Friend · Web Site · Insurance Company · Radio/TV · Physician · Newspaper/Magazine · Electronic Newsletter · Search Engine		

Responsibility Party Name (if patient is under 18 OR other than patient)		
Address/City/State/Zip		Social Security No.
Phone	Date of Birth	Employer Name & Phone No.

Pharmacy Location	Phone

Name of individuals who we may speak to on your behalf (scheduling, medical results, etc) 1. 2.	Phone
Messages may be left at: (circle one or more) HOME WORK CELL	

Primary Insurance Carrier		
Policyholder Name (if other than patient)		Social Security no Date of Birth (of policy holder)
ID/Policy No	Group No	Primary carrier Phone

Secondary Insurance	Phone
Policy holder name(if other than patient)	SSN
ID/Policy No	Group #

Please allow us to copy your insurance cards

I authorize my insurance company to pay directly any and all claims submitted from Thompson Peak Internal Medicine, Gary A. Betz, II MD. I accept responsibility for any unpaid balance following insurance reimbursement or should insurance deny coverage for services for any reason and will pay the balance in a timely manner.

* My signature on this document allows Thompson Peak Internal Medicine to communicate to me via my e-mail address.

** My signature on this document allows Thompson Peak Internal Medicine to request copies of any and all medical records from any source pertinent to my medical care.

*** To ensure confidentiality and privacy for our patients, any type of electronic recording is prohibited at this office.

I acknowledge that the office's Notice of Privacy Practices has been made available to me

Signature** _____ Date _____

_____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Gary Betz II, MD
7010 E Chauncey Lane # 145
Phoenix, AZ 85054

THOMPSON PEAK INTERNAL MEDICINE

Please bring the following questionnaire to your examination. It will help the physician to know not only about your health but also about your family history.

Name:_____ DOB: _____ Date:_____

Are you employed? ☐ Yes ☐ No ☐ Retired If yes, what is your occupation: _____
Have you traveled outside the US in the last 5 years? If yes, where?_____

Prescription Medications: If you have more than six (6) medications, please bring a list to your appointment.

Medication:	Dose:	Frequency:

Non Prescription Medication:	Dose:	Frequency:

Please check any illnesses which have occurred in any of your **blood relatives**.

☐ Bleeding Tendencies ☐ Diabetes ☐ Hypertension ☐ Nervous Disorders
☐ Cancer ☐ Heart Disease ☐ Kidney Disease ☐ Stroke

Please check any illnesses or conditions **you** have had or been diagnosis.

☐ Asthma ☐ Blood Clots ☐ Cancer _____ ☐ Diabetes
☐ Elevated Cholesterol ☐ Glaucoma ☐ HIV ☐ Heart Disease
☐ Hepatitis ☐ Hypertension ☐ Hypothyroidism ☐ Jaundice
☐ Kidney Disease ☐ Obesity ☐ Pneumonia ☐ Reflux
☐ Rheumatic Fever ☐Sleep Apnea ☐ Stroke/TIA (circle one) ☐ Tuberculosis
☐ Other(s)_____

Do you have any known **drug allergies**? If yes, please list **drug name** and **reaction**:

Non-seasonal allergies and reactions: (latex, tape, contrast, etc?)

Surgical History:

_____ _____
_____ _____
_____ _____

Date of your last colonoscopy:_____
Was it normal? ☐ Yes ☐ No

Have you ever taken cortisone-type steroids? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Women Only

Date of last Pap Smear: _____
Normal? ☐ Yes ☐ No
Date of last Mammo:_____
Normal? ☐ Yes ☐ No
Date of last Bone Density:_____
Normal? ☐ Yes ☐ No

Family History:

	Living?	Present age or age at death?	Significant health problems or cause of death:
Father	☐ Yes ☐ No	_____	_____
Mother	☐ Yes ☐ No	_____	_____

		Present age or age at death?	Significant health problems or cause of death:
Brothers	Number Living	_____/_____	_____
	Number Non-Living	_____/_____	_____
Sisters	Number Living	_____/_____	_____
	Number Non-Living	_____/_____	_____
Daughters	Number Living	_____/_____	_____
	Number non-Living	_____/_____	_____
Sons	Number Living	_____/_____	_____
	Number non-Living	_____/_____	_____

Social History:

Tobacco use: □ Never □ Presently □ Past History Packs per day?_____ How many years?_____
When did you quit?_____

What type of physical activities do you perform (including exercise, hiking, Yoga, etc.)?

_____

Do you engage in any other healing or alternative therapies (e.g. acupuncture, massage, hypnosis, etc.)?

_____

Alcohol use: □ Yes □ No How many drinks per ____ Day ____ Week ____ Month
How often do you have 6 or more drinks on one occasion?:_____
Caffeine use: □ Yes □ No ☐ Coffee ☐ Soda Frequency: □ Daily □ Weekly □ Socially □ Occasionally
Number of cups:_____

Recreational drug use: □ Yes □ No

Please check the Immunizations you have received:

□ Hepatitis A □ Hepatitis B □ Influenza □ German Measles (Rubella)
□ Measles □ Mumps □ Pneumonia □ Polio
□ Shingles □ Tetanus

What is your main medical problem now, and how long have you had this problem?
_____
_____
_____

What other medical problem(s) do you want the physician to know about?
_____
_____
_____

Other physicians involved in your care:
Name:_____ Phone:_____
Name:_____ Phone:_____
Name:_____ Phone:_____

In order to support your continuing care Thompson Peak Internal Medicine may share a summary of our findings with the above listed physician.

Signature: _____ Date:_____

PLEASE CIRCLE YES TO ANY SYMPTOMS YOU ARE **CURRENTLY** EXPERIENCING AND NO TO ALL OTHERS

Name_____ DOB:_____ DATE: _____

General		
Fever	Yes	No
Chills	Yes	No
Night Sweats	Yes	No
Fatigue	Yes	No
Weight Gain	Yes	No
Weight Loss	Yes	No
Loss of Appetite	Yes	No
Weakness	Yes	No

Neurology		
Headache	Yes	No
Tingling Numbness	Yes	No
Seizures	Yes	No
Insomnia	Yes	No
Dizziness	Yes	No

Psychology		
Anxiety	Yes	No
Depression	Yes	No

ENT		
Difficulty Swallowing	Yes	No
Cough	Yes	No
Hearing Loss	Yes	No
Change in Voice	Yes	No
Sore Throat	Yes	No
Ringing of the Ears	Yes	No

Allergy		
Sinus Pressure/Pain	Yes	No
Post Nasal Drip	Yes	No
Sneezing	Yes	No
Runny Nose	Yes	No
Scratchy Throat	Yes	No
Itchy Eyes	Yes	No
Ear Fullness	Yes	No
Sinus Congestion	Yes	No

Ophthalmology		
Diminished Vision	Yes	No
Eye Irritation	Yes	No
Blurring of Vision	Yes	No
Loss of Vision	Yes	No

Respiratory		
Shortness of Breath	Yes	No
Chest Congestion	Yes	No

Cardiology		
Chest Pain	Yes	No
Palpitations	Yes	No
Leg Edema	Yes	No

Gastroenterology		
Nausea	Yes	No
Heartburn	Yes	No
Vomiting	Yes	No
Abdominal Pain	Yes	No
Diarrhea	Yes	No
Constipation	Yes	No
Blood in Stool	Yes	No
Hemorrhoids	Yes	No

Musculoskeletal		
Joint Stiffness	Yes	No
Joint Pain	Yes	No
Joint Swelling	Yes	No
Leg Cramps	Yes	No

Male		
Difficulty w/ Erection	Yes	No
Diminished Sex Drive	Yes	No

Female		
Abnormal Vaginal Bleeding	Yes	No
Abnormal Vaginal Discharge	Yes	No
Irregular Periods	Yes	No
Pelvic Pain	Yes	No
Breast Pain	Yes	No
Nipple Discharge	Yes	No
Hot Flashes	Yes	No
Date of Last Period		

Urology		
Urgency	Yes	No
Weak Stream	Yes	No
Frequent Urination	Yes	No
Incontinence	Yes	No
Blood in Urine	Yes	No
Incomplete Urination	Yes	No
Nightime Urination	Yes	No
Pain w/ Urination	Yes	No

Dermatology		
Rash	Yes	No
Moles	Yes	No
Lumps	Yes	No
Hives	Yes	No
Dry/Sensitive Skin	Yes	No
Skin Cancer	Yes	No

Hemotology/Oncology		
Swollen Glands	Yes	No
Varicose Veins	Yes	No
Easy Brusing	Yes	No

Endocrinology		
Skin Changes	Yes	No
Hair Changes	Yes	No
Cold Intolerances	Yes	No
Heat Intolerances	Yes	No

If you circled yes to anything on this sheet, please explain.

THOMPSON PEAK
INTERNAL
MEDICINE

Patient Insurance-Financial Responsibilities Notification

To all patients:

Thompson Peak Internal Medicine the office of Dr. Gary Betz, commonly requests blood work or consultation with other specialists regarding your care. For those of you who have limitations in terms of managed care programs, or insurance contracts with laboratories or imaging facilities, it is your responsibility to make sure that the laboratory or imaging facility which is used is proper for your coverage, or make sure that necessary insurance authorization is obtained before your consultation, lab work or diagnostic testing.

Although we make an effort to try to make sure our referrals and orders are in accordance with the individual patient's health plan, we cannot take responsibility for this.

For those who have Medicare and other insurances, we attempt to provide the coding necessary for Medicare and insurances to cover your blood work, but it is not always possible that blood work ordered is covered by Medicare or insurance. We make no representation that we can guarantee insurance coverage, and will not accept any responsibility for payment of laboratory or diagnostic imaging charges. If you decide that you do not wish to have diagnostic studies or laboratory tests performed which are recommended by our physicians, because of insurance coverage, that responsibility is yours, including responsibility for failure to diagnose a disease which otherwise would have been found.

It is regrettable that we have to issue this letter, but "circumstances" with today's complex insurance / Medicare rules and regulations require this. Please contact the office if you have any questions.

Sincerely,

The office staff of Thompson Peak Internal Medicine

I have read and understand the above.

Patient: _____ Date: ____/____/____

THOMPSON PEAK
INTERNAL
MEDICINE

GARY A. BETZ, II, MD
Board Certified
Internal Medicine

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Thompson Peak Internal Medicine and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by Dr. Betz and his staff.

My signature certified that I read and understand the scope of this consent and that I authorize the access

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

7010 E. Chauncey Lane, Suite 145 • Phoenix, AZ 85054
Phone 480-502-5533 • Fax 480-502-5761 • www.thompsonpeakinternalmedicine.com

Thompson Peak Internal Medicine
FINANCIAL POLICY 2015

We appreciate that you have entrusted Thompson Peak Internal Medicine (TPIM) with your health care. Our office is dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. Because healthcare benefits and coverage options have become increasingly complex, we have developed this policy which details our financial requirements to help you better understand your responsibilities as a patient.

It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, precertifications, preauthorizations, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments, and/or coinsurance. This applies to all payors regardless of whether or not our physicians participate. It is your responsibility to notify the office of any changes in your coverage prior to service.

Our office understands the value of insurance benefits, as a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. Payment of fees for the Provider's services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

Due to increased insurance company demands, we ask you to read and agree to the following TPIM provisions:

Private Pay Patients: If you have no insurance coverage, full payment is expected at the time of service.

Services not covered by your insurance plan: Services not covered by your insurance plan are your responsibility. You will receive a statement from us for the amount due. We advise you to contact your insurance company in advance to verify coverage for specific benefits such as well checks, immunizations, behavioral visits and lab services.

Patients with contracted insurance plans: Your copayments and/or coinsurance are due at the time of your visit. As a courtesy, our office will submit your claim to your insurance carrier.

Patients with private insurance/out of network plans/out of state plans: Payment in full is due at the time of your visit. A paid receipt will be provided to you to submit to your insurance company.

Payment options: We accept Cash, Check, Visa, Master Card, Discover Card (sorry, no American Express)

Statements: Statements will be mailed to the address that we have on file for you.

Outside Collections: If your outstanding balance has not been paid to TPIM within 120 days, your account will be turned over to RSKM, LLC, our outside collection agency, (phone number 602u 395u 0718). Thereafter, within 60 days of receipt by RSKM, LLC, if your balance has not been paid or payment arrangements have not been made, dismissal from TPIM will occur.

Laboratory Fees: You will receive a separate laboratory fee for their services. Any lab services that are not covered by your insurance will be your responsibility.

Address and Insurance Changes: Please let us know if your address, phone numbers, insurance, etc. change, so that your information is always current and accurate in your records. It is your responsibility to make sure we have the most up to date information for you.

Payment Policy Schedule*:

Co-payments	Full payment is due at time of service
Deductible and coinsurance	Full payment is due at time of service
Non-covered services	Full payment is due at time of service

Non-participating insurance plan	Full payment is due at time of service
Other charges/fees*:	
Missed Appointment Fee	The office requires at least 24 hours notice when cancelling an appointment. - Failure to provide this notice will result in a charge of: $50 for routine or problem-focused visits $100 for physical exams or extended visits
Blocked Call fee:	When paging the Provider after hours, your phone must be "unblocked" in order to reach you. Failure to do so will result in a delayed response and a $25 charge.
Returned Check Fee:	$25 (only cash, debit cards and credit cards are accepted in the office)
Statement Fee:	After your initial statement, each subsequent mailed statement with a balance showing, will incur a $25 Processing fee
Collection Fee:	Any outstanding balances after 120 days will be sent to collections. A collection service fee of $50 will be incurred. Legal interest on the indebtedness and related attorney fees will be added. Delinquent accounts will result in discharge from practice, at which time, 30 days from time of notice, only emergent care will be provided while you establish with another physician
Medical Records:	A fee of $25 is due prior to receipt of records
Special Paperwork:	A $25-$75 fee for completing medical forms or other health related paperwork

* subject to change at any time

We realize that medical care can often become very expensive. If you have concerns about your ability to pay for service, we recommend that you contact us for assistance in management of your account.

Should you have any questions with regard to our financial policy we encourage you to ask. It is our goal, not only to provide the best quality of medical care, but to help you by answering any questions you might have.

I have read and understand TPIM's Financial Policy and agree by its terms. I understand that I am financially responsible for all charges incurred in the event my insurance denies payment after a claim has been submitted by Thompson Peak Internal Medicine. I understand that my insurance is an arrangement between myself and my insurance company, and that it is my responsibility to understand my benefits.

Patient Name & Date of Birth (Please print) _____

Responsible Party Name (Please Print) _____

Your Signature _____ Date _____