We Care Family Wellness Center

2730 S. Val Vista Drive
Suite 138, Bldg. 7
Gilbert, AZ 85295
480.686.9686
Fax: 480.686.9508
www.wecarefwc.com

Welcome! This new patient packet contains:

- Patient Welcome Letter (2 pgs.)
- Map and Directions
- Notice of Privacy and Patient Rights (2 pgs.)
- Patient Demographic Form
- Patient Medical History (4 pgs.)
- Consent for Phone Contact Form

Please read each form, fill out and sign the appropriate forms PRIOR TO YOUR first visit and bring the ENTIRE PACKET WITH YOU to your first visit.

PLEASE NOTE OUR NEW OFFICE HOURS:

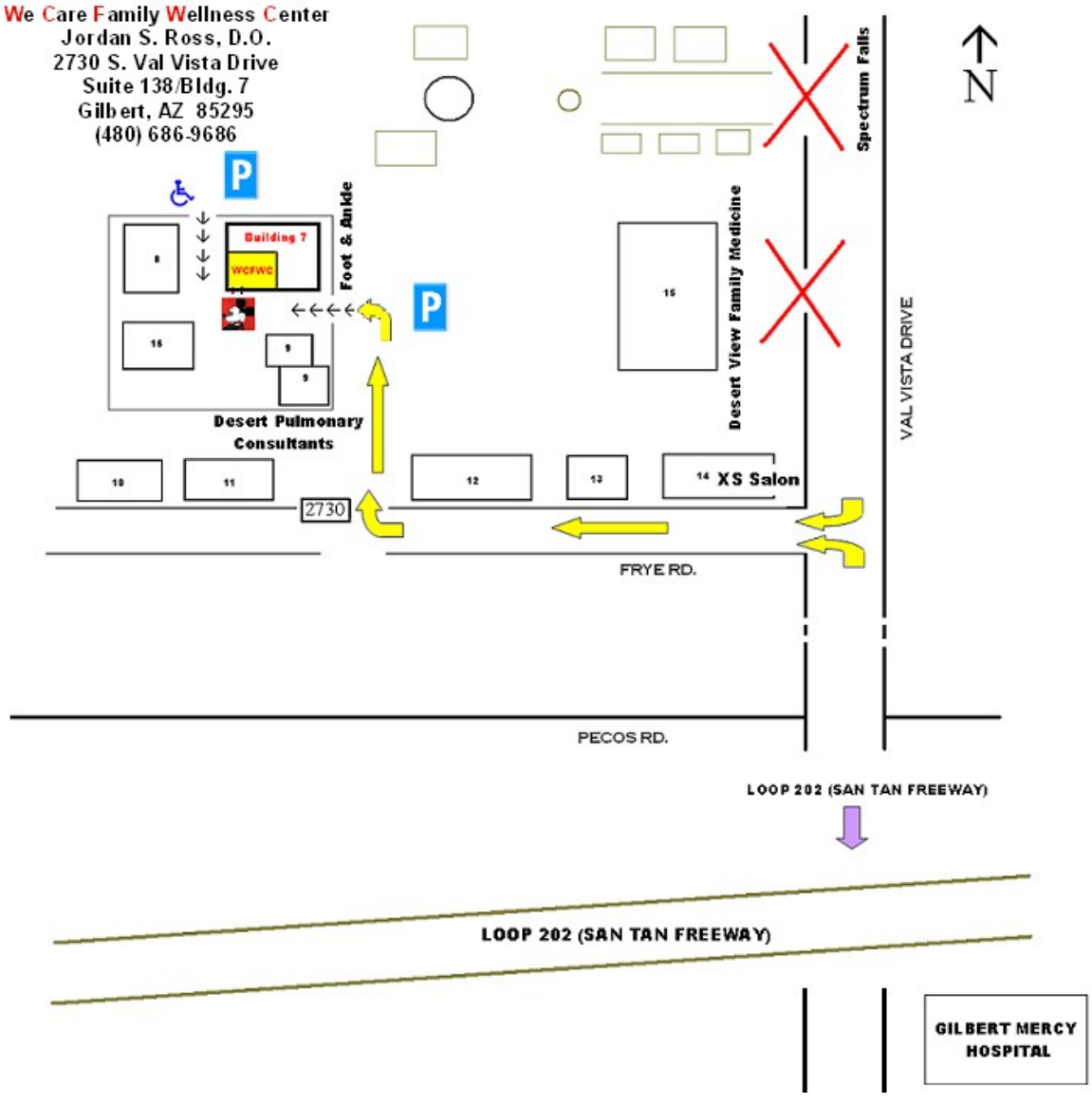
Mon 9am – 5pm
Tue 9am – 5pm
Wed 9am – 5pm
Thurs 8am – 4pm
Fri 8am – 3pm

Directions to We Care Family Wellness Center

We are located in Gilbert, just North of the SOUTHERN loop of the 202 (San Tan Freeway) on the West side of Val Vista Drive.

From I-10 East (towards Tucson), the 101 South, or surface streets, take the 202 (San Tan Freeway) East to Val Vista Drive. Turn left at end of ramp on to Val Vista. Go 0.8 miles [thru 3 lights]; turn Lt on Frye (a small side street) and take the first right into the "Spectrum Falls" complex; we're in Bldg 7, Ste. 138 with a courtyard entrance (take the walkway between "Western Family Medicine" and "Foot and Ankle")

*We Care Family Wellness Center



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PATIENT WELCOME LETTER

Welcome to **We Care Family Wellness Center**, the office of Jordan S. Ross, D.O. and Cheryl L. Simmons, FNP-C. We are a full service family practice office dedicated to providing personalized, high quality medical care for patients of all ages.

Stop! We realize that this document will require a few minutes of your time to read. But please read it anyway. Why? Because this practice is NOT like any other you've been to. It is imperative that you understand our advantages, our policies and our expectations of you before becoming a patient. We ask that you read this letter in its entirety and sign at the bottom, acknowledging that you understand its contents.

This practice has been created in response to patient feedback solicited over the past eleven years of family practice. Finally, you have found a doctor who is listening. How is **We Care Family Wellness Center** different?

We pledge to provide:

- personalized, compassionate care
- longer office visits
- the highest quality medical care
- short wait times
- flexible, accessible hours of operation (please see website for details: www.wecarefwc.com)
- a knowledgeable, dependable and interested staff, which includes two registered nurses (RN's)
- a peaceful, welcoming office environment
- a commitment to preventive care and health maintenance
- 24/7 on-call coverage for emergencies **by your own doctor**!**
- specialty Osteopathic manipulative care integrated throughout your family practice needs
- And Most Importantly……..A Doctor who Listens!

These principles are the essence of our practice. Our mission statement (printed below) is not just rhetoric but the philosophy by which we will conduct ourselves **every** day with **every** patient. We do this because…… **We Care**!

** Please note that Dr. Ross and Cheryl are on-call for this practice 24/7. If you have a true medical emergency, dial 911 or proceed to the nearest emergency room. If you have an urgent medical problem that cannot wait until the next business day, call (480) 993-6660 to speak to Dr. Ross or Cheryl. For routine matters (medication refills, billing questions, appointment changes, etc), please have the courtesy of waiting until the next business day.

We Care Family Wellness Center Mission Statement:

*At **We Care Family Wellness Center**, we strive to partner with our patients in order that we can assist each person to achieve optimal health. We pledge to provide the highest quality up-to-date medical care to all ages in a welcoming, friendly, honest and compassionate environment. We will listen, take each patient seriously and provide support, education and comprehensive treatment in an effort to help each patient to help himself/herself. We will do all this because……..**We Care!***

We Care Family Wellness Center

This practice is geared toward and limited to patients who are highly motivated to seek optimal health and who are willing to actively participate in their own health care. We will tailor the treatment plan to your individual needs and provide you with information and guidance which will assist you in seeking health and enable you to become more self-reliant. If you are the kind of patient who expects everything to be done for you without your active participation in this process, this practice may not be right for you.

Patient responsibilities:

- Please arrive at our office on time for your appointments
- Please provide pertinent past medical records or assist us in obtaining them
- Co-payments, fees applied to deductibles and co-insurance fees are expected as services are rendered
- We accept cash, personal checks and major credit and debit cards. We will assist you however possible with insurance companies but it is ultimately the patient's responsibility to settle outstanding balances and to contact insurance companies regarding questions of coverage, benefits, etc.
- Because we limit the number of daily appointments and spend long visits with each patient, failure to appear for your scheduled appointment is impolite and unfair to us. Please give us the courtesy of at least 24 hours notice when canceling scheduled appointments. We reserve the right to assess patients a $50 charge for same day cancellations or "no-shows"

At We Care Family Wellness Center, we are determined to provide the highest quality family medicine care in a friendly, welcoming and relaxed environment. We accept most private insurance plans, regular Medicare (not Railroad Medicare), Tricare, and commercial insurance plans. We are NOT contracted with any AHCCCS plans: (Mercy Care, Health Choice, Phoenix Health Plan, Care 1st, Maricopa Health Plan, and others), nor can we bill worker's compensation. Please be aware that if your insurance requires written referrals for diagnostic tests, specialist visits, etc., you will need to allow several days for processing as we are a small office.

If you have questions regarding your particular health insurance plan, please do not hesitate to call us. (480) 686-9686.

We Care Family Wellness Center is in federal compliance with HIPPA laws and will protect your right to medical confidentiality. As required by law, you will be asked to sign a notice of privacy practices and patient rights at your first visit. Upon request, you are welcome to a written copy of these HIPPA regulations.

Dr. Jordan Ross is committed to medical education and has been an associate clinical professor at the Arizona College of Osteopathic Medicine for many years. He is committed to training the next generation of physicians. As such, I understand that a medical student may be present during my visits and may, under direct supervision, participate in providing my medical care.

Please bring the attached forms with you to your first visit. If you have questions, please feel free to contact us.

I understand the above policies and would like to become a patient at We Care Family Wellness Center and to be an active partner in my own health care.

Name of Patient (print) _____

Signature _____

Date _____

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Notice of Privacy Practices and Patient Rights

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 obtain access to your health information. This notification is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

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. We realize that these laws are complicated but we must provide you with the following important 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 to do so 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 Worker's 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 at work. We will accommodate reasonable requests.

We Care Family Wellness Center

Notice of Privacy Practices and Patient Rights (page 2)

2. You can request a restriction in our use or 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 to We Care Family Wellness Center, 2730 S. Val Vista Dr., Ste. 138, Gilbert, AZ 85295.

4. You may ask us 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 and submitted to We Care Family Wellness Center, 2730 S. Val Vista Dr., Ste. 138, Gilbert, AZ 85295. You must provide us with a reason that supports your request for amendment.

5. 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.

6. If you believe that your privacy rights have been violated, you many file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Jordan Ross, We Care We Care Family Wellness Center, 2730 S. Val Vista Dr., Ste. 138, Gilbert, AZ 85295. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. You have the right to authorize the use or disclosure of your health information for all other uses. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Jordan Ross, We Care Family Wellness Center, 480 686-9686.

I hereby acknowledge that I have been presented with a copy of We Care Family Wellness Center's Notice of Privacy Practices.

Name of Patient (print) _____

Signature _____

Date _____

We Care Family Wellness Center

New Patient Demographic Form

Patient Name: _____

(Policy Holder's Name/relationship): _____

Home Address: _____ City/State/Zip:_____

Home Phone #: _____ Work Phone #: _____ Cell Phone #:_____
(please circle the number at which we are most likely to reach you)

Email address: _____

Social Security #: _____ Gender: Male / Female Date of Birth: _____ Age: _____

Marital Status: Single Married Partnered Widowed Other:

Spouse/partner's name: _____

Spouse/partner's address & phone #: _____

Emergency contact's name & phone # (if different):_____

Patient's occupation: _____ Employer:_____

Employer's address & phone #:_____

I was referred to this office by: _____

Medical Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

Policy Holder's Birthdate: _____ Policy Holder's Birthdate: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Subscriber ID #: _____ Subscriber ID #: _____

Group Number: _____ Group Number: _____

Patient's signature: _____ Date: _____

(or parent if minor)

We Care Family Wellness Center

New Patient Medical History Form

Name (First, Middle, Last): _____ **Today's Date**: _____

Date of Birth: _____

Problem(s) you are seeking help with:

Any Current Medical Diagnoses:

Immunizations:
Date of last Tetanus:_____
Date of last Pneumovax:_____
Date of last flu shot:_____

Health Maintenance:
Date of last blood work:_____
Date of last colonoscopy:_____

For Women Only:
Last Pap Smear:_____
Last Menstrual Period:_____
Last Mammogram:_____
Last Bone Density Scan:_____
Number of pregnancies:_____
Age/Gender of Children:
_____

For Men Only:
Last Physical:_____
Last Prostate Exam:_____
Last PSA screen:_____

Is it possible that you are pregnant?_____

Have you had any of the following:

Abnormal Pap Smears	YES ○	NO ○	If yes, when?_____
Bleeding between periods	YES ○	NO ○	
Breast lumps	YES ○	NO ○	
Extreme menstrual pain	YES ○	NO ○	
Hot flashes	YES ○	NO ○	
Weight gain	YES ○	NO ○	
Difficulty sleeping	YES ○	NO ○	

Surgeries (including dates):

Drug Allergies:
Yes ☐ No ☐
If yes, please provide the following information:
Drug:_____
Reaction:_____
Age of onset:_____

Food Allergies:
Yes ☐ No ☐
If yes, which foods?_____
_____

Seasonal Allergies: Yes ☐ No ☐

Patient Signature: _____ Date: _____

New Patient Medical History Form (page 2)

Medications:
Prescription Meds:

Over-The-Counter Meds/Supplements/Vitamins:

Family History:

	Age	Health Conditions	Living/Deceased	Age of Death
Father				
Mother				
Brothers				
Sisters				

Any family history of the following conditions?
Cancer - Type/Who?_____
Diabetes – Type/Who? _____
Heart Disease – Who?_____
High Blood Pressure – Who?_____

Tobacco Use:
Yes ☐ No ☐
If yes, please answer the following:
Cigarettes – how many per day?_____
Cigars – how many/how often?_____
Other (chew, pipe, etc) –how many/how often? _____

Alcohol Use:
Yes ☐ No ☐
If yes, how much/how often?_____

Patient Signature: _____ Date: _____

New Patient Medical History Form (page 3)

Please circle each symptom/condition that applies to you:

GENERAL
Anxiety
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Night sweats
Numbness
Sleep Disturbance

CARDIOVASCULAR
Chest Pain
High Blood Pressure
Irregular Heart Beat
Low Blood Pressure
Poor Circulation
Rapid Heart Beat
Swelling of Ankles
Varicose Veins

EYE, EAR, NOSE, THROAT
Bleeding gums
Blurred vision
Difficulty swallowing
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nosebleeds
Persistent cough
Ringing in ears
Sinus problems

GASTROINTESTINAL
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

GENITO-URINARY
Blood in urine
Erectile Dysfunction
Frequent urination
Lack of bladder control
Loss of Libido
Painful urination
Penile discharge
Vaginal discharge

MUSCLE/JOINT/BONE
Pain/Weakness/Numbness in:
Arms
Back
Feet
Hands
Hips
Knees
Legs
Neck
Shoulders

SKIN
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sores that do not heal

_____

Fill out THIS SECTION <u>if you suffer from headaches</u>:

Do you suffer from chronic headaches? _____ How often? _____

Do you suffer from chronic migraines? _____ How often? _____

Age of onset _____

Have you been evaluated by a neurologist? _____ Had a CT scan / MRI scan of your brain? When? _____

Longest interval WITHOUT a headache/migraine over the past year: _____

Known triggers:_____

Patient Signature: _____ Date: _____

New Patient Medical History Form (page 4)

Please circle each condition that you currently have or have had over the past year:

AIDS
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lump
Bronchitis
Bulimia
Cancer (specify)
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease/Heart attack
Hepatitis
Hernia
Herpes
High Cholesterol
HIV Positive
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononucleosis
Multiple Sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate Problem
Psychiatric Care
Rheumatic Fever
Scarlet Fever
Seizures
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tooth Decay
Tuberculosis
Typhoid Fever
Ulcers
Vaginal Infections
Valley Fever

Please include any additional pertinent medical history below:

Patient Signature: _____ Date: _____

We Care Family Wellness Center

Consent for Phone Contact Form

If we attempt to contact you and do not reach you in person, please indicate which method(s) of leaving messages are acceptable to you:

- o It is OK to leave a voicemail message for me on my
- o Home Phone _____
- o Cel Phone _____
- o Work Phone _____
- o Other (specify) _____

_____

- o It is OK to discuss medical information regarding me with:
- o My husband/wife/partner _____ (print name)
- o My power of attorney _____ (print name, relationship)
- o Other _____ (print name, relationship)

- o Never leave any medical information on any message for me, simply ask me to call back.
- o It is OK to email me with medical information @

_____