MR#_____

ACKNOWLEDGEMENT OF PRIVACY POLICIES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

I have received a copy of the HUG Clinic's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand the HUG Clinic has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

GateWay Community College
HUG Clinic
555 N. 18TH Street Ste 301
Phoenix, AZ 85006

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

☐ **I do not wish to keep the Privacy Policies for further review**

_____

Name of Patient (Please print)

_____

Signature of Patient

_____ _____

Signature of Legal Guardian for patient under 18 years old **Date**

MR # _____

US PULM PT OT MASSAGE
(CIRCLE APPLICABLE SERVICE(S))

Patient Information Form

Patient Name (Last) (First) (MI)

Address (Street) (Apt.)

(City) (State) (Zip Code)

( ) ( )
Primary Phone (Cell/Home) ((Area Code) – XXX – XXXX) Additional Phone (Cell/Home) ((Area Code) – XXX – XXXX)

Patient Email Address

( )
Emergency Contact (Name) Emergency Contact Phone ((Area Code) – XXX – XXXX)

Patient Date of Birth (mm/dd/yyyy) Patient Age

Employer

Address (Street)

(City) (State) (Zip Code)

( )
Work Phone ((Area Code) – XXX – XXXX) Driver's License No. State

( )
Primary Care Physician Phone Number ((Area Code) – XXX – XXXX)

Address (Street)

(City) (State) (Zip Code)

☐ **Check here if your medical insurance is Meritain Health provided by Maricopa Community College (for our tracking purposes only...we do NOT Bill insurance).**

I certify that the above information is accurate:

Signature of Patient or Parent/Legal Guardian Date

MR#_____

PAST MEDICAL HISTORY FORM

_____ _____

Name Date

_____ _____

Age Allergies

Reason for Today's Visit _____

Physician _____

Marital status ☐ Married/Partner's Name _____ ☐ Single ☐ Widowed

Who lives with you at home _____

Occupation _____ Employer _____

Current status: ☐ Full Time/Full Duty ☐ Part Time/Part Duty ☐ Retired ☐ Disability ☐ Not Working

Review of Symptoms: Please Check **all** the apply

☐ Arrhythmia
☐ Arthritis
☐ Alcohol use
☐ Anxiety
☐ Cancer
_____
☐ Changes in a mole
☐ Kidney/ Prostate
☐ Chest Pain
☐ Circulatory Disorder
☐ Claustrophobia
☐ Cold/Heat Intolerance
☐ Cough
☐ Cryoglobulinemia
☐ Diabetes:_____
☐ Rheumatoid Arthritis

☐ DVT or blood clot
☐ Eye Disease/Glaucoma
☐ Fainting
☐ Foreign Body/Metal Implants
_____
☐ headaches or Migraines
☐ Fracture(Year) _____
☐ Anemia
☐ Heart Conditions
_____
☐ Heart Attack
☐ Heartburn
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Stroke/CVA

☐ HIV/AIDS
☐ Joint Replacement:_____
☐ Lung Disease (see below)
☐ Lupus
☐ Memory Loss
☐ Neurological Condition
☐ Osteoporosis
☐ Insomnia
☐ Pacemaker
☐ Pregnancy
☐ Psychiatric/ Depression
_____
☐ Raynauds
☐ Recent Fever
☐ Recent Infection
☐ Seizures

☐ Shortness of Breath ☐ Swollen Feet ☐ Unexpected weight loss or gain

☐ Steroid usage ☐ Tobacco use ☐ Wound

Personal Medical History, Serious Injury and Surgical History: Please list all prior operations (with dates)

_____

_____

Do you need ADVANCED DIRECTIVES For Medical Care:

☐ Durable Power of Attorney

☐ Do Not Resuscitate Order

☐ Decline

Latex Allergy ☐ Yes / ☐ No

Environmental Allergies _____

Medications

Drug	Dosage	Frequency

Drug	Dosage	Frequency

RESPIRATORY ONLY

Supplemental O2 Pulsed/Continuous Ipm _____

Drug Allergies _____

Pulmonary History

☐ Sleep Apnea CPAP/BILEVEL ☐ COPD ☐ Chronic Bronchitis ☐ Lung CA

☐ Interstitial Pulmonary Fibrosis ☐ Emphysema ☐ Pulmonary Embolism ☐ Bronchiectasis

☐ Pulmonary Hypertension ☐ Asthma

☐ Tobacco Use Type_____

Current_____ ☐ Quit ☐ ppd x _____ yrs

Other_____ _____

Exposure History

☐ Asbestos ☐ Solvents ☐ Cotton Dust ☐ Other Dusts

☐ Mining ☐ Farming ☐ Paint Fumes ☐ Other Fumes

I attest that the above questions have been answered correctly to the best of my knowledge.

_____

Name of Patient (Please Print)

_____ _____

Signature of Patient or Parent/Legal Guardian Date

MR#_____

HUG CLINIC CONDITIONS OF ADMISSION AGREEMENT

ACKNOWLEDGEMENTS

_____ I acknowledge, understand and agree to give general consent for registration, diagnostic testing, observation and treatment performed by GWCC Physical Therapy Assisting, Sonography and Health Unit Coordinating students under the supervision of GWCC faculty as well as evaluation by licensed GWCC faculty. This consent applies to all visits in the HUG clinic.

_____ I affirm that all information (including demographic and health) given by me or my representative to the staff of the HUG clinic in writing, electronically and verbally is truthful and accurate.
_____ I understand and acknowledge that the HUG clinic does not provide emergency medical services. I release the HUG clinic from any liability arising from a lack of emergency care.

_____I acknowledge receipt of GateWay Community College's HUG Clinic Notice of Privacy Practice as well as Patient Bill of Rights and general information about Advance Directives.

_____ I understand that the HUG clinic is not responsible for personal valuables brought by me to the clinic.

_____ I consent to GWCC recording, photographing, or filming me for purposes of treatment or GWCC's HUG clinic internal operations, such as improvement of quality of care and educating students and participants.

_____ I acknowledge, understand and agree that services provided at HUG Clinic are pro bono and as such no more than 24 visits or one fiscal year period may be utilized. At that time, a patient may be placed on the patient wait list for future visits in order to allow services to be available to other members of the community.

_____ I understand that I may review upon written request, my own medical records according to ARS 12-2293, 12-2294 and 12-2294.01

NON-DISCRIMINATION: Access to available treatment that is medically indicated is provided regardless of race, creed, religion, gender, national origin, political belief, sexual preference/orientation, mental or physical status.

_____

Name of Patient (Please print)

_____ _____

Signature of patient **Date**

MR#_____

Population Health Survey:

We are committed to diversity, equity and inclusion at the HUG Clinic. We view data as an essential tool to practice this commitment.

The data collected will help us understand how we reflect the communities we serve, to equip our staff with critical data to better serve the needs of our communities, and to track our progress with our board, grantees and communities.

1. Which category below includes your age?

☐ 17 or younger ☐ 21 - 29 ☐ 40 - 49 ☐ 60 - 69

☐ 18 - 20 ☐ 30 - 39 ☐ 50 - 59 ☐ 70 - 79

2. What is your residential zip code? _____

3. What is your gender? ☐ Female ☐ Male ☐ Other

4. How much total combined money did all members of your HOUSEHOLD earn last year?

☐ $0 to $24,999 ☐ $25,000 or greater

4. Do you have medical insurance? ☐ Yes ☐ No

If you have medical insurance, why are you seeking services at HUG?
☐ Price of copays/coinsurance for current plan is too expensive?
☐ Ran out of insurance for the year
☐ Other: _____

5. Which of the following best describes you? Please select one answer.

☐ **Latinx** — A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
☐ **White** — A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
☐ **Black or African American** — A person having origins in any of the black racial groups of Africa.
☐ **Native Hawaiian or Other Pacific Islander** — A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ **Asian** — A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent
☐ **Native American or Alaska Native** — A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐ **Two or More Races** — A person who self-reports as belonging to more than one racial category.

6. Do you speak a language other than English at home? ☐ Yes ☐ No

   For persons speaking a language other than English. What language? _____

7. Data Standard for Disability Status:
   - Are you deaf or do you have serious difficulty hearing? ☐ Yes ☐ No
   - Are you blind or do you have serious difficulty seeing? ☐ Yes ☐ No
   - Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? ☐ Yes ☐ No
   - Do you have serious difficulty walking or climbing stairs? ☐ Yes ☐ No
   - Do you have difficulty dressing or bathing? ☐ Yes ☐ No
   - Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? ☐ Yes ☐ No

8. Have you ever served in the U.S. military or a retired Veteran? ☐ Yes ☐ No

Questions in population surveys are not mandatory for HUG Clinic services but used to assess whether we are working to achieve our mission for community outreach efforts

_____*For Office Use only*_____

☐ Inputted into Google Forms (admin to sign/date): _____

☐ Patient declination _____

MR#_____

AUTHORIZATION FOR RELEASE OF INFORMATION (ROI) OF PERSONAL HEALTH INFORMATION (PHI) FORM

I, _____ hereby authorize:

PATIENT'S PRINTED NAME

HUG CLINIC AT GATEWAY COMMUNITY COLLEGE
555 N. 18th Street Ste 301
Phoenix, AZ 85006

To release, upon request the below medical information contained to my patient records in its custody to:
PERSON(S) OR ORGANIZATION(S) TO WHOM DISCLOSURE IS TO BE MADE:

1. _____
NAME OR ORGANIZATION PHONE

_____
ADDRESS

2. _____
NAME OR ORGANIZATION PHONE

_____
ADDRESS

I hereby consent to the release of all medical records and other documentation in your possession regarding:

☐ ULTRASOUND TECHNICAL IMPRESSIONS ☐ ULTRASOUND IMAGES OR CD ☐ ULTRASOUND IMAGES AND TECHNICAL IMPRESSIONS TO REFERRAL SOURCE ☐ ULTRASOUND IMAGES OR CD AND REFERRAL TO RADIOLOGY REPOSITORY ☐ PHYSICAL THERAPY TREATMENT ☐ PULMONARY REHAB TREATMENT ☐ ALL

Delivery of Records

☐ MAIL ☐ PICK-UP (MUST BRING ID) ☐ FAX ☐ NON-ENCRYPTED EMAIL

Email Address for record delivery

(Complete ONLY if requesting records via email)

Purpose

☐ SELF ☐ CONTINUING CARE ☐ OTHER _____

I understand that the HUG Clinic has no responsibility for the use of this distributed information by the party to whom it is released. I release The HUG Clinic from all liability, which may arise from your compliance with this request to release records.

_____
SIGNATURE OF PATIENT HUG PIN

_____ _____
SIGNATURE OF LEGAL GUARDIAN FOR PATIENT UNDER 18 YEARS OLD DATE

The maximum time frame for record retrieval is 30 days per HIPAA regulations. Follow up on either verification of identity or authorization can be through notary attestation, in person with valid ID, signed form via mail or upon submission of updated "Supplemental HUG ROI" form may be required