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#__________________

COVID-19 Patient Education Form

By signing this form I attest that I have been educated on the efforts of HUG Clinic at Gateway to reduce the risk of spreading COVID-19. Here is a list of what HUG Clinic is doing:

All staff and students self-assess everyday upon arrival to clinic. If screening is failed you will be unable to return until 10 days symptom free or negative COVID-19 test is provided.

Guests will arrive 15 minutes early for appointments and call upon arrival.

Anyone who enters the building will don a mask.

Guests will be escorted to room #328 for screening by a student/clinician.

If screening is failed you will be unable to return until 10 days symptom free or negative COVID-19 test results can be provided to us.

Waiting room chairs are 6 feet apart.

Patients/Clients will be allowed only one guest per visit to reduce exposure to COVID-19. No exceptions.

Treating clinicians/students will don masks and face shields during treatment times. Face shields will be cleaned after each visit.

Please bear with us during this difficult time as we do our best to provide high quality care while keeping everyone as safe as possible.

Print Name:_______________________________________

Patient Signature:____

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#__________________

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