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
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:________________________________________________
# Patient Information Form

<table>
<thead>
<tr>
<th>Patient Name (Last)</th>
<th>(First)</th>
<th>(MI)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address (Street)</th>
<th>(Apt.)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>(City)</th>
<th>(State)</th>
<th>(Zip Code)</th>
</tr>
</thead>
</table>

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

- **Patient Email Address**

<table>
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<table>
<thead>
<tr>
<th>Emergency Contact (Name)</th>
<th>Emergency Contact Phone ((Area Code) – XXX – XXXX)</th>
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<table>
<thead>
<tr>
<th>Patient Date of Birth (mm/dd/yyyy)</th>
<th>Patient Age</th>
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</table>

<table>
<thead>
<tr>
<th>Employer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address (Street)</th>
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</table>

<table>
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<tr>
<th>(City)</th>
<th>(State)</th>
<th>(Zip Code)</th>
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</thead>
</table>

- **Work Phone** ((Area Code) – XXX – XXXX)
- **Driver’s License No.**

<table>
<thead>
<tr>
<th>State</th>
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<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Phone Number ((Area Code) – XXX – XXXX)</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Address (Street)</th>
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<table>
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<tr>
<th>(City)</th>
<th>(State)</th>
<th>(Zip Code)</th>
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</table>

**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:

<table>
<thead>
<tr>
<th>Signature of Patient or Parent/Legal Guardian</th>
<th>Date</th>
</tr>
</thead>
</table>
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 □ DVT or blood clot □ HIV/AIDS
□ Arthritis □ Eye Disease/Glaucoma □ Joint Replacement: ______
□ Alcohol use □ Fainting □ Lung Disease (see below)
□ Anxiety □ Foreign Body/Metal Implants □ Lupus
□ Cancer ________________________________ □ Memory Loss
□ headaches or Migraines □ Neurological Condition
□ Changes in a mole □ Fracture(Year) □ Osteoporosis
□ Kidney/ Prostate □ Anemia □ Insomnia
□ Chest Pain □ Heart Conditions □ Pacemaker
□ Circulatory Disorder ________________________________ □ Pregnancy
□ Claustrophobia □ Heart Attack □ Psychiatric/ Depression
□ Cold/Heat Intolerance □ Heartburn ________________________________
□ Cough □ Hemophilia □ Raynauds
□ Cryoglobulinemia □ Hepatitis □ Recent Fever
□ Diabetes: ______ □ High Blood Pressure □ Recent Infection
□ Rheumatoid Arthritis □ Stroke/CVA □ Seizures

MR# ________________________________
☐ 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

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Frequency</th>
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<tbody>
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</table>

RESPIRATORY ONLY

Supplemental O2 Pulsed/Continuous
1pm

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 Dirts
☐ 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
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
WHITE CLINIC
Healthcare United at Gateway

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 IMPRESSIONS
☐ ULTRASOUND IMAGES OR CD
☐ ULTRASOUND IMAGES AND TECHNICAL IMPRESSIONS TO REFERRAL SOURCE
☐ ULTRASOUND IMAGES OR CD AND REFERRAL TO RADIOLGY REPOSITORY
☐ PHYSICAL THERAPY TREATMENT
☐ PULMONARY 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.