PATIENT INFORMATION

Paradise Valley Medical Clinic
Douglas M. Lakin MD

9977 N 90th Street, Suite 180 **PLEASE COMPLETE ONLINE OR PRINT LEGIBLY** Date: _____
Scottsdale, AZ 85258 Phone: 480.614.5800 SSN: _____

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____ Spouse: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Phone (Home): _____ Work: _____ Mobile: _____

Current Employment Status: _____ Email Address: _____

Employer: _____ Address: _____ City: _____ ST: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Pharmacy Name: _____ Phone: _____

INSURANCE INFORMATION

We will need your current insurance card and driver's license. Please give to our receptionist to make copies

Are you on Medicare Insurance: Y _____ **N** _____ ****This office is committed to regular Medicare & supplementary insurances, not advantage or replacement Medicare plans.**

PRIMARY INSURANCE:

Name: _____ Billing Address: _____

Member ID#: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____ Relationship: _____

SECONDARY INSURANCE:

Name: _____ Billing Address: _____

Member ID#: _____ Group#: _____

Subscriber's Name: _____ Date of Birth: _____ Relationship: _____

By signing this form, I authorize payment of medical benefits to Paradise Valley Medical Clinic for my healthcare charges. I also understand and agree I am responsible for the payment of all office fees and uncovered/denied medical charges incurred on behalf of a family member or myself.

Signature: _____ Relationship: _____

****Please bring completed form with you to your office visit with Dr Lakin. Thank you!**

Medical Conditions/Surgical History & Medications - Past/Current

Date: _____

Patient Name: _____

CURRENT or PAST CONDITIONS: (Please list any current or past diagnoses)

1._____

2._____

3._____

SURGICAL HISTORY: (Please list any past surgeries you have had)

1._____

2._____

3._____

MEDICATION HISTORY

**** ATTN NEW PATIENTS: Dr. Lakin does not prescribe or manage chronic/long term pain medications. This practice refers to the recommended Pain Clinics on our website for prescribing and management.**

DRUG ALLERGIES

1._____ 2. _____

PRESCRIPTION MEDICATIONS: Please list all medicines or drugs being taken **NOW** that were **PRESCRIBED BY A DOCTOR** (include what you take for chronic conditions, birth control, etc., AND any OTC medication such as aspirin, antacids, sleep medicine, allergy, cold medicine, vitamins).

*****CONTINUE MED'S ON REVERSE SIDE IF NECESSARY OR IF YOU DO NOT HAVE A LIST WITH YOU*****

MEDICINE NAME	DOSAGE	HOW OFTEN TAKEN
1.		
2.		
3.		
4.		
5.		

Rev: 7-2025

HIPAA Privacy Notice
Paradise Valley Medical Clinic, PC
Douglas M. Lakin MD

We are required by law to maintain the privacy of, and provide individuals with, a notice of our privacy practices with respect to protected health information. Our protected health information pamphlet is posted on our website, or available by asking our receptionist to furnish you a copy.
If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by phone at 480-614-5800.

I give permission to the office of Dr. Douglas M. Lakin to release medical information on myself to the following persons:

Phone #: _____

Phone #: _____

Phone #: _____

Phone #: _____

Phone #: _____

Your signature below is only acknowledgement that you give permission to release information to the persons referenced above:

_____
Print Name

_____ _____
Signature **Date**

_____ _____
Witness **Date**

Paradise Valley Medical Clinic
Office Financial Policy

revised 7.1.25

Please read and sign our patient and financial office policies. Our goal is to educate and avoid any misunderstandings regarding our office policies and all financial liabilities. *Please be aware that you must provide correct and accurate information regarding your address and insurance. If you provide our office with false information, you will be responsible for all charges incurred during your visit.*

Payment Policy: Each patient is responsible for payment of all services provided at the time of service. We will submit claims to In-Network insurance plans only; however, it is the patient's responsibility to know the benefits of his or her own health plan before services are rendered. All In-Network insurance claim submissions are dependent on each patient providing accurate insurance information.

- **Important Notice:**
  Please be advised that we do **not accept any HMO plans or AHCCCS plans**. We are unable to schedule appointments for patients covered under these insurance policies.
  We recommend reviewing your insurance plan documents or contacting your insurance provider directly to find covered Healthcare Providers.

- **Self-Pay or Out-of-Network Insurances**: Payment is due at time of service, and we are strictly a "cash-pay entity" regarding Out of Network Insurances. **We do not submit claims to any Out of Network Commercial Insurance plans for any reason or circumstance**. Some insurance plans may allow patients or the patients' representative to send claims to them directly for reimbursement. We may supply you with the necessary information you will need if you choose to submit claims to your insurance plan. **Please note**: the doctor's visit does not include lab work, vaccinations, injections, tests, or procedures, therefore extra charges may apply if Dr Lakin feels they are necessary for your medical care either at the time of service or afterward.
- **Medicare (in-network):** You are responsible for paying your annual deductible, co-payments, co-insurance and any non-covered services. Medicare Advantage or Medicare Replacement plans are **not** In-Network with this Office. Since these Advantage or Replacement plans are classified as Out-of-Network, they retain the right to modify or deny claims based on their Out-of-Network coverage policies.
- **Cigna PPO, OAP, First Health/CNN, AZFMC (in-network)**: Patients are responsible for meeting their annual deductible and co-pays at time of service as well as any amount deemed by insurance to be patient responsibility.
- **Annual Administration Fee**: This practice does have an annual Administration Fee. All patients are expected to pay this fee yearly. The Admin Fee is billed and due during the anniversary month you first joined or re-established with the Practice. Please contact our office if you have any questions regarding the Admin Fee.
- **NSF Checks**: There is a $45 charge for all non-sufficient checks. Patients are responsible for all charges.

Medical Records Policy:

- There is a charge for any medical records requested by attorneys, record retrieval companies, etc. There is no charge for transmitting records to another covered medical entity, or physician's office. No records will be released without a legal signature. This is to protect your medical information and align with HIPAA guidelines. Please contact our office if you have any questions regarding Medical Record fees.
- We do not accept third party billing for auto accidents or injury accounts. Payment is due at the time of service and a receipt will be provided for your submission.

Please sign & date, return to our office Staff, and retain a personal copy for future reference.

Patient's Signature: _____ Date: _____

Patient's PRINTED Name: _____ Staff Initials: _____

****Effective 7/15/2025 – PVMC will NO longer be submitting claims to Out of Network Commercial Insurance plans****

Authorization for Release of Protected Health Information

Name: _____ **Date of Birth:** _____
Address: _____ **Phone:** _____
_____

Disclosing Entity:
Physician/Facility: _____
Address: _____
_____
Phone: _____
Fax: _____

Recipient:
Paradise Valley Medical Clinic, PC
9977 North 90th Street, Suite 180
Scottsdale, Arizona 85258
Ph: (480) 614-5800 Fax: (480) 614-6322

Records Released:
Date Range: _____
Type of Records: _____

Purpose of Authorization: _____

Right to Revoke Authorization & Re-Release of Records:
I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to the attention of the Disclosing Entity's Privacy Officer located at _____. I understand that my revocation will not be effective to the extent that the Disclosing Entity has taken action in reliance on this Authorization.

I understand that neither the Disclosing Entity nor the Recipient may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand that as a covered entity, Recipient (i.e., PVMC) may only use or disclose protected health information in accordance with applicable law.

This Authorization will automatically expire 90 days after the date of execution unless a different end date or event is specified herein: _____. A photocopy of this Authorization will be considered as effective and valid as the original.

Drug/Alcohol, HIV, and Communicable Disease Information:
I understand and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases, and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, the Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records that may be protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the Recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient or Patient's Representative

Please do not fax records over 50 pages. Instead, send records over 50 pages by mail or CD. Thank you!