ALLIED CLINIC

your neighborhood walk-in care

Patient Registration Form

Patient Full Name:	**Date Of Birth:**
Sex:	Social Security No:
Street Address:	Marital Status:
City,State,Zip:	Emergency Contact:
Cell Phone:	Emergency Phone:
Home Phone:	Relationship to Patient:
Primary Care Physician:	Employer:
Physician Phone:	Work Phone:
REASON FOR VISIT:	How did you hear about us?

COMPLETE THIS SECTION ONLY IF UNDER THE AGE OF 18

Parent/Guardian Name:

Consent to Medical Treatment Form

I voluntarily present for treatment and consent to my physician and whomever they may designate as their patient care staff to provide my care. Such as care may include, but not be limited to, blood draws, laboratory tests, medication administration, and other procedures considered advisable in my diagnosis, treatment and course of care. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at Allied Clinic.

I acknowledge that treatment at Allied Clinic is intended to address specific episodic illnesses or injuries and is not intended as a substitute for a primary care physician or other specialized physician. This consent shall remain in force until such time as it is specifically revoked in writing.

I have reviewed the Allied Clinic Notice of Privacy Practices and have read the terms and conditions on the back of this form and accept financial responsibility in full at the time of service rendered.

SIGNED:_____ DATE:_____

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CONTACT AUTHORIZATION RELEASE

According to the Allied CLinic HIPPA policy, I allow the release of my medical information to the following:

1. Myself only:_____
2. The following individual:

Name:_____

Phone:_____

Relationship:_____

I, the undersigned. allow Allied Clinic to contact me for follow-up on my visit via the following:

1. Home phone:_____(number)
   Leave message on answering machine: Y_____ N_____

2. Cell phone:_____(number)
   Leave message on cell phone: Y_____ N_____

Pharmacy Preference:

1. Name:_____

2. Location:_____ (only cross streets needed)

3. Phone:_____

SIGNATURE:_____ DATE:_____

PATIENT NAME:_____ DATE OF BIRTH:_____

1147 E Glendale Avenue
Phoenix, AZ 85020
Phone: 602-279-3800
Fax: 602-279-3803
contact@alliedclinic.com

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Allied Health Clinic Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING MEDICAL INFORMATION: The privacy of your medical information is important to us. We understand that you medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our facility, and we need this record to provide you with quality care and to comply with certain legal requirements. This notice will describe the ways we may use and share this information .

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: I authorize the Doctor ti release any medical information and records pertaining to treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. i further understand that any person(s) that receive these medical records will not release any of the information obtained by this authorization without a further authorization signed by me for release of the information.

USE AND DISCLOSURE: Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health,diagnosing medical conditions, and providing treatment. For example; results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by our staff members.

REMINDERS/NOTIFICATIONS: Our staff will use your health information to send you follow-up care, referral, or appointment reminders. We may also send you information describing changes occurring at ALLIED CLINIC such as, address changes, new locations or changes in business hours.

TREATMENT INFORMATION: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that may be of interest to you.

HEALTHCARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of ALLIED CLINIC. This might include measuring, and improving quality, evaluating the performances of employees, conducting training programs and getting accreditations, certificates, licenses, and credentials we need to serve you.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change you mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, you decision to revoke the authorization will not affect or undo any use or disclosures of information that occurred before you notified us of your decision to revoke authorization.

INDIVIDUAL RIGHTS: You have certain right under the federal privacy standards. These include:
- the rights to request restrictions on the use and disclosure of your protected health information .
- the rights to receive confidential communication regarding your medical condition and treatment.
- the right to inspect and copy your protected health information.
- the right to an accounting of how and to whom your protected health information has been disclosed.
- the right to receive a printed copy of this notice.

ALLIED CLINIC DUTIES: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY POLICIES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. These revised policies and practices will be applied to all protected health information we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION: You may generally inspect or copy the protected health information the we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contracting the receptionist or Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny any request.

COMMENTS AND COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to this office, attention: Privacy Official.
If you believe that your privacy rights have been violated, you should bring the matter to our attention by sending a letter describing the cause of your concern to the address listed above. You will not be penalized or otherwise retaliated for filing a complaint.

FOR ADDITIONAL INFORMATION: Please inquire at the reception desk for a copy of the ALLIED CLINIC Privacy Standards.

EFFECTIVE DATE: This notice is on or after January 1, 2006