

Samuel D. Benjamin MD, MD(H) PLLC

15721 N. Greenway Hayden Loop Suite #103

Scottsdale, Az. 85260

Ph: (480)661-1880 Fax: (480)661-1890

Today's Visit

(PLEASE PRINT)

Name:	Date:
Date of Birth:	

Address:		
City:	State:	Zip code:
Hm Phone: ()	Cell Phone: ()	Wk Phone: ()
Email address:	Employer:	
In case of emergency contact:	Phone:	
Relationship:		

Main reason for today's visit:
Other concerns I would like to discuss if there is time:

Check all that apply:
<input type="checkbox"/> I have prescriptions that need to be refilled
<input type="checkbox"/> I need a school /work excuse
<input type="checkbox"/> I need a referral for my insurance company
<input type="checkbox"/> I would appreciate prayer today
<input type="checkbox"/> Other:

(PLEASE CHECK and SIGN)

<input type="checkbox"/> I was provided with a copy of the Notice of Privacy Practices	
Signature:	Date:

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SIGNATURE AUTHORIZATION FOR INSURANCE

I request that payment of allowed insurance and any other insurance benefits be made directly to Samuel D. Benjamin MD, MD(H) PLLC for services provided to me. I authorize any holder of medical information about me to be released to Samuel D. Benjamin MD, MD(H) PLLC and staff any information needed to determine these benefits or the benefits payable for related services. I understand that if my financial account needs collections all collection fees will be added to the original balance.

Signature: _____ Relationship: _____
(Patient or Responsible Party)

INSURANCE WAIVER FOR NON COVERED PROCEDURES

I am aware that any non covered procedure will be billed to my insurance company, however I am responsible for payment at the time of service. Procedure: Acupuncture, cold laser, vitamin C IV therapy, and any other non covered IV fluids, vitamin B-12 injections, and other non covered injections, homeopathy, and some specialized labs.

Signature: _____ Relationship: _____
(Patient or Responsible Party)

RECORDS RELEASE AUTHORIZATION

I authorize and request Samuel D. Benjamin MD, MD(H) PLLC to release the complete medical records in their possession concerning my illness and/or treatment to my primary care physician or my insurance company.

Signature: _____ Relationship: _____
(Patient or Responsible Party)

WAIVER OF REFERRAL

(HMO POLICIES) I understand that I am responsible for obtaining my referrals from my primary care physician for each and every visit with this office. I understand that IF I do not have my referral for my visit, or wish to waive the use of my referral under my HMO program, I am responsible for my balance.

Signature: _____ Relationship: _____
(Patient or Responsible Party)

RELEASE OF MEDICAL CONDITION TO OTHER

I DO____, I DO NOT____: Authorize Samuel D. Benjamin MD, MD(H) PLLC, or their agents to discuss my medical condition or results of labs or pathology reports with family members listed below.

Name of person: _____ Relationship: _____

Signature: _____ Relationship: _____
(Patient or Responsible Party)

NO SHOW, & CANCELLATION POLICY

As a courtesy to our patients, as well as our office staff, we REQUIRE a 24-HOUR notice of cancellation for all appointments. Any charges will be the patient's responsibility and cannot be billed to your insurance company. THERE WILL BE A \$50.00 CHARGE FOR A FAILED OFFICE APPOINTMENT.

Initial_____

RETURNED CHECK POLICY

If a check for services is returned to us there will be a \$39.00 returned check fee applied to your account. At that point you will be notified by mail and telephone. You then will have five (5) days to replace the check via cash, credit card, debit card, or money order. If payment is not replaced within five days, your account will be placed with a collection agency.

Initial_____

COLLECTION AGENCY FEE

If for any reason your account is turned over to an outside collection agency all collection agency fees and any additional costs with the collection of your account balance will be added to the total amount owed.

Initial_____

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Reimbursement for Services Policy and Confirmation of Non participation in Insurance Reimbursement

I fully understand that Dr. Benjamin's practice ONLY participates in the following plans:

- **Aetna**
- **Banner**
- **Blue Cross Blue Shield**
- **Cigna**
- **Great West**
- **Lifewise of Arizona**
- **United Healthcare**
- **Medicare**
- **TRICARE**

He **DOES NOT** participate in any Medicare Advantage plans or Medicare replacement plans. EXCEPT FOR SECURE HORIZONS

Any alternative modalities, (IE: Acupuncture, Cold Laser, Homeopathy, Vitamin C IV therapy) **ARE NOT COVERED BY MOST INSURANCE COMPANIES.**

Payment in full is due at the completion of services. Payment can be made by cash, check, or credit card. (Visa, Mastercard, Discover, or American Express)

Patient Name: _____
(PLEASE PRINT)

Signature of Patient: _____
(Or signature of guardian if patient is a minor)

GUARDIAN NAME: _____
(PLEASE PRINT)

DATE: _____

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INFORMED CONSENT FOR ACUPUNCTURE/ COLD LASER

Patient Name: _____

Acupuncture/ cold laser is an art of healing which involves the stimulation of specific points on the body to treat disease or relieve pain. The stimulation may be produced by needles, heat, digital pressure, electrical currents and other means. Rarely, patients may experience certain side effects or reactions including fainting, bleeding, pneumothorax, puncture or viscera, broken needles and other hazards associated with the treatment procedure.

Acupuncture/ cold laser has been used in the Orient and Europe as a therapeutic modality, and has been accepted by the National Institutes of Health in the United States for some disorders.

Special consideration is required in people with a history of bleeding disorder or current anticoagulant therapy, implanted pacemaker, prosthetic valve, or pregnancy. I have informed **Samuel D Benjamin MD**, my acupuncturist if any of these conditions exist.

Certain medications or social habits are known to lesson the potential results of acupuncture/ cold laser, these include alcohol, tobacco, steroids, narcotics, and other recreational drugs. I have informed **Samuel D Benjamin MD**, my acupuncturist of any substances and medications which I have used in the past months.

I understand that a series of treatments is usually required to significantly change my condition, and that some people experience no relief.

I the undersigned, do hereby give my voluntary consent for the administration to me of the medical treatment of the method known as acupuncture/ cold laser. This technique is to be applied by, or under the direction and supervision of **Samuel D Benjamin MD**.

I hereby certify that I understand the above authorization and the risk of possible complications. I knowingly waive and decline further information. All questions which I have asked have been answered by **Samuel D Benjamin MD**.

Signature of Patient or Authorized Agent

Date

Signature of Witness

Date

Samuel D. Benjamin MD, MD(H) PLLC
15721 N. Greenway Hayden Loop Suite 103
Scottsdale, AZ 85260
(480)661-1880

Patient Name: _____
(PLEASE PRINT)

Date: _____

NOTICE TO PATIENTS

A physician must notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. A.R.S. §32-140(27) (ff). (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services (I/We) have prescribed are not available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

SUPPLEMENTAL PRODUCTS

ARE THESE SERVICES AVAILABLE ELSEWHERE ON A COMPETITIVE BASIS?

NO

The law provides for the acknowledgment of your having read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file; you will receive a copy if requested.

ACKNOWLEDGEMENT: (I/We) have read this “Notice to Patients” form, and (I/We) understand the disclosures that it contains.

Signature of Patient or Guardian

Date

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day <input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	