



Up 2 Par is a golf-themed Primary Care Clinic dedicated to exceeding the medical expectations of Yumans.

## WELCOME TO UP2PAR MEDICAL CLINIC

Welcome to a new way of doing medicine. A patient centered approach that values your time and your health and puts a premium on prevention.

We value your time and therefore we DO NOT OVERBOOK. New Patients are given 60 minutes, Hospital Follow-ups are given 40 minutes and Routine follow-ups are given 20 minutes. If you have a Routine Follow-up scheduled, but have more than two (2) new complaints, you may be asked to make a follow-on appointment in order to have your needs properly met. (Please do not save up a “laundry list” of problems for your 20 minute appointment) We are a “hands on” clinic so expect a full physical on your first visit and brief physical exam for most new complaints.

Since we do not overbook, we strongly encourage you not to miss your appointment or cancel 24 hrs prior to your appointment. If you do not cancel ahead of time, a \$50 charge will be collected before you can schedule another appointment. Also since we run on-time, you will be considered a missed appointment if you are more than 11 minutes late for your appointment, otherwise it would run into the next patients’ appointment.

We do offer Same-Day appointments for urgent illnesses. Each provider has 5 Same-Day appointments and if you call EARLY in the day we will almost always get you in, although it may not be your regular Primary Care Provider if they are already booked.

If you are scheduled for an Annual Physical Exam or want to make a Pre-Op appointment, we strongly encourage you to get the labs done ahead of your visit to prevent the need for follow up visits.

We try to be a “one-stop shop” for most of your health needs. We offer Well Woman Exams (PAP/Pelvic and order Mammograms), dermatology services (cryotherapy, skin biopsies) including Botox and Fillers, Botox for Migraines, Hormone Replacement Therapy (Pellets at VERY reasonable prices), joint injections, In-House Ultrasounds, and we insert Norplant Birth Control for women.

We have two offices; the original on 8<sup>th</sup> Ave in Yuma and the Foothills Blvd location. Both have a Sonora Quest drawing station for our patient’s convenience. We encourage you to use Sonora Quest as they are linked directly to our Electronic Medical Records and the data integrates seamlessly.





**Up 2 Par Medical Clinic, reserves the right to modify the privacy practices outlined in the notice.**

I have received a copy of the Notice of Privacy Practices for Up 2 Par Medical Clinic.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Date

**(Required if the patient is a minor or an adult who is unable to sign this for**



**24 Hour Cancellation/Reschedule, “No Show” Fee Policy & Electronic communication consent**

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **Up 2 Par Medical Clinic reserves the right to charge a fee of \$50.00 for all missed appointments** (“no-shows”) and appointments which, absent a compelling reason, are not cancelled or rescheduled with a 24-hour advance notice.

“No-show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. **If your account is sent to collections, 40% of the total bill will be added for collection fees.**

Multiple “no-shows” in any 12-month period may result in termination from our practice.

By signing this form you are consenting to receive messages from us, your healthcare provider, that utilizes an automatic telephone dialing system to deliver a text, voice, pre-recorded messages, or e-mails that may contain health related information or healthcare management advice at the telephone number(s) and/or e-mail that you have provided. Types of messages include but are not limited to, appointment reminders, notification of lab results, prescription notifications, vaccination reminders, etc. **We respect your privacy and Up 2 Par Medical Clinic will not send you telemarketing related messages or share your contact details with anyone.**

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**



## **Financial Responsibility**

Verification of eligibility and benefits are conducted every time you have an office visit. However, per your insurance, this is not a guarantee of payment.

A copayment may apply if an illness is evaluated or procedure is performed during a Well Exam.

Please, be advised that you may be subject to a deductible, co-insurance amount or co-payment which we may not be aware of until the claim for the office visit has been processed by your insurance carrier.

Should there be a remaining balance due after your insurance carrier has processed the claim; a statement will be sent to you for payment.

Also, please be advised that failure to provide correct, new or additional insurance information in a timely manner may result in additional financial charges. This includes any private insurance coverage as well as AHCCCS.

In the event that I have failed to pay for the services provided by this office, and the account is placed for collection, I understand and agree that an additional amount equal to 40% of the balance owing at the time the account is placed for collection, will be added to the current balance owing. In addition to a collection fee of 40% of the balanced owed, I agree to pay interest at the rate of (10%) ten percent per annum until the amount owed is paid in full. I further agree to pay all attorneys fees and court costs, necessary to collect this balance.

**I have read the above statement and understand my financial responsibility.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**PLEASE PRINT**

**PATIENT INFORMATION**

**Pharmacy of choice:** \_\_\_\_\_

Name: \_\_\_\_\_ MI \_\_\_\_\_ Prefix: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last First

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: (PO Box if Required) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Referred to clinic by: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**PATIENT EMPLOYER**

Employer: \_\_\_\_\_ Employment Status: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Student Status: \_\_\_\_\_

**GUARANTOR INFORMATION**

**GUARANTOR EMPLOYER**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip

City State Zip

Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY:** \_\_\_\_\_ ID# \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

**SECONDARY:** \_\_\_\_\_ ID# \_\_\_\_\_ Group#: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Last First

Relationship to Patient: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS-FINACIAL ARRANGEMENT**

I hereby give authorization for payment of insurance benefits to be made directly to Up2Par Medical Clinic and any assisting physicians and or billing agents for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I agree that a photocopy of this agreement shall be as valid as the original.

**I AM AWARE THAT THESE CHARGES ARE ESTIMATES ONLY AND THAT I MAY RECEIVE ADDITIONAL BILLING.**

Patient, Parent, or Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature



**Health History Questionnaire**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Print and fill out completely**

**Current medications (prescribed and over the counter) and supplements**

Name of medication	Reason you take it for?	Dose/Strength	How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Currently not taking any medication**

**Current medical problems**

- |   |  |
|---|--|
| <input type="radio"/> Asthma            | <input type="radio"/> Seizures                   |
| <input type="radio"/> Cardiac disease   | <input type="radio"/> Stroke                     |
| <input type="radio"/> Dizziness         | <input type="radio"/> Fatigue                    |
| <input type="radio"/> Hypertension      | <input type="radio"/> Gall bladder               |
| <input type="radio"/> Depression        | <input type="radio"/> Stomach, bowel problems    |
| <input type="radio"/> Cholesterol       | <input type="radio"/> Kidney or bladder problems |
| <input type="radio"/> Headaches         | <input type="radio"/> Anemia                     |
| <input type="radio"/> Migraine          | <input type="radio"/> Cancer (Type of...) _____  |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Diabetes Type 1 or Type 2  |

**Additional information:** \_\_\_\_\_  
(Diagnosis, treatment, etc.)

# Medical History

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**Medication allergies/intolerance:**

**Type of reaction:**

_____	_____
_____	_____
_____	_____

**Surgeries:**

List any surgeries and dates. Try to be as **Specific** as possible

Type	Date

**Hospitalizations:**

List any hospitalizations, other than surgeries, and dates:

Reason	Date

**Family History**

Members	Alive/ Deceased	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Disorder	Cancer
Father			<input type="radio"/>					
Mother			<input type="radio"/>					

**Additional Family history:**

\_\_\_\_\_

Siblings: Brothers \_\_\_\_\_ Sisters \_\_\_\_\_ Healthy: Yes or No

Children: Sons \_\_\_\_\_ Daughters \_\_\_\_\_ Healthy: Yes or No

**YUMA:** 2775 S 8th Ave Yuma, AZ 84364 PH: (928) 341-0700 Fax: (928) 341-0900

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# Social History

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## Do you use Tobacco products?

- Current       Never       Former

Type of product

- Cigars       Chew       Cigarettes       Vape

If former:

How long has it been since last smoked? \_\_\_\_\_

## Alcohol:

Did you have a drink containing alcohol in the past year?

- No       Yes

If yes, how often did you have six or more drinks on one occasion in the past year?

- Never       2 to 3 times a week  
 Less than monthly       4 or more times a week  
 2 to 4 times a month

If yes, in the past year, how many drinks did you have on a typical day? \_\_\_\_\_

If yes, how often did you have a drink containing alcohol in the past year? \_\_\_\_\_

## Sexual History:

Had Sex in the past 12 months: Yes: \_\_\_\_ No: \_\_\_\_

- Men       Women       Both Men & Women

Use Protection? Yes: \_\_\_\_ No: \_\_\_\_

Prevention Strategies: Abstinence: \_\_\_\_ Condoms: \_\_\_\_ Other: \_\_\_\_

Have you ever had an STD? Yes: \_\_\_\_ No: \_\_\_\_

- Chlamydia       Gonorrhea       Syphilis       Herpes       Other

## Miscellaneous:

Are you currently:

- Employed       Unemployed       Retired

Recreational drug use

- Yes       No       Former

Do you exercise?

- Regularly       Rarely       None

Marital Status:

- Single       Married       Divorced       Widowed

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# Preventive Health History (Please fill out completely)

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Have you had a Diabetic eye exam this year? Yes: \_\_\_\_ No: \_\_\_\_

Have you had a hemoglobin A1C blood test this year? Yes: \_\_\_\_ No: \_\_\_\_

If you are over the age of 65 have you had a fall since the beginning of this calendar year? Yes: \_\_\_\_ No: \_\_\_\_

## Colonoscopy:

No: \_\_\_\_ Yes: \_\_\_\_ Date: \_\_\_\_\_

- Benign Polyps
- Pre-Cancerous Polyps
- Cancer
- Diverticulitis
- Hemorrhoids
- Normal

## Mammogram:

No: \_\_\_\_ Yes: \_\_\_\_ Date: \_\_\_\_\_

- Suspicious Calcifications
- Benign Calcifications
- Breast Cancer
- Normal

## Bone Density:

No: \_\_\_\_ Yes: \_\_\_\_ Date: \_\_\_\_\_

- Normal
- 
- Osteopenia
- Osteoporosis

## Pap Smear:

No: \_\_\_\_ Yes: \_\_\_\_ Date: \_\_\_\_\_

- Normal
- Abnormal

## Advanced Directives

Do you have Advanced Directive?  No  Yes

Do you have a Living Will?  No  Yes

Do you have a Medical Power of Attorney?  No  Yes

If you answered yes to any of this questions please give a copy to the receptionist.

## Preventative Medicine (immunizations):

Tetanus	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
Pneumococcal	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
Influenza	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
Covid	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
Meningococcal	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
HPV	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
Shingles Vaccine	<input type="radio"/> No	<input type="radio"/> Yes	Date: _____
Allergy to eggs	<input type="radio"/> No	<input type="radio"/> Yes	

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## Patient Health Questionnaire-9 (PHQ-9)

**Patient Name:**

**Date:**

<b>Over the last 2 weeks, how often have you been bothered by any of the following problems?</b>	<b>Circle your answer</b>			
	Not at all	Several days	More than half the days	Nearly every day
<b>1.</b> Little interest or pleasure in doing things	0	1	2	3
<b>2.</b> Feeling down, depressed, or hopeless	0	1	2	3
<b>3.</b> Trouble falling or staying asleep, or sleeping too much	0	1	2	3
<b>4.</b> Feeling tired or having little energy	0	1	2	3
<b>5.</b> Poor appetite or overeating	0	1	2	3
<b>6.</b> Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
<b>7.</b> Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
<b>8.</b> Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
<b>9.</b> Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
<b>10.</b> If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<b>Not Difficult at all</b>	<b>Somewhat difficult</b>	<b>Very Difficult</b>	<b>Extremely Difficult</b>



## GAD-7

**Patient Name:**

**Date:**

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Circle your answer			
	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
8. If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	<b>Not Difficult at all</b>	<b>Somewhat difficult</b>	<b>Very Difficult</b>	<b>Extremely Difficult</b>