Welcome to **CooperCareAZ, PLLC** Family Practice

We are a traditional Family Practice office with a personal touch. At CooperCareAZ we treat hypertension, hyperlipidemia, diabetes, hypothyroidism, generalized anxiety, depression and a host of other diagnoses. We believe in annual wellness and physicals and provide both Medicare and commercial complete physical exams.

Hours of Operation:

- **Tuesdays**: 7:00 am - 4:30 pm IN OFFICE
- **Wednesdays**: 8:00 am- 4:30 pm Telemedicine ONLY *(Telemedicine services are based on reason for visit)*
- **Thursdays:** 7:00 am - 4:30 pm IN OFFICE
- **Mondays & Fridays**: CLOSED

CooperCareAZ accepts most insurances with the exception of **Medicaid** and **AHCCCS**.

Dr. Cooper always requires appointments for any paperwork to be completed, but she does not complete long-term disability forms.

Dr. Cooper chooses NOT to treat the following issues:

- ADD or ADHD
- Bipolar disorder
- Chronic pain
- DOT physicals
- Hormone replacement or testosterone therapy
- Motor vehicle accidents
- Personal injury
- Workers comp

The office will NOT prescribe narcotics/pain medications, sleeping pills, or medications such as Xanax or Valium for long term use.

All cases are individual and will be discussed during your office visit. With over 25 years of practice in the Valley, Dr. Cooper can provide physician referral suggestions for those issues she chooses not to treat.

If you are more than 15 minutes late for your appointment, you may be asked to reschedule.

If you No-Show your appointment, there will be a **$50** charge that must be paid prior to next appointment. If you No-Show multiple times, you will be discharged from the practice.

Rude or inappropriate behavior to the physician or staff is never tolerated and will result in immediate discharge from the practice.

Copays, balances and deductibles are due at the time of service.

I have read and understand the above policies of CooperCareAZ, PLLC and have been provided with a written copy.

Patient Signature: _____ **Date:** _____

CooperCareAZ, PLLC

New Patient Registration – Medical Information

Patient Name: First _____**Middle**_____**Last** _____

Date of Birth: _____ / _____ / _____

Medical/Surgical History.

Do you currently have or ever had:

HEAD: Please CIRCLE all current or past medical problems or conditions.

Aneurysm	Brain tumor	Chronic headaches	Dementia
Migraines	Mini-stroke	Parkinson's	Seizures
Stroke	Other _____		

EYE: Please CIRCLE all current or past medical problems or conditions.

Cataracts	Cataract surgery	Dry eyes	Eye lift
Glaucoma	Lasik	Lazy eye surgery	Macular degeneration
Other_____			

NOSE/THROAT: Please CIRCLE all current or past medical problems or conditions.

Allergies	Chronic sinus infections	Ear tubes or surgery	Jaw surgery
Sinus polyps	Sinus surgery	Sleep apnea surgery	TMJ
Tonsils removed	Other_____		

NECK: Please CIRCLE all current or past medical problems or conditions.

Carotid stenosis or surgery	Esophagus stricture or surgery	Neck tumors	Parathyroid surgery
Thyroid surgery	Other_____		

BREAST: Please CIRCLE all current or past medical problems or conditions.

Abnormal mammogram	Breast biopsy	Breast cysts	Breast lift/implant
Implant removal	Mastitis	Other_____	

HEART Please CIRCLE all current or past medical problems or conditions.

AFIB	Aortic aneurysm or repair	Artery disease in the neck or legs	Bypass surgery
Heart murmur	Heart stents	Heart valve replacement or repair	High cholesterol
High/low blood pressure	Irregular heart rhythm	Other_____	

LUNGS: Please CIRCLE all current or past medical problems or conditions.

Asbestosis	Asthma	COPD	Emphysema
Lung surgery	Pneumonia	Sarcoidosis	Sleep apnea
TB	Valley fever	Other_____	

GI/KIDNEYS: Please CIRCLE all current or past medical problems or conditions.

Adrenal adenoma	Appendix removal	Bladder dropped or repair	Bowel obstruction
Bowel surgery	Chronic kidney disease	Chronic UTI	Dialysis
Diverticulosis	Fatty liver	Gallstones or surgery	Gastric bypass or sleeve
GI bleed	Gluten intolerance	Heartburn	Hemorrhoids
Hiatal hernia or repair	Kidney cysts	Kidney removal	Kidney stones or removal
Lactose intolerance	Pancreatic insufficiency	Pancreatitis	Reflux
Renal artery disease	Spleen removal	Stomach ulcers	
Other_____			

MEN'S HEALTH: Please CIRCLE all current or past medical problems or conditions.

ED	Enlarged prostate or surgery	Low testosterone	Prostate cancer or surgery
Prostatitis	Vasectomy or reversal	Gender reassignment surgery	
Other_____			

WOMEN'S HEALTH: Please CIRCLE all current or past medical problems or conditions.

Bladder lift or repair	C-section	Chronic UTI	Chronic vaginal infections
Currently on birth control	Endometrial biopsy	Endometriosis	Hormone replacement
Irregular periods	IUD	Menopause	
Number of times pregnant _____		Number of live births _____	
Ovarian cysts or removal	Partial or complete hysterectomy	STD	Tubes tied
Gender reassignment surgery	Other_____		

SKIN: Please CIRCLE all current or past medical problems or conditions.

Eczema	Fungal nails	Psoriasis	Skin biopsy or surgery
Other_____			

ENDOCRINE: Please CIRCLE all current or past medical problems or conditions.

Adrenal tumor or insufficiency	Goiter	Graves' disease	Hashimoto's thyroiditis
Hyperthyroid	Hypothyroid	Pancreas tumor	Parathyroid tumor or surgery
Pituitary gland tumor or removal	Prediabetes	Diabetes – type 1	Diabetes – type 2 or adult onset
Thyroid nodules	Other_____		

BLOOD: Please CIRCLE all current or past medical problems or conditions.

Anemia Blood clots in legs Blood clots in lung Clotting problems
DVT Thalassemia Other_____

MUSCULOSKELETAL: Please CIRCLE all current or past medical problems or conditions.

Arthritis FMS Fracture: _____
Joint replacement: Hip / Shoulder / Knee
Joint surgery: _____ Other_____

CANCER: Please indicate type(s) of cancer.

Other_____

MENTAL HEALTH: Please CIRCLE all current or past medical problems or conditions.

ADD / ADHD Anxiety Bipolar Depression
Schizophrenia Other _____

FAMILY MEDICAL HISTORY: Please check all current or past medical problems or conditions.

	Cancer	Dementia	Diabetes	Heart Disease	Mental Illness	Other
Father						
Mother						
Sibling(s)						
Grandparent(s)						

If **Cancer** and/or **Other** checked, please provide details:

_____

Please list all medications.		
Name	**Dose/Strength**	**Frequency Taken**

Please list all supplements, over the counter drugs, creams and inhalers.		
Name	**Dose/Strength**	**Frequency Taken**

Allergies or intolerances to medications?	
Name	**Reaction**

Social History											
Alcohol Use – Please circle your response.											
Glasses of wine per week	0	1	2	3	4	5	6	7	8	9	10+
Cans of beer per week	0	1	2	3	4	5	6	7	8	9	10+
Shots of liquor per week	0	1	2	3	4	5	6	7	8	9	10+
Mixed drinks	0	1	2	3	4	5	6	7	8	9	10+

Sexual Activity – Please check your response.			
Sexually active?	☐ Currently	☐ Never	☐ Not Currently
Sexual Partners?	☐ Men	☐ Women	☐ Both
Birth control used?	☐ Condom	☐ Implant	☐ IUD
	☐ The Pill	☐ N/A	☐ Other

Illicit Drug Use – Please check your response.				
☐ None	☐ Amphetamines	☐ Marijuana		
Tobacco Use – Please check your response.				
☐ Smoke every day	☐ Smoke some days	☐ Former smoker	☐ Heavy smoker	
☐ Light smoker	☐ Never smoked	☐ Second-hand exposure		
If ever smoked, how many packs/day average? Please include Vape and Cigars.				
☐ ½	☐ 1	☐ 1 ½	☐ 2	☐ 3 or more
Have you ever chewed? ☐ Yes ☐ No				

Who are your current specialists?	
Provider name	Specialty

Advance Directives (Living will and medical power of attorney)		
Do you have an advance directive?	☐ Yes	☐ No
Would you like information or a copy of advance directive forms?	☐ Yes	☐ No

Preventive Care					
	Date		**Date**		**Date**
Annual physical		Prostate screen		Eye exam	
Colonoscopy		Pap screen			
Bone density		Mammogram			
Dental exam					

Immunizations					
	Date		**Date**		**Date**
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		COVID	

CooperCareAZ, PLLC

New Patient Registration – Demographics and Insurance

Patient:

Name/First: _____ Middle: _____ Last: _____

SSN:_____ DOB: _____ Sex: M | F

Patient Street Address: _____

Patient address additional: _____

City: _____ State: _____ ZIP: _____

Primary Phone Number: _____ Mobile | Home | Work

Secondary Phone Number: _____ Mobile | Home | Work

Email address (for patient portal): _____

What is your primary language? _____Interpreter Required? ☐ Yes ☐ No

Marital Status: Divorced | Legally Separated | Married | Other | Sig. Other | Single | Widowed

The U. S. government requires we ask the following two questions:

1. How do you identify your ethnicity?

   ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I prefer not to answer

2. How do you identify your race?

   ☐ American Indian or Alaska Native
   ☐ Native Hawaiian
   ☐ White or Caucasian
   ☐ I prefer not to answer
   ☐ Black or African American
   ☐ Other Pacific Islander
   ☐ Asian

Who would you like to list as an **Emergency Contact**?

Name: _____

Address: _____

_____

Relationship to you: _____

Phone Number: _____ Mobile | Home | Work

Who is the **guarantor** of your account? Who is financially responsible for any amount not paid by the insurance company? Please write "self" if you are financially responsible.

Guarantor:

Name/First: _____ Middle: _____ Last: _____

SSN:_____ DOB: _____ Sex: M | F

Address: _____

_____

Phone Number: _____ Mobile | Home | Work

Medical Insurance Company Name: _____

Member/Subscriber Identification # _____Group #: _____

Medical Insurance Company Address: _____

Relationship of the insurance subscriber to the patient: Self | Parent | Spouse | Other:_____

Subscriber:

Name/First: _____ Middle: _____ Last: _____

SSN:_____ DOB: _____ Sex: M | F

Address: _____

_____

Phone Number: _____ Mobile | Home | Work

Do you have any additional insurance? Yes | No

Please present all insurance cards.

CooperCareAZ, PLLC

On Call and After Hours Policy

1. **CooperCareAZ, PLLC does not provide after hours or on call services. If you have a medical emergency, you will need to use an Urgent Care or ER for immediate attention.**

2. **For routine questions and appointments, please call during regular business hours:**
   7:00 am – 4:30 pm Tuesday, Wednesday, and Thursday

   Our office is closed Monday, Friday, Saturday, Sunday and all major holidays.

3. **We do not call in treatment for a new medical concern without an appointment.**

4. **We do not call in prescriptions for a new medical concern without an appointment.**

I have read and understand the above policies of CooperCareAZ, PLLC and have been provided with a written copy.

Patient Signature: _____

Date: _____

CooperCareAZ, PLLC

TELEMEDICINE PROGRAM

TELEMEDICINE PATIENT CONSENT FORM

I, (**name of patient or parent/guardian**) _____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care.
*[**Note**: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].*

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at both the referring site facility and the consulting site facility.

I understand that some or all of my medical information may be used for teaching or educational purposes.

I agree to have my telemedicine medical records reviewed for the purposes of *evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings)*. I understand that any presentation will not identify me by name or other identifiable markers.
DECLINE _____ (initials of patient)

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes.
DECLINE _____ (initials of patient)

FOR DEMONSTRATIONS ONLY: I agree to permit other persons who are not involved in my medical care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation.
DECLINE _____(initials of patient)

Signature of patient (or parent/guardian): _____ Date: _____

Please print the above name: _____

Signature of witness: _____ Date: _____

For withdrawal from a telemedicine evaluation, please complete this information:

❑ **(MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY).**

I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian): _____ Date: _____

Signature of witness: _____ Date: _____

ARIZONA HIPAA MEDICAL RELEASE FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize _____ to disclose the following information
(Name of clinic, individual, etc.)

from the health records of:

_____ _____ / _____ /_____
Name (Please print first/last name) Date of Birth (MM/DD/YY)

(_____)_____
Phone Number

_____
Street Address

_____ _____
City / State / Zip E-mail Address

I authorize the following persons (or class of persons) to receive my Protected Health Information (PHI):

_____
Name (Please print)

_____
Address

_____ (_____)_____
City / State / Zip Phone Number

_____
E-mail Address

Please continue to page 2.

INFORMATION TO BE RELEASED (check as applicable):

□ Allergy Records □ Consultations □ Developmental/Behavioral □ Discharge Summary
□ Drug/Alcohol Treatment □ Genetic Testing □ HIV/AIDS □ History & Physical
□ Hospital Records & Reports □ Immunizations □ Surgical Reports □ Laboratory Reports
□ Prescriptions □ Psychiatric □ Sexual Assault □ Sexually Transmitted Disease
□ Treatment or Tests □ X-Ray Reports □ Other Communicable Disease
□ Other (Specify):

- OR –

□ ENTIRE RECORD **excluding** the following (CIRCLE as applicable):

¯ Sexually Transmitted Disease ⌋ HIV/AIDS ⊏ Other Communicable Diseases | Genetic Testing

⊓ Developmental/Behavioral Health Care/Psychiatric Care ⌈ Treatment of Alcohol and/or Drug Abuse

☐ Information about Child Abuse/Neglect

FOR THE FOLLOWING DATE(S) OF SERVICE:

From (MM/DD/YYYY): _____ / _____ / _____ To (MM/DD/YYYY): _____ / _____ / _____

PURPOSE FOR DISCLOSURE (Check applicable categories):

□ Treatment □ Research □ Medical Hardship Waivers □ Legal Investigation or Action
□ Insurance Eligibility/Benefits □ Other (Specify):

Please continue to page 3.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

SIGNATURE: _____ DATE: _____

Description of Authority to sign if personal/legal representative:

_____

IDENTITY OF REQUESTOR VERIFIED VIA: □ Photo ID □ Matching signature □ Other: _____

CooperCareAZ, PLLC

MEDICAL RECORDS REQUEST TO RECEIVE RECORDS FOR

Patient Name: _____ Date: _____

Date of Birth: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City / State / Zip: _____

CooperCareAZ, PLLC, 20033 N. 19th Ave, Suite 111, Building 3, Phoenix, AZ 85027
Phone: (623) 582-2355 FAX: (623) 248-0798

IS REQUESTING RECORDS FROM:

Doctor's Office / Hospital: _____
Address: _____
City / State / Zip: _____
Phone Number: _____ Fax Number: _____

I authorize the release of copies of:

❑ All Medical Records
❑ The last Two Years
❑ Only those records pertaining to the following:

_____

Sensitive Information:

I understand that this may include information relating to:

❑ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
❑ Behavioral health services, psychiatric care, mental health treatment
❑ Sexually Transmitted Disease
❑ Diagnosis / Treatment for alcohol and / or drug abuse
❑ Information for research purpose

Patient / Responsible Party Signature _____

Date: _____

CooperCareAZ, PLLC

MEDICAL RECORDS REQUEST TO RELEASE RECORDS FOR

Patient Name: _____ Date: _____

Date of Birth: _____ SSN: _____

Home Phone: _____ Cell Phone: _____

Street Address: _____

City / State / Zip: _____

CooperCareAZ, PLLC, 20033 N. 19th Ave, Suite 111, Building 3, Phoenix, AZ 85027
Phone: (623) 582-2355 FAX: (623) 248-0798

IS RELEASING RECORDS TO:

Doctor's Office / Hospital _____
Address: _____
City / State / Zip: _____
Phone Number: _____ Fax Number: _____

I authorize the release of copies of:

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❑ Behavioral health services, psychiatric care, mental health treatment
❑ Sexually Transmitted Disease
❑ Diagnosis / Treatment for alcohol and / or drug abuse
❑ Information for research purpose

Patient / Responsible Party Signature _____

Date: _____