Preventative
HEALTH ALLIANCE

Dear Patient:

Welcome to our practice. We are honored to be your Physicians, and we are committed to providing you with the best care. The goal is that we form an alliance to keep you as healthy as possible, no matter what your current state of health. We will share our medical expertise with you, and we hope you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being. As few of us, have a completely healthy lifestyle, but each day we can take a step closer to a healthier life.

Here are some important steps you can take toward better health:

- Don't smoke cigarettes or use other tobacco products.
- Drink alcohol in moderation, if at all, and never drive when you've been drinking.
- Eat a diet low in fat and high in vegetables and fruits.
- Exercise at least three times a week.
- Wear your seat belt whenever you're in a car.
- Learn about ways to deal with stress and tension.
- Discover what spirituality means to you and practice it.
- Maintain ties with your family, neighbors, co-workers or your church community.

It will be our great pleasure to work with you on these goals, using our expertise.

Our goal is to have everyone involved in our Preventative Health Care Alliance program. Everyone who joins our practice should start by having a complete physical exam followed by periodic check-ups to test for a few specific diseases.

We look forward to working with you as designated Health Care Team. Please contact our office to talk about anything you think may be affecting your health. It is our hope that we can have a relationship where the lines of communication are open and communication goes both ways. Let us work together to help you live the satisfying life that you deserve.

Sincerely,
Your Health Care Team @ Preventative Health Care Alliance

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Take an Active Role in your Health Care

We are committed to getting you healthy and helping you stay that way, but you're a key player in making that happen. Here are suggestions from the Agency for Healthcare Research and Quality that all patients should follow:

- Speak up if you have questions or concerns. You have a right to question anyone who is involved with your care.
- Make sure that someone, such as your primary care doctor, is in charge of your care. This is especially important if you have many health problems or are in the hospital.
- Make sure that all health professionals involved in your care have important health information about you. Do not assume that everyone knows everything they need to.
- If you have a test, **don't assume that no news is good news**. Ask about the results.
- Learn about your condition and treatments by asking your doctor and by using other reliable sources. For example, treatment recommendations based on the latest scientific evidence are available from the National Guideline Clearinghouse at *www.guideline.gov*.

Once you leave the doctor's office:

- If you have questions, call.
- If your symptoms get worse, or if you have problems with your medicine, call.
- If your doctor said you need to have certain tests, make appointments at the lab or other offices to get them done. **If you do not hear from us a week after doing your test(s), call.**
- If your doctor said you should see a specialist, make an appointment.

Medicines:

- Make sure that all of your doctors know about everything you are taking. This includes prescription and over-the-counter medicines, and dietary supplements such as vitamins and herbs.
- Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.
- When medicine is prescribed for you, ask the following questions:
    - What is the medicine for?
    - How should I take it, and for how long?
    - What side effects are likely? What do I do if they occur?
    - Is this medicine safe to take with other medicines or dietary supplements I am taking?
    - What food, drink, or activities should I avoid while taking this medicine?
- When you pick up your medicine, ask: Is this the medicine that my doctor prescribed?

Sources: "Patient Fact Sheet: 20 Tips to Help Prevent Medical Errors," AHRQ publication No. 00-PO38, February 2000; and "Quick Tips—When Talking with Your Doctor," AHRQ publication No. 01-0040a, May 2002. Agency for Healthcare Research and Quality, Rockville, MD. For complete text, go to *www.ahrq.gov/consumer/20tips.htm* and *www.ahrq.gov/consumer/quicktips/doctalk.htm*.

- Ask your pharmacist for the best device to measure your liquid medicine. Special devices, like marked syringes, help people measure the right dose. Being told how to use the devices helps even more.
- Ask for written information about the side effects your medicine can cause. If you know what might happen, you will be better prepared if it does. If something unexpected happens, you can report the problem right away and get help before it gets worse.
- For **prescription refills, call your local pharmacy 5-7 business days** before your medication runs out. We do not call patients to inform them that their medication request has been filled as we send approvals directly to the pharmacy. **If the pharmacy is unable to refill your medication within 2 – 3 days after your request, call our office directly**.
- Usually, for safety reasons and a high potential for abuse, you will need to see the doctor to have **prescriptions for controlled substances and anxiolytics** refilled, which the physician will refill only during regular office hours. Our office does not fill prescriptions for controlled substances, anxiolytics and antibiotics over the weekend/and or holidays.

If you have to go to the hospital:

- Please make sure the hospital is aware that we are your Health Care Providers and please make sure you contact our office to make us aware.
- When you are discharged, ask your doctor to explain the home treatment plan. This includes learning about your medicines and finding out when you can get back to your regular activities.
- If you are having surgery, make sure that you, your doctor, and your surgeon agree and are clear on exactly what will be done.
- Ask a family member or friend to be there with you and to be your advocate (someone who can help get things done and speak up for you if you can't). Even if you think you don't need help now, you might need it later.
- Be sure to discuss your Advance Care Planning with us at your follow up visit.

Sources: "Patient Fact Sheet: 20 Tips to Help Prevent Medical Errors," AHRQ publication No. 00-PO38, February 2000; and "Quick Tips—When Talking with Your Doctor," AHRQ publication No. 01-0040a, May 2002. Agency for Healthcare Research and Quality, Rockville, MD. For complete text, go to *www.ahrq.gov/consumer/20tips.htm* and *www.ahrq.gov/consumer/quicktips/doctalk.htm*.

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A FIRST-VISIT HANDOUT

Your First Visit

Thank you for choosing **Preventative Health Alliance** for your health care needs. During your first visit, you will meet our staff, complete a few brief forms and, of course, meet your doctor. As your primary care provider, we will try to solve your current medical problem, and detect or prevent other health issues. We hope to make the first visit not just an opportunity to deal with any medical concerns you may have, but also a time to get acquainted with you.

The First Examination

When you enter the waiting room, you will be asked to fill out forms by a staff member, and then you will be brought to the vital signs station where he or she will measure your height and weight and take your temperature. You will also be asked health questions which the physician will review with you inside the examination room. Depending on your medical problem, you may be asked to undress and put on a gown in the privacy of the exam room. This enables the doctor to better evaluate your health. After the examination, your physician will suggest a treatment plan and future visits, if necessary.

We hope that after your visit you will feel confident that you have made a wise decision by choosing our practice. Please let us know if you have any questions.

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Specialty Referrals and Managed Care

If you belong to an HMO, your insurance company may have asked you to choose a "primary care provider" to manage all your health care needs. Internists (doctor of adults) are well-qualified to fulfill this role. We have been trained to provide adult care for you and your family. We diagnose and treat diseases from skin rashes to heart attacks. We are skilled at preventing disease. And we want to build doctor-patient relationships based on mutual trust and respect.

Internists can treat 85 to 90 percent of their patients' medical problems. How do we handle the few problems we are unable to treat? We refer patients with those problems to the appropriate specialists.

The referral process

Referrals work pretty much the same for all patients, with one exception: If you are in an HMO, we can generally refer you only to specialists who participate with your HMO. That is, if a physician is not on your HMO's list of "participating providers," your HMO will not pay for visits to that physician. To check, simply call your health plan's customer service line or consult its current provider directory.

As you have chosen us as your Health Care Providers at Preventative Health Alliance we ask that you give us the trust to bring you quality health care. Part of that trust involves trusting our Team to decide when to call in a physician who specializes in certain health problems. We refer patients only after we have had a chance to evaluate their conditions. For example, if you had an earache, you would not immediately seek the care of an ear, nose and throat specialist. Instead, you would visit our office so that we could diagnose and treat your earache appropriately. If your case required special treatment, we would then refer you.

Once a referral is made, our office staff will guide you in setting up an appointment with the specialist based on the information you have given us. It is therefore

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necessary to **make sure you have given us accurate and complete information**. When you go to the specialist's office for your first visit, take your referral forms with you. The specialist will then work with us to diagnose and treat your special problems. Once the specialist has completed his or her evaluation or treatment, we will continue your care.

We thank you for your trust in choosing our Health Care Team as your health care providers.

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New Patient Registration
Medical Information

Patient Name: First_____Middle_____Last_____

Date of Birth: _____/_____/_____

Who are your current medical providers?	
Provider name	Specialty, or condition for which they treat you

Preventive Care					
	Date		Date		Date
Annual physical		Prostate screen		Cholesterol test	
Colonoscopy		Pap screen		Diabetes screen	
Bone density		Mammogram		Eye exam	
Dental exam					

Immunizations					
	Date		Date		Date
Tetanus (Td or Tdap)		HPV (Gardasil)		Influenza (flu)	
Hepatitis A		Hepatitis B		Meningitis	
Pneumonia		Shingles		Other (please write below)	

Allergies or intolerances to medications?	
Name	Reaction

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

Patient Name: First_____ Middle _____Last_____ Date of Birth: ____/____/_____

Please circle all current or past medical problems or conditions.		
Heart Failure	High Blood Pressure	ADD/ADHD
Chronic Lung Disease	Hyperthyroidism	Seasonal Allergies
Heart Artery Disease	Hypothyroidism	Anemia
Depression	Kidney Disease	Anxiety
Diabetes Type 1	Migraines	Arthritis
Diabetes Type 2	Heart Attack	Asthma
Emphysema	Stomach/Intestine Ulcers	Bipolar Disorder
Heartburn	Seizures	Blood Clots
Glaucoma	Sexually Transmitted Infection	Blood Transfusion
Heart Murmur	Stroke	Cancer
HIV/AIDS	Substance Abuse	Cataracts
High Cholesterol	Valley Fever	

Please circle all major operations or surgeries.		
None	Colon	Joint Replacement
Appendectomy	Coronary Artery Stent	Spine
Breast Augmentation	Cosmetic Surgery	Thyroid Surgery
Breast Surgery	Eye	Tonsillectomy
Cesarean Section	Fracture Repair	Tubes Tied
Heart Bypass	Hernia repair	Heart Valve surgery
Gallbladder	Hysterectomy	Ovaries

Family Medical History – Please check the appropriate box if a condition is/was present.

	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	High Cholesterol	High Blood Press	Kidney Disease	Mental Illness	Miscarriages	Stroke	Vision Loss	Alzheimer's	Other
Father																				
Mother																				
Siblings																				
Children																				
Other																				

Patient Name: First_____ Middle _____Last_____ Date of Birth: ____/____/_____

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 with 0.5 ounces alcohol per week	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? ☐ Pulling out ☐ Condom ☐ Diaphragm ☐ Implant ☐ Inserts ☐ IUD
☐ The Pill ☐ Patch ☐ Rhythm ☐ Spermicide
☐ Sponge ☐ Surgical ☐ Not applicable

Drug Use – Please check your response.

☐ None ☐ Amphetamines ☐ Benzodiazepines ☐ "Crack" Cocaine ☐ Cocaine
☐ Heroin ☐ Marijuana ☐ Methamphetamines ☐ PCP ☐ Huff Gasses

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?
☐ ½ ☐ 1 ☐ 1½ ☐ 2 ☐ 3 or more
How many years smoked?

You ever chewed? ☐ Yes ☐ No

If you currently use any tobacco product, are you ready to quit? ☐ Yes ☐ No

Hospitalizations		
Reason	Year	Comments

Major Injuries		
Type	Year	Comments

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

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New Patient Registration
Demographics and Insurance

Patient: Name/First _____Middle_____Last_____

SSN: _____-_____-_____ Date of Birth: _____/_____/_____ 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: _____

What is your primary language? _____ Interpreter Required? Yes | No

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

Religious preference: _____ ☐ I prefer to not answer.

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 to not answer.

2. How do you identify your race?
   _____ American Indian or Alaska Native _____ Black or African American
   _____ Native Hawaiian _____ Other Pacific Islander
   _____ White or Caucasian _____ Asian
   _____ I prefer to not answer

Who is your primary care physician? _____

Name of the primary care practice: _____

Employment Status: Full-Time | Part-Time | Retired | Disabled | Student | Unemployed

Employer Name: _____

How many employees work at your company? ☐ 1-19 ☐ 20-99 ☐100+ ☐ Don't know

Patient Name: First_____ Middle_____ Last_____ Date of Birth: ____/_____/_____

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: _____-_____-_____ Date of Birth: _____/_____/_____ 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: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: M | F

Address: _____

_____

Phone Number: (_____) _____-_____ Mobile | Home | Work

Do you have any additional insurance? Yes | No
Please present all insurance cards.

LIVING WILL (End of Life Care)
Instructions

GENERAL INSTRUCTIONS: Use this form to make decisions now about your medical care if you are ever in a terminal condition, a persistent vegetative state or an irreversible coma. You should talk to your doctor about what these terms mean.

The Living Will is your written directions to your health care power of attorney, also referred to as your "agent", your family, your physician, and any other person who might make medical care decisions for you if you are unable to communicate yourself.

It is a good idea to talk to your doctor and loved ones if you have questions about the type of care you do or do not want.

IMPORTANT: If you have a Living Will and a Health Care Power of Attorney, you must attach the Living Will to the Health Care Power of Attorney.

If you fill out this form, make sure you **DO NOT SIGN UNTIL** your witness or a notary public is present to watch you sign it.

PLEASE NOTE: At least one adult witness, not to include the proxy if there is one, OR a notary public must witness you signing this document.

DO NOT have the documents signed by both a witness and a notary, just pick one. If you do not know a notary or cannot pay for one a witness is legally accepted.

Witnesses or notary public CANNOT be anyone who is:
(a) under the age of 18
(b) related to you by blood, adoption, or marriage
(c) entitled to any part of your estate
(d) appointed as your agent
(e) involved in providing your health care at the time this form is signed

OFFICE OF THE ARIZONA ATTORNEY GENERAL
KRIS MAYES

Living Will

My Information (I am the "Principal"):

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Email: _____

Some general statements about your health care choices are listed below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully BEFORE you initial your preferred statement. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care. You may initial any combination of paragraphs 1, 2, 3 and 4, BUT if you initial paragraph 5 the others should not be initialed.

_____ 1. If I have a terminal condition I do not want my life to be prolonged, and I do not want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death.

***Comfort care is treatment given in an attempt to protect and enhance the quality of life without artificially prolonging life.*

_____ 2. If I am in a terminal condition or an irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable, I do want the medical treatment necessary to provide care that would keep me comfortable, but I DO NOT want the following:

_____ a. Cardiopulmonary resuscitation (CPR). For example: the use of drugs, electric shock and artificial breathing.

_____ b. Artificially administered food and fluids.

_____ c. To be taken to a hospital if at all avoidable.

_____ 3. Regardless of any other directions I have given in this Living Will, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ 4. Regardless of any other directions I have given in this Living Will, I do want the use of all medical care necessary to treat my condition until my doctors reasonably conclude that my condition is terminal or is irreversible and incurable or I am in a persistent vegetative state.

_____ 5. I want my life to be prolonged to the greatest extent possible (If you initial here, you should not initial any of the others).

PLEASE NOTE: You can attach additional instructions on your medical care wishes that have not been included in this Living Will form. Initial or put a check mark by box A or B below. Be sure to include the attachment if you check B.

_____ A. I HAVE NOT attached additional special instructions about End of Life Care I want.

_____ B. I HAVE attached additional special provisions or limitations about End of Life Care I want.

MY SIGNATURE VERIFICATION FOR THE LIVING WILL

My Signature (Principal): _____ Date: _____

If you are unable to physically sign this document your witness/notary may sign and initial for you. If applicable, have your witness/notary sign below.

Witness/Notary Verification: The principal of this document directly indicated to me that this Living Will expresses their wishes and that they intend to adopt it at this time.

Witness/Notary Signature: _____

Name Printed: _____ Date: _____

SIGNATURE OF WITNESS

I was present when this form was signed (or marked). The principal appeared to be of sound mind and was not forced to sign this form.

Witness Signature: _____ Date: _____

Name Printed: _____

Address: _____

OR

SIGNATURE OF NOTARY

Notary Public (NOTE: If a witness signs your form, you SHOULD NOT have a notary sign):

NOTORIAL JURAT: Pertains to all three pages of this Living Will

Dated _____, 20_____.

STATE OF ARIZONA) ss

COUNTY OF _____)

_____

Principals Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____

My Commission Expires: _____

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PATIENT'S RIGHTS AND RESPONSIBILITIES

We respect your rights as a patient and want you to understand your responsibility as a partner in your care.

Patient's Rights

For this reason, we want you to have a summary of your rights as a patient.

- You have a right to considerate and respectful care.
- You have the right and we encourage you to actively participate in the development and implementation of your plan of care.
- You will not be denied access to care due to race, creed, color, national origin, sex, age, sexual orientation, disability, or source of payment.
- You have the right to information about your diagnosis, condition, and treatment in terms that you can understand.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the possible consequences of the refusal.
- You may consent or refuse to participate in experimental treatment or research.
- You are entitled to be free from all forms of abuse or harassment.
- You have the right to make or have a representative of your choice make informed decisions about your care.
- You have the right to appropriate assessment and management of pain.
- You are entitled to information about rules and regulations affecting your care and conduct.
- You have the right to know the names and professional titles of your physicians and caregivers.
- You can request a change of provider or a second professional opinion if you so choose.
- You have the right to personal privacy and confidentiality when seeking or receiving care except for life threatening conditions or situations.
- You have the right to express concerns or grievances regarding your care.
- The confidentiality of your clinical and personal records will be maintained.

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- You have the right to see your medical record within the limits of the law. Copies forwarded to other healthcare providers needed for continuity of care will be free of charge. Requests for medical records for personal use will be charged a nominal and reasonable fee.
- You have the right to an explanation of all items on your bill.

Patient's Responsibilities

- Provide complete information about one's illness/problem, to enable proper evaluation and treatment.
- Ask questions so that an understanding of the condition or problem is ensured.
- Show respect to health personnel and other patients. Any form of sexual harassment will not be condoned and is reason for immediate discharge from the practice.
- Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, we request you cancel or reschedule an appointment **at least 24 hours prior** to your scheduled appointment. Otherwise, it will be considered a "No Show". Multiple "no shows" in any twelve month period may result in **termination** from our practice. A **nominal fee** may also be charged.
- Pay bills or file health claims in a timely manner and **immediately inform the clinic** of any **changes** in your **healthcare/insurance coverage**, employee status, including change of **address**, **phone number** and **other contact information**. Giving the office **incorrect/incomplete information** may result in **denial** of a claim and patient will be **responsible for any outstanding balances.**
- Use prescription or medical devices for oneself only. Forging prescriptions are cause for immediate termination from the practice. Allow **5 – 7 business days for prescription refills** so you do not run out of your medications in case there are any problems with your insurance and/or pharmacy. We do NOT REFILL **narcotics** and/or **sedatives** over the weekend.
- Inform the doctor if one's condition worsens or an unexpected reaction occurs from treatment.

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Notice of Privacy Practices

Effective date: December 28, 2006

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called ***protected health information***, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Angie Sanchez Privacy Officer
4150 N. 108th Avenue, Suite 142
Phoenix, AZ 85037
623-322-1145

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for

the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes **except** when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by

law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted without the waiver,

(C) The research could not practicably be conducted without access to and use of the PHI.

8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Patients Rights Notification

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Angie Sanchez, Office Manager/privacy officer at the

above address specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Angie Sanchez, Privacy Officer at the above address.

Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Eileen E. De Castro, Privacy Officer at the above address in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Angie Sanchez, Privacy Officer at the above address. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless

the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Angie Sanchez, Privacy Officer at the above address. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Angie Sanchez, Privacy Officer at the above address.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Angie Sanchez, Privacy Officer at the above address. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time ***in writing***. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Angie Sanchez, Privacy Officer at the above address.

Preventative
HEALTH ALLIANCE

Please sign indicating receipt of our Notice of Privacy Practices and Patients Rights Notification:

Patients Name:_____
(Please print)

Signature:_____

Authorized Representative:_____
(Please print)

Signature:_____Date:_____

Preventative
HEALTH ALLIANCE

What is HIPAA?

The **Health Insurance Portability and Accountability Act** of 1996 **(HIPAA)** is a law passed by Congress to protect patient privacy with regards to medical records and to control the flow of health information. Also, HIPAA was designed to lower administrative costs by setting standards for the filing and processing of insurance claims. HIPAA regulations will affect people at all levels of healthcare, including patients and their physicians.

What is TPO?

Treatment, payment and operations (TPO) include the routine processes involved in receiving healthcare. There are several examples that encompass TPO. Oftentimes it is necessary to share your health information between healthcare providers, such as providing a referral to a specialist. This is part of **treatment.** Information about your diagnosis and other health information is required for **payment** from insurance companies. Evaluations of medical records to ensure high quality care provided by our physicians are considered part of **operations**.

Why Should I Care about TPO?

HIPAA legislation outlines significant differences for the handling of health information for TPO and reasons other than TPO. The laws created by HIPAA are designed to expedite healthcare by placing no restrictions on the sharing of your health information for TPO and severely restricting information not required for TPO. (e.g. releasing information to other people, even your family members, or for marketing reasons).

How Will HIPAA Affect Me as a Patient?

HIPAA will benefit patients in many ways. For example, Phoenix West Internal Medicine will provide all patients with information about their rights to privacy. Also, the new regulations will make it illegal for healthcare providers to sell your health information to marketers and advertisers without your written authorization. As a patient, you have the right to review your medical records if you believe something is incorrect and request a change. However, only your physician can determine if your medical record is inaccurate.

Will HIPAA Have Any Negative Effects?

The intention of HIPAA is to improve the level of privacy for patients. However, the law requires the patient's written permission before his or her health information can be released for reasons other than TPO. For example, relatives cannot call to the clinic and get any **protected health information (PHI)** without you signing an authorization first. Please understand the clinic is working to protect the privacy of all patients and may have stricter policies for the release of such information.

Preventative
HEALTH ALLIANCE

Acknowledgement of Receipt of Notice of Privacy Practices

I have had the opportunity to receive and/or review a copy of ***Preventative Health Alliance*** Notice of Privacy Practices that outlines how confidential patient health information (PHI) will be used, disclosed, and protected.

_____

Printed Patient Name

_____

Printed Name & Relationship if signed by individual other than the patient

_____ _____

Signature Date

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but could not because: (circle)

- **Individual Refused to Sign**
- **Communication Barrier**
- **Care Provided was Emergent/Urgent**
- **Other:**_____

_____

_____

_____

_____ _____

Printed Employee Name **Date**

Preventative
HEALTH ALLIANCE

Acknowledgement of Receipt of Patient Consent Form

I have been provided with the "Patient Consent Form" and have read and understand this form. I understand that I may request and be provided with a written copy of this notice. By signing this form, I am consenting to allow *Preventative Health Alliance* to use and disclose my PHI to carry out TPO.

Signature of patient or responsible party

Date

Printed Name

Acknowledgement of Receipt of Financial Policy

I have read and understand the practices' financial policy and agree to abide by its guidelines. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient or responsible party

Date

Printed Name

By signing below, I attest that I have been provided the opportunity to discuss Advance Care Planning with my physician. I understand that I can, upon request, be given information on this at any time.

Signature of patient or responsible party

Date

Printed Name

Preventative
HEALTH ALLIANCE

Our Financial Policy

Thank you for choosing us as your primary care provider. We are dedicated to providing you with quality and affordable health care. We want you to completely understand our financial policy. Please read it and ask us any questions you may have. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. *Knowing your insurance benefits is your responsibility*. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance*. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance* of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Preventative
HEALTH ALLIANCE

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and *you are responsible for the fees incurred and may be discharged from this practice.* If this is to occur, you will be notified by regular and/or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. The same policy applies to patients who file for **bankruptcy**. Any outstanding balances owed to the practice will be waived upon presentation of proof, but the patient-physician relationship will be dissolved and the patient will be discharged from the practice unless he decides to voluntarily make payment arrangements to pay off the debt.

8. Missed appointments. Our policy is to charge for no shows and for missed appointments not canceled within a reasonable amount of time. *Any cancellations or reschedules less than 24 hours of your appointment will be considered a* ***no show***. These charges will be your responsibility and billed directly to you. Each time you miss an appointment without providing us proper notice, another patient is prevented from receiving care.

Multiple "no shows" in any twelve (12) month period may result in termination from our practice. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

Preventative
HEALTH ALLIANCE

PREFERRED METHOD OF PATIENT COMMUNICATION

_____ _____

Patient Name – Please Print Date

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. ***Preventative Health Alliance*** will make a reasonable attempt to communicate with patient according to the patient's request indicated below.

I wish to be contacted by ***Preventative Health Alliance*** in the following manner (check all that apply).

Home Telephone Number with Area Code:_____

- ☐ Leave message with detailed information.
- ☐ Leave message with callback number only.
- ☐ Leave a message with the person below:

_____

Written Communication

- ☐ Permission to mail to my home address.
- ☐ Permission to mail to my work/office address
- ☐ Permission to fax to this number:_____

Work Telephone Number with Area Code:_____

- ☐ Permission to leave message with detailed information
- ☐ Leave message with callback number only

Other :_____

_____ _____

Patient's signature or authorized representative Date

_____

Printed Name & relationship, if signed by other than patient

Preventative
HEALTH ALLIANCE

RECORD RELEASE or REQUEST/AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name:_____
Please Print **Last** **First** **Middle**

Home Address:_____

Home Telephone:_____ **Date of Birth:** _____
(area code included)

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH):

The information that may be released or requested (circle which) under this Authorization includes

☒ Discharge Summary	☒ Progress/Physician Notes	☒ X-Ray Report
☒ Pathology Report	☒ History & Physical	☒ Nurses Notes
☒ EKG/EMG/EEG Report	☒ Consult Report	☒ Emergency Report
☒ Laboratory Report	☒ Operative Report	☒ Entire Record

☐ Other_____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

☐ Information about mental health or mental retardation services
☐ Psychotherapy Notes created by a mental health professional
☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
☐ Information about sexually transmitted diseases
☐ Information about alcohol or drug abuse treatment program services
☐ Information about sexual assault
☐ Information about child abuse and neglect

☐ **RELEASE Information To:**_____
☐ **REQUEST Information From:**_____
Name: _____
Address:_____
City: _____ State: _____ Zip Code: _____
Telephone: (____)_____ Fax: (___)_____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until the _____day of _____, 20___.
☐ Until ***Preventative Health Alliance*** fulfills this request.
☐ Other: _____

_____

PURPOSE: I authorize ***Preventative Health Alliance*** to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s):

[Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]

_____

Preventative
HEALTH ALLIANCE

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once Preventative Health Alliance discloses my health information to the recipient, Preventative Health Alliance cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that Preventative Health Alliance may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Preventative Health Alliance; except, however, if my treatment at Preventative Health Alliance is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Preventative Health Alliance may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Preventative Health Alliance Privacy Office at the address listed below. The revocation will be effective immediately upon Preventative Health Alliance receipt of my written notice, except that the revocation will not have any effect on any action taken by Preventative Health Alliance in reliance on this Authorization before it received my written notice of revocation.

I understand that there may be a charge for producing record copies according to state regulations.

I may contact Preventative Health Alliance Privacy Office by mail at:

Angie Sanchez Privacy Officer
4150 N. 108th Avenue, Suite 142
Phoenix, AZ 85037
(623) 322-1145

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize Preventative Health Alliance to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

Note: If Patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date