



MRN No. _____

PATIENT ADMISSION PACKET - Patient Identification and Financial Responsibility Acknowledgement

Patient Name (Last, First, Middle): _____

Email Address: _____ Date of Birth: _____ (Check One) Male Female

Race (check one) American Indian Alaska Native Asian African American Native Hawaiian Caucasian

Language(s): _____ Ethnicity (check one) Hispanic or Latino Not Hispanic or Latino Decline

Address: _____
Street Address Apt # (if applicable) City State Zip

Phone: _____ Parent/Legal Guardian (if applicable) _____

Primary Care Physician: _____ Phone: _____

Behavioral Health Provider (external): _____ Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____
Street Address City State Zip

In case of a medical emergency or any other emergency, please list two emergency contacts below. By listing these contacts below, you are authorizing DMG to contact these individuals and share your relevant Protected Health Information with them for the purpose of ensuring your safety during a medical emergency or any other emergency.

Name _____ Relationship _____ Phone: _____
Name _____ Relationship _____ Phone: _____
If under the age of eighteen (18) please list the name(s) of the individuals to whom the child may be released: (If names are present, please ask for a medical release form to fill out and sign).
Name _____ Relationship _____ Phone: _____

FOR MINORS ONLY: If biological parents are divorced and share medical decision-making, please list the following demographic information for the non-custodial parent (or the parent who is not completing these forms):

Name: _____ Phone: _____

Address: _____
Street Address Apt # (if applicable) City State Zip

If 18 years of age or older do you have a **medical advance directive**? Yes No

If yes, please provide our office with copy. If no, would you like information on **medical advance directives**? Yes No

If 18 years or older do you have a **psychiatric advance directive**? Yes No

If yes, please provide our office with copy. If no, would you like information on **psychiatric advance directives**? Yes No

Do you have any religious or cultural beliefs that may affect your healthcare? Yes No

If yes, please describe: _____

I certify that this information is true to the best of my knowledge. _____

Signature Patient/Parent/Guardian

MRN No. _____

Primary Insurance Information:			
Primary Insurance Co. Name	Identification Number	Group Number	
Address of Primary Insurance	City	State	Zip Code
Policyholder Name (if Different from Patient)	Phone Number of Policyholder	Relationship to Patient	
Policyholder's Social Security No.	Policyholder's Date of Birth	Relationship to Patient	
Policyholder's Employer	Home Phone	Cell Phone	

Is there a secondary insurance company? ____ Yes ____ No

***If yes, please provide additional information to staff.**



MRN No. _____

Financial Responsibility Acknowledgment

Initial each section

_____ I acknowledge full financial responsibility for services rendered by DMG. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to DMG.

_____ I understand that DMG verifies my health benefits through my insurance as a courtesy to me. I further understand that it is my responsibility to ensure services are covered and/or what my exact benefits are. DMG will assist me in this process to the best of its ability. I understand that I am ultimately responsible for payment of all services rendered. I understand that any co-pays, deductibles, or any other payments of outstanding balances are due prior to services being rendered. I understand that it is my responsibility to update DMG of any insurance changes.

_____ I understand that health insurance is a contract between me and the insurance company and/or my employer, not DMG. If there are any disputes of benefit coverage I understand that I need to contact my insurance company.

_____ I have read and fully understand the above financial responsibility and insurance authorization.

Signature of Patient/Parent/Legal Guardian

Date

Print name of Patient/Parent/Legal Guardian



MRN No. _____

Consent for Purpose of Information, Payment, and Healthcare Operations

I consent to the use and disclosure of _____'s Protected Health
Print Patient Name

Information by District Medical Group (DMG) for the purpose of diagnosing, providing treatment, obtaining payment for health care bills, or to conduct health care operations of the DMG clinic. I understand that the diagnosis or treatment by the DMG clinic providers may be conditioned upon the consent as evidenced by the authorizing signature and initials on this document.

Initial each section

_____ By initialing and signing this consent form I am agreeing that this DMG clinic can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ I understand that all information gathered in the course of my treatment is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law. Examples of such disclosures include medical emergency cases; situations of an emergency involving a serious an imminent threat to a person or the public; the reporting of child or adult abuse or neglect, court ordered disclosures. I understand that my treatment information may be discussed by other members of my clinical team, and other professionals at DMG clinics.

_____ I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the DMG clinical practice and that the DMG clinical practice is not required to agree to the restriction. However if the DMG clinic agrees to the restriction that I request, the restriction is binding on the DMG clinic. I have the right to revoke this consent, in writing at any time, except to the extent that the DMG clinic has taken action in reliance on this consent.

_____ My "Protected Health Information" means health information, including demographic information, collected from me and created or received by the DMG provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to past, present or future physical or mental health or condition and identifying information, or there is a reasonable basis to believe the information may personally identify the patient named above.

_____ I understand I have a right to review the DMG clinic Notice of Privacy Practices prior to signing this document. DMG clinic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information that will occur in treatment, payment of bills, or in the performance of healthcare operations of the DMG clinic. This notice of Privacy Practices also describes client rights and DMG Clinic duties with respect to protected health information.

_____ The DMG Clinic reserves the right to change the Privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____ The DMG Clinic has my permission to input clinical images (example: photo or video, etc.) into the Electronic Medical Record as requested by providers to assist in my treatment.

Signature of Patient/Parent/Legal Guardian

Date

Print name of Patient/Parent/Legal Guardian

Patient Record of Disclosures

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 is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home/Mobile Telephone: _____

- OK to leave message with detailed info
- Leave message with call-back number only
- Decline personal phone messages

Work Telephone: _____ Work Fax: _____

- O.K. to fax to this number
- O.K. to leave message with detailed info
- Leave message with call back number only
- Decline work phone messages

Written Communications:

Email: _____

- O.K. to send detailed email to this address
- O.K. to mail to my work/office address
- O.K. to mail to my home address

Patient Representative to whom information may be given:

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Patient/Parent/Guardian Signature

Printed Name



MRN No. _____

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Consent for Treatment

Initials

_____ General consent: I consent to medical care at this facility, including telephonic evaluation and management if medical services are not performed in-person. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.

_____ I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.

_____ In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Arizona law.

_____ I understand that District Medical Group utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.

_____ I understand that District Medical Group utilizes an electronic prescribing mechanism for electronic transmission of prescriptions to local pharmacies and mail order pharmacies.

_____ I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician or provider.

_____ The DMG Clinic has my permission to input clinical images (example photo or video, etc.) into the Electronic Medical Record as requested by providers to assist in my treatment.

_____ I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

By signing this document, I agree that photocopies of this document are as legally binding as the original.

I have read and understand and agree to the above terms.

 Patient or Guardian signature Printed Name Relationship to Patient Date

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION

Our notice of Privacy Practices provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our use and disclosure form.

 Patient or Guardian signature Printed Name Relationship to Patient Date



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Page left intentionally blank



MRN No. _____

AUTHORIZATION TO CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, _____ Mother/Father of _____
Printed Name of Parent/Legal Guardian Child's Name

am the parent or legal guardian of the above named CRS patient. For a variety of reasons, there may be occasions when I will be unable to personally accompany child named above to his/her appointments. Adults listed below are 18 years of age or older and are authorized to discuss care and treatment needs with appropriate clinic staff, and are authorized by me to give consent to the performance of only routine procedures such as lab and x-ray. I understand these individuals must have knowledge of my child's diagnosis and treatment so that care may be discussed with the physicians. If these individuals cannot provide an adequate history as required by the physician then I understand that the appointment may be rescheduled. I have read and understand and agree to the

terms above. _____ (Initials)

Do hereby authorize and appoint (please print):

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

AUTOMATIC ONE-YEAR DURATION. This authorization will automatically expire after one (1) year from date of execution unless a different end date or event is specified below.

End date _____ or Event Name _____

COPY RECEIVED. I acknowledge receipt of a signed copy of this authorization. _____ (Initials)

Any questions or concerns regarding this authorization may be directed to me at:

(Please select preferred method of contact)

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Parent/legal Guardian Signature: _____ Date: _____

CRS Staff Witness: _____ Date: _____

Notary Public / This form may be taken from the CRS clinic.

This document MUST be notarized if not signed in the presence of a CRS staff member.

Notary Date

CRS Family/Patient Information Sheet Social work is available for CRS patients and families. The information in this worksheet will help us to better serve your family. Please complete in pen

Name of the person filling out this form: _____ Signature: _____

Relationship to the patient: _____ Today's date: _____

What is the patient's medical condition or illness? _____

Medical provider information (The patient's primary care provider).

Methods of learning new material that I like best are:

Verbal Instruction Written Instruction Visual (Pictures, videos etc.) Hand outs

Level of Education Completed:

<6th Grade 6th – 8th Grade 9th Grade 12th Grade 1-4 Years of College > 4 years of College

Name	Address	Phone Number

Family/Guardian/Decision Making

Who Lives at home with the patient?

Name	Relationship to Patient	Age

Is there a parent who does not live in the house? Yes No If yes, what is their name? _____

Does your child have visits with this parent? Yes No

Will this parent ever bring the patient to appointments at CRS? Yes No

Will anyone who is not the parent or legal guardian bring your child to the clinic? Yes* No

*****If Yes, Please complete the authorization to consent for medical treatment of a child. Page 8*****

Name of person who makes medical/legal decisions for the patient? _____



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Safety and Support

Are you afraid of anyone who lives in (or out of) your home? Yes No
 Do you want to speak with a Social Worker today? Yes No
 Does your child have a behavior problem for which you are not getting help? Yes No

If yes, what is your concern? _____

CRS Staff Witness: _____ Date: _____

How do you get to your appointments at CRS? Please circle all that apply.

Personal Car AHCCCS Taxi Bus/Light Rail Friends/Family Dial a Ride Community Resources

Does your family or the child receive any of the following? Please check all that apply.

Services	Yes	No	Have Applied
AzEIP (Arizona Early Intervention Program) PT OT ST Developmental Specialist			
DDD (Division of Developmental Disabilities) PT OT St Respite Habilitation			
WIC (Women, Infants and Children Food Program)			
Food Stamps/SNAP			
Cash Assistance / TANF (Temporary Assistance for Needy Families)			
SSI (Supplemental Security Income)			
Other:			
Comments:			

How confident are you that you can control and manage most of your health issues?

Strongly Agree Agree Neutral Disagree Strongly Disagree

Education

Is your child in school yet? Yes No

Name of School	Grade

Does your child have an IEP? (Individualized Education Plan) or 504 plan? Yes No

Circle all of the services the child receives at school:

Regular Classes Special Education Resources Homeschool/Online school/Homebound instruction
 Physical Therapy (PT) Occupational Therapy (OT) Speech Therapy (ST)

CRS has several social workers. You may reach them by calling the CRS call center and asking for the social worker who is on-call for the day.

DISTRICT MEDICAL GROUP NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how the DMG Clinic may use and disclose your medical information to carry out treatment, payment or health care operation and for other purposes that are permitted or required by law. This notice also describes your rights concerning your medical information.

1. HOW WILL WE USE AND DISCLOSE YOUR MEDICAL INFORMATION?

Your medical information may be used and disclosed by your provider, our office staff and others outside of our office involved in your care and treatment for the purpose of providing health care services to you. Your medical information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice.

Following are examples of the types of uses and disclosures of your medical information that your provider's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use or disclose our medical information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. We may also disclose medical information to other physicians or providers who may be treating you. For example, your medical information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your medical information from time to time to another physician or health care provider (e.g. a specialist or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: We may use or disclose your medical information in order to obtain payment for your health care service provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant medical information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose your medical information to improve the quality of care provided to patients or to support the business activities of the office. Your medical information may be used to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. We will share your medical information with third party "Business Associates" that perform various activities (for example, billing or transcription services) and for our office. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, will have a written contract that contains terms that will protect the privacy of your medical information.

Family Members, Friends and Others Involved in Your Care: We may disclose your medical information to a family member or friends who are involved in your medical care, or to someone who helps to pay for your care. We may use or disclose your medical information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death. We may use or disclose your medical information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Required by the Law: We may use or disclose your medical information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your medical information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your medical information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your medical information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your medical information if we believe that you have been a victim of abused neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your medical information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance as required.

Legal Proceedings: We may disclose medical information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose medical information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) Legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose medical information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Medical information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your medical information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your medical information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your medical information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose medical information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of our eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your medical information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: We may disclose your medical information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your medical information if you are an inmate of a correctional facility and your physician created or received your medical information in the course of providing care to you.

2. OTHER USES AND DISCLOSURES

We will ask for your written authorization if we plan to use or disclose your medical information for reasons not covered in this notice. You have the right to revoke the authorization at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Radiology reports
- Medical history
- Clinic and doctor visit information
- Medications
- Health plan enrollment and eligibility
- Allergies
- Lab test results
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.

Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.

3. YOUR RIGHTS

- i. **Right to this Notice:** You may request a paper copy of this Notice of Privacy Practices from us at any time.
- ii. **Right to request your medical information:** You may request access to the medical information about you that we have in our records. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.
- iii. **Right to request an amendment to your medical information:** You may request an amendment of your medical information that you believe is incorrect or incomplete. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- iv. **Right to request a restriction of your medical information:** You may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You may also request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to a restriction that you may request. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of the restriction unless it is needed to provide emergency treatment.

You may request that a health care item or service not be disclosed to your health plan for payment purposes or health care operations. We are required to honor your request if the item or service is paid out of pocket and in full. This restriction does not apply to the use or disclosure of your medical information related to your treatment.
- v. **Right to request confidential communications from us by alternative means or at an alternative location.** You may request that we communicate with you in a way that is more confidential. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

In order to exercise any of your rights described above, contact the office manager for the necessary forms.

4. CHANGES TO THIS NOTICE

We reserve the right to amend the terms of this Notice. If this Notice is amended, the amended terms will apply to all medical information that we maintain at that time. You may request a copy of the revised version by calling the office and requesting that a copy be sent to you in the mail or asking for one at the time of your next appointment.

5. QUESTIONS OR CONCERNS

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices, or wish to register a complaint related to our privacy practices, please send your written complaint to the Privacy Officer at:

District Medical Group
Office of Corporate Compliance 2929 E. Thomas Rd.
Phoenix, AZ 85016

You may also file a written complaint with Secretary of the US Department of Health and Human Services (HHS) at:

Office for Civil Rights
US Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Attn: OCR Regional Manager

You may also complain about your service to the Arizona Department of Health at:

150 N. 18th Avenue
Phoenix, AZ 85007
(602) 364-4764

We will not make you waive your right to file a complaint with HHS as a condition of receiving care from us, or penalize you for filing a complaint with HHS.

This notice was published and becomes effective on **01/01/2013**.

PATIENT RIGHTS

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnoses;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To not be subjected to: Abuse, Neglect, Exploitation, Manipulation, Sexual Abuse, Sexual Assault, Restraint or Seclusion;
4. To not be retaliated against for submitting a complaint to the Arizona Department of Health or any other regulatory agency;
5. To not have private property misappropriated (taken or stolen) by any employee, volunteer or student at the outpatient treatment center;
6. To review, upon written request, the patient's own medical record according to Arizona Revised Statutes [12-229](#), [12-2294](#), and [12-2294.01](#);
7. To receive a referral to another health care institution if the outpatient treatment center is unable to provide physical health services or behavioral health services for the patient;
8. To participate or have the patient's representative participate in the development of, or decisions concerning treatment;
9. To participate or refuse to participate in research or experimental treatment;
10. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights;
11. Except in an emergency the patient has the right to consent to or to refuse treatment and may withdraw consent before the treatment is started;
12. Except in an emergency the patient will be informed of alternatives to a proposed psychotropic medication or surgical procedure and is informed of associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
13. To receive privacy in treatment and care for personal needs;
14. The patient will be informed on the outpatient treatment center's policy on advanced directives and the clinic's complaint and grievance process;
15. The patient has the right to consent or to refuse having a photograph taken, except when the patient is admitted for administrative identification procedures;
16. To be treated with consideration, respect, and dignity;
17. To send complaints or claims to members of clinical staff, or to outside entities or other individuals without limitation or retaliation;
18. To make fair, timely, and impartial complaints. To receive, upon discharge or transfer, recommendations for treatment; and
19. Except as otherwise permitted by law, the patient has the right to provide written consent for the release of information regarding the patient's medical or financial records.