Phoenix Medical Group, PC
PATIENT CONSENT AGREEMENT

PHOENIX MEDICAL GROUP, P.C.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Phoenix Medical Group, PC and all entities operated and owned by Phoenix Medical Group, PC for the purpose of diagnosing or providing treatment to me, evaluating treatment through research, obtaining payment for my healthcare bills and laboratory bills, referring my care to outside specialists when necessary, or to conduct healthcare operations including my provider's participation in The Network, the statewide Health Information Exchange (HIE). I understand that diagnoses or treatment of me by Phoenix Medical Group, PC may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Phoenix Medical Group, PC is not required to agree to the restrictions that I may request. However, if Phoenix Medical Group, PC agrees to a restriction that I request, the restriction is binding on the practice and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Phoenix Medical Group, PC has taken action in reliance on this consent.

My "protected health information" (PHI) means health information including my demographic information, collected from me and created or received by my dentist, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Phoenix Medical Group, PC Notice of Privacy Practices prior to signing this document. Phoenix Medical Group, PC's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performances of dental care operations by Phoenix Medical Group. The Notice of Privacy Practices for Phoenix Medical Group is also posted in the waiting room of the office. This Notice of Privacy Practices also includes and describes my rights and Phoenix Medical Groups, PC's duties with respect to my protected health information.

Per the HIPAA Privacy Rule, my signature on this consent form authorizes the use of my Personal Health Information between Phoenix Medical Group and all other practices, for the continuity of my care.

_____If the patient has initialed on this line, patient is **declining** the release of behavioral health information including, but not limited to: psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501), drug abuse, alcoholism, or other substance abuse, sickle cell anemia, and records which may indicate the presence of a communicable or venereal disease which may include but are not limited to diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS testing or results.

Phoenix Medical Group, PC 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 requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Personal Representative's Authority

_____ _____
Witness Date

Phoenix Medical Group, PC
NO SHOW POLICY / PATIENT PERMISSION FORM

- All patients must provide accurate and complete personal and insurance information prior to being seen by Phoenix Medical Group (herein referred to as "Practice")

- Payment is required at the time of service and may be in the form of cash, check or credit card.

- Practice may disclose all or part of a patient's medical or financial records (including information related to alcohol and drug abuse, mental health diagnosis and treatment, HIV related or other communicable disease related information) to third parties to obtain payment for services provided.

- We will gladly file a courtesy claim with your health insurance company. It is your responsibility to comply with any pre-determination or notification requirements of your insurance plan. Many of the services provided may be covered and paid for by your insurance company. Unfortunately, insurance companies do not pay for all services that the provider may deem appropriate.

- In all cases we require the guarantor, the person who is financially responsible, to be personally liable for all balances.

- We believe the fees we charge to be reasonable and customary fees. If your insurance company uses a different fee schedule, you may be responsible for any balance remaining.

- Practice may charge reasonable fees for services related to your account including, but not limited to, returned check fees, interest on unpaid accounts, and medical record copies.

- Individuals who do not show up for their scheduled appointment or do not give at least 24 hours cancellation notice may be subject to a $25 no-show fee.

- Should it become necessary to forward an account balance to a collection agency, the guarantor, the person who is financially responsible, will be responsible for reasonable collection costs.

- You are responsible for informing the Practice of any change in demographic information, including telephone number, address, and health insurance coverage.

- We may collect a deposit on the charges you incur today toward your balance (e.g. copay, deductible, self pay) and bill you for any remaining balance. All bills are due upon receipt.

- Federal laws require that we submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. We are not allowed to change information just so the insurance company can pay a claim.

I have read and understand the financial policy and agree to abide by it. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am authorized to act on behalf of the patient and sign this agreement.

_____		_____
Patient First & Last Name (printed)		Witness
_____	_____	_____
Signature	Relationship to Patient	Date

Phoenix Medical Group, PC
NO SHOW POLICY / PATIENT PERMISSION FORM

Patient Name:_____ Date of Birth_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Our goal is to provide quality medical care in a timely manner.
If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. To cancel or reschedule an appointment, please call 623-815-7800.

Late cancellations will be considered as a "no-show". "No-shows" inconvenience those individuals who need access to medical care in a timely manner. Any "no-show" will be subject to a $25.00 fee.

I have read and understand the Cancellation / No Show Policy.

Patient Signature X _____ Date_____

Initial

X_____I give permission for_____ to accompany me in the examination room during the physician visit.

X_____I give permission to call _____ Home _____ Work _____ Cell _____ Email

X_____I give permission to contact me regarding research opportunities ____Phone _____Email

X_____I give permission to leave a message at my _____ Home _____ Work _____ Cell

X_____ Message may include _____ Normal Test Results _____ All Test Results

X_____I give permission for_____ to speak with Phoenix Medical Group regarding my _____ Test Results _____ Billing Issues

X_____ I give permission to have normal results mailed to my home address.

Patient Signature_____ **Date**_____

Witness Signature_____ **Date**_____

Phoenix Medical Group, PC
ACKNOWLEDGEMENT OF RECEIPT OF NOPP

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Phoenix Medical Group's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in the Phoenix Medical Group's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Phoenix Medical Group Patient Privacy Officer as indicated on your Notice.

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

Patient Name (Printed): _____

If Patient Representative, Name (Printed): _____

Relationship to Patient (Printed): _____

Account # or Medical Record #: _____

Signature: _____ Date received: _____

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 we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

Following are examples of the types of uses and disclosures of your protected health information that your physician'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 will use and disclose your protected health 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. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health 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 protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services 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 an office visit may require that your relevant protected health information be disclosed to the health plan. You will however be able to restrict disclosures to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact

you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health 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 protected health information for public health 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 prevention or control of communicable diseases, injury or disability, reporting information such as adverse reactions to medications or products, suspected abuse, neglect or exploitation of children, disabled adults or the elderly, or domestic violence.

Health Oversight: We may disclose protected health 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.

Law Enforcement: We may also disclose protected health 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 protected health 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 protected health 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. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health 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 protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health 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 protected health 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 protected health 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 your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health 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.

Workers' Compensation: We may disclose your protected health information as authorized to comply

with workers' compensation laws and other similar legally-established programs.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health 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.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment.

Psychotherapy Notes: Use and disclosure of psychotherapy notes maintained by your healthcare provider is allowed only with your written authorization.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health 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. Finally, we may use or disclose your protected health 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.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physicians practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee to copy your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not

use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by providing a written letter to your provider. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. 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. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. 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. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

1. You have the right to or will receive notification of breaches of your unsecured protected health information as required by Do your providers routinely document patient or family's participation in the development of a care plan?

law.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

ATTN: Privacy Officer
9145 W Thunderbird Rd.
Peoria, AZ 85381

PHOENIX MEDICAL GROUP, P.C.

Medications Notification

Dear Patient;

Phoenix Medical Group does not provide continual chronic pain management through the use of opioids or other controlled substances. Patients in need of these services will be referred to the appropriate health care provider.

Because opioids cause physical dependence when taken regularly, you may experience withdrawal symptoms when you decrease or stop taking the medications. We may provide non-opioid medications to minimize withdrawal symptoms. Please follow the directions provided to taper off the medications. We do not provide opioid medications to bridge gaps in care or if you have been released from a pain management facility.

Our goal at Phoenix Medical Group is to provide the best care to our patients.

I have read and understand the medication notification above. I am the patient, the parent of a minor child, or the legally authorized representative of the patient and am authorized to act on behalf of the patient and sign this agreement.

_____ _____

Patient First & Last Name (printed) Witness

_____ _____ _____

Signature Relationship to Patient Date