BEEWELL
HEALTHCARE

First Name: ______________________________ Last Name: ________________________ (MI): _____

DOB: ____________ Sex: _______ Marital Status: _______________________

Community/Facility Name: ___________________________ Facility Move-in Date: _________________

Social Security Number: _____________________________ Medicare Number: _____ ______________

Preferred Language: ________________ Race: _____________ Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Patient Current Address: ________________________ City: __________ State: AZ__ Zip Code: ______

Current Specialists /Current Hospitalizations
Contact:_________________________ Phone#: __________________ Date: _____________

Contact: _________________________ Phone #: __________________ Date: _____________

Emergency Contact: First Name: ________________ Last Name: ________________ Medical Power of Attorney? Yes No
Phone Number: _______________________ Relationship: ________________ Legal Power of Attorney? Yes No

• *Please provide us with a copy of any Power of Attorney paperwork* •

Is the patient currently enrolled with a ***Hospice*** or ***Home Health Program***? Hospice Home Health
Name of Program: ______________________ Phone Number of Program: ______________________

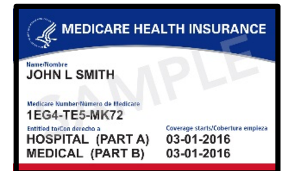
-Please complete all sections that apply-

*Without **accurate** insurance information we will be unable to bill your insurance and we will have to bill you directly.*

PRIMARY INSURANCE (Medicare, Medicare Advantage, Commercial Plan - Part B, Part C)

Insurance Provider **and** Plan Name: ____

Member ID# ____



SECONDARY INSURANCE (Medicare **Supplement** Plan or "Medi gap" Plan - Part F, G, K, L, M, N, Etc.)

Insurance Provider **and** Plan Name: ____

Member ID# ____

Medicaid/AHCCS/ALTCS or TRICARE (Medicaid is always the last payer to other insurances)

Insurance Provider **and** Plan Name: ____

Member ID# ____

How did you hear about us: ____

Name of referring provider or facility: ______________________________________

Name of Patient Resource Manager (PRM) who is assisting you: ___________________________

FAX COMPLETED FORMS AND ALL INSURANCE CARDS TO:
480-444-1478 or Email to: info@beewellaz.com

BEEWELL
HEALTHCARE

Current Medications List

Name: ____________________

Emergency Contact Name: ____________________
Emergency Contact Phone: ____________________

Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken for	Physician who Prescribed Medication	Notes

Allergies

Pharmacy/Prescription Drug Plan

BEE WELL
HEALTHCARE

AUTHORIZATION TO RELEASE RECORDS

Patient Name: ______________________________ Social Security Number: ______________

Date of Birth: ____________ Primary Phone#: ______________________

Street Address: ____

City, State, Zip: ____________ AZ ____________

I hereby authorize and consent to release of medical records information concerning the above-noted patient.

- **By leaving the "FROM" below blank you authorize Bee Well Healthcare to request release of records necessary to coordinate my care. This includes any physician, hospital, or other facilities where I have been a patient.**

DO NOT FILL BELOW OUT

FROM:

____

____

____

____

To be sent to:

Bee Well Healthcare
10214 N. Tatum Blvd
Suite A 1600
Phoenix, AZ 85028

Fax:
480-444-1478
Phone:
480-694-7042

☐ Continuation of Care

Information to be released:

☐ Office notes ☐ Laboratory Test ☐ X-ray reports ☐ Other: ______________

Dates of Service to cover: From: ______________________ To: ______________________

I authorize the release of photocopies of the above-noted medical records in the possession or control of Bee Well Healthcare, LLC, its employees and/or agents. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

I have given my consent freely, voluntarily, and without coercion. I may revoke this authorization at any time providing I notify Bee Well Healthcare, LLC in writing to that effect. I understand that the revocation will not apply to information that has already been released in response to this signed authorization. I further understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that a photocopy/facsimile of this authorization is considered acceptable in lieu of the original. If I have any questions about the release of records, I can contact Bee Well Healthcare, LLC at their primary practice location at: 10214 N. Tatum Blvd Suite A 1600, Phoenix, AZ, 85028 or utilize their phone number to communicate my questions - **480-694-7042**

______________________________ ______________

Signature of Patient or Legal Representative Date

BEE WELL
HEALTHCARE

AUTHORIZATION FOR USE OF/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my health provider Bee Well Healthcare, LLC to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipients: I authorize my health care information to be release to the following recipient(s); **(Name of people/person information can be shared with)**

Name: ________________________________ Address: ____

Full house #, Street, City, State and ZIP, please

Purpose: I authorize release of my health information to the following recipient(s):

____

(**Note:** "at the request of the patient" is enough if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the appropriate box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to my medical history, mental and physical condition and any treatment received by me.
- ☐ Only the following records for types of health information:

Term: I understand that this authorization will remain in effect during treatment with Bee Well Healthcare, LLC

Re-disclosure: I understand that my healthcare provider cannot guarantee that the recipient will not read or disclose 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.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, will not affect the quality of my treatment at Bee Well Healthcare, LLC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Bee Well Healthcare, LLC - Compliance at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice and that the revocation will have no effect on services provided by my healthcare provider. Reliance is made on this Authorization before a written notice of revocation.

Questions: I will contact Bee Well Healthcare, LLC - Compliance for answers to my questions about the privacy of my information at:

10214 N. Tatum Blvd Suite A 1600, Phoenix, AZ, 85028 Phone: (480) 694-7042; Fax: (480) 444-1478

____	________________	____________________________________
Signature of Patient or Legal Representative	Date	Patient Name
____	________________	____________________________________
Signature of Witness	Date	Witness Name

If an individual is unable to sign this authorization, please complete the information below:

____	________________	________________
Name of Guardian/Representative	Legal Relationship	Date

BEE WELL
HEALTHCARE

Name of Patient: ________________________________ **Date of Birth:** ______________
Community/Facility Name: _________________________

I hereby request medical care and treatment by Bee Well Healthcare, PLLC. I designate Bee Well Healthcare, PLLC as my only Primary Care Providers and request that they monitor and assist with all aspects of my health care including Chronic Care Management to provide me with best care. I agree to provide Bee Well Healthcare, LLC with a detailed medical history.

CONSENT FOR PRESCRIPTION OPIOID SEARCH - As you may be aware, there is a new law for prescribing opioids for treatment of acute and chronic pain. This law applies to all physicians, dentists, optometrists, podiatrists, physician assistants, certified nurse midwives, or advanced practice nurses authorized to prescribe controlled substances. I agree to allow Bee Well Healthcare, PLLC to run an AZPMP pharmacy search of all my prescribed medications.

I consent for prescription Opioid Database Search: ________________________________ ______________
Signature of Patient or Legal Representative Date

CHRONIC CARE MANAGEMENT (CCM) - I agree to allow Bee Well Healthcare, PLLC to provide me with Chronic Care Management (CCM) services and to be designated as my only CCM provider. Services include: consultation and guidance in managing my chronic conditions, reviewing my medications, help with scheduling specialist visits and tests that my doctor ordered, receiving a plan of care with personal health goals, sharing e-records and coordination of care with other providers. I understand that Bee Well Healthcare, PLLC may bill my insurance for these services and, depending on my insurance, I may be responsible for a small co-pay. I can refuse or opt out of these services and stop my CCM at the end of any month by contacting Bee Well Healthcare, PLLC by telephone or in writing.

I consent for Chronic Care Management: ________________________________ ______________
Signature of Patient or Legal Representative Date

FINANCIAL RESPONSIBILITY - I authorize Bee Well Healthcare, PLLC to bill my Insurance and for my insurance company to make direct payments to Bee Well Healthcare, PLLC on my behalf. I accept financial responsibility for payment of insurance mandated charges such as Deductibles, Copays, and Coinsurance. Bee Well Healthcare, PLLC cannot bill your insurance if we are provided with incorrect information; therefore, to avoid being billed directly, I understand that it is my responsibility to continuously provide up-to-date Insurance information. Many secondary insurers do not automatically crossover after Medicare has made their 80% payment. Occasionally, secondary insurers will consider medical house calls as a "non-covered charge". I understand that I may be responsible for unpaid charges which will be invoiced to me. These unpaid amounts may include: 1) Unpaid 20% (by secondary insurer) if Medicare pays 80% or no secondary coverage is available; 2) Denials that cannot be resolved within 60 days or 3) Annual deductibles for primary and secondary insurance. As a courtesy, we always attempt to bill your insurance. Without resolution of a claim within 60 days of the date of service, we will charge the patient account and you may submit this charge to your insurance for reimbursement as applicable.

Please be advised, any disputes regarding insurance coverage are the responsibility of the patient/POA/representative. Bee Well Healthcare, PLLC does NOT dispute insurance coverage with insurance companies.

In the event that a statement of charges should need to be mailed to a physical address other than the patients address, please provide the address where we should send the statement. By providing this information, you are accepting financial responsibility for charges incurred.

Address: ________________________________ City:________________ State: __________ Zip: __________

Guarantor Name: ________________________________ Best Phone Number for Guarantor:________________

I understand my financial responsibility: ________________________________ ______________
Signature of Patient or Legal Representative Date

BEE WELL
HEALTHCARE

Name of Patient: ________________________________

- **PHI/HIPAA** - I have been given information regarding PHI & HIPAA related to release of medical information for my care.(form attached)
- **PHOTOGRAPHS** - I give consent to be photographed for ID purposes and/or wound management.
- **GRIEVANCE PROCEDURE** - I have been given a copy of Bee Well Healthcare, PLLC Grievance procedures and understand my rights when wishing to voice a complaint. (form attached)
- **NOTICE OF PRIVACY PRACTICES** - Medical information is considered private and confidential. However, I am aware, that my information may be shared or disclosed verbally, electronically, and on paper as needed to others who are involved in my care and as needed for medical billing. Furthermore, I understand that Bee Well Healthcare, PLLC may disclose my health information when required to do so by law. (form attached)
- **HOSPICE CARE** - I understand that in the event that hospice services are required,Bee Well Healthcare, PLLC will remain as a primary care provider (PCP) and act as my Hospice care -Attending Provider, unless you choose otherwise on hospice election of benefit form.
- **TRANSFER OF CARE** - I understand Bee Well Healthcare, PLLC may not remain as my primary care provider (PCP) in the event I were to move from my residence. Bee Well Healthcare, PLLC also reserves the legal right to terminate services, at any time, without cause, upon thirty (30) days prior notice. I understand that if a change in provider is needed for any reason, that prompt notification will be sent to Bee Well Healthcare, PLLC
- **NON-DISCRIMINATION POLICY** - I have been given the Non-Discrimination policy and understand my rights. I may request a copy at any time. (form attached)
- **COMPLAINTS** -You or your personal representative have the right to express complaints to Bee Well Healthcare, PLLC and to the Office of Civil Rights (1-800-368-1019) if you or your representative believe that your privacy rights have been violated. Any complaints to Bee Well Healthcare, PLLC should be made in writing and mailed to their offices located at: 10214 N. Tatum Blvd, Suite A1600, Phoenix, AZ 85028, ATTN Privacy Officer or filed at az.ohs.gov/medical complaints. Bee Well Healthcare, PLLC encourages you to express any concerns you may have regarding the privacy of your information. You will not face retaliation of any kind for filing a complaint.

My Signature below certifies that I have read and understand and consent to ALL terms and conditions listed herein. I have also received copies of all terms and conditions as identified above in terms that I can understand.

This agreement is to remain in the patient's chart

________________________________ ________________

Signature of Patient or Legal Representative Date

BEE WELL
HEALTHCARE

Patient Email and Text Message Informed Consent

Bee Well Healthcare, PLLC may communicate with you or persons caring for you (ie caregiver) by e-mail, text message, and/or other forms of unencrypted electronic communication (together, "Electronic Messaging") to the telephone number(s), email address(es). This form provides information about Bee Well Healthcare, PLLC use, risks, and conditions of Electronic Messaging. It also will be used to document your consent for Bee Well Healthcare, PLLC communication with you by Electronic Messaging.

How we will use Electronic Messaging: Bee Well Healthcare, PLLC may use Electronic Messaging to communicate with you regarding a wide range of healthcare related issues, including:

- reminders of appointments or actions for you to take before an appointment, follow-ups from appointments, and notices about preventive services, treatment options, coordination of your care and other available health services;
- how to use our secure patient portal
- information regarding insurance, billing, eligibility for programs/benefits, and account balances.

Bee Well Healthcare, PLLC may use automatic dialers or pre-recorded voice messages when it communicates with you through Electronic Messaging. All Electronic Messaging may be made a part of your medical record.

Risk of using Electronic Messaging: Electronic Messaging has a number of risks that you should consider, including:

- Electronic Messaging can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper.
- Senders can easily misaddress Electronic Messaging and send the information to an unintended recipient.
- Backup copies of Electronic Messaging may exist even after deletion.
- Electronic Messaging may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection.
- Electronic Messaging service providers may charge for calls or messages received.
- Employers and online providers have a right to inspect Electronic Messaging sent through their company systems.
- Electronic Messaging can be used as evidence in court.

Conditions for the use of Electronic Messaging: Bee Well Healthcare, PLLC cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the messages we send. By signing where indicated below, you acknowledge your consent to the use of Electronic Messaging on the following conditions:

- **IN A MEDICAL EMERGENCY, DO NOT USE ELECTRONIC MESSAGING, CALL 911.** Urgent messages or needs should be relayed to us by using regular telephone communication. Non-urgent messages or needs should be relayed to us by using regular telephone communication or our secure patient portal.
- Electronic Messaging may be filed into your medical record.
- Bee Well Healthcare, PLLC is not liable for breaches of confidentiality caused by you or any third party.
- You are solely responsible for any charges incurred under your agreement with your Electronic Messaging service provider (for example, on a per minute, per message, per unit-of-data-received basis or otherwise).

Expiration and Withdrawal of Consent: Unless you earlier withdraw your consent, this consent will expire upon the end of your treatment relationship with Bee Well Healthcare, PLLC. You may choose to stop participating in Electronic Messaging at any time by informing Bee Well Healthcare, PLLC in writing as described herein. You further understand that withdrawing this consent will not cause you to lose any benefits or rights to which you are otherwise entitled, including continued treatment, payment or enrollment or eligibility for benefits. To withdraw consent and stop participating in Electronic Messaging, please contact Bee Well Healthcare, PLLC.

Patient Acknowledgment and Agreement: I have read and fully understand this consent form. I understand the risks associated with the use of Electronic Messaging between Bee Well Healthcare, PLLC and me, and other people involved in my care. I consent to the conditions and instructions outlined, as well as any other instructions that Bee Well Healthcare, PLLC may impose to communicate with me by Electronic Messaging.

I understand that Bee Well Healthcare, PLLC will send Electronic Messaging to those telephone number(s) and email address(es) in my account:

Release. In consideration of Bee Well Healthcare, PLLC services and my request to receive Electronic Messaging as described herein, I hereby release Bee Well Healthcare, PLLC from any and all claims, causes of action, lawsuits, injuries, damages, losses, liabilities or other harms resulting from or relating to the calls or messages, including but not limited to any claims, causes of action, or lawsuits based on any asserted violations of the law (including without limitation the Telephone Consumer Protection Act, the Truth in Caller ID Act, the CAN-SPAM Act, the Fair Debt Collection Practices Act, the Fair Credit Reporting Act, the Health Insurance Portability and Accountability Act, any similar state and local acts or statutes, and any federal or state tort or consumer protection laws).

BY SIGNING BELOWING YOU ARE AGREEING TO RECIEVE TEXT MESSAGES AND EMAILS

______________________________	______________________________	__________
Patient (or Authorized Representative) Signature	**Patient's Printed Name/Relationship to patient**	**Date**

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION"

PLEASE READ CAREFULLY

Protected Information:
While receiving care from Bee Well Healthcare, PLLC, information regarding your medical history, treatment and payment for your health care may be originated and/or received by us. Information which can be used to identify you and which relates to your past, present or future medical condition, receipt of health care payment for health care ("Protected Health Information").

Our Responsibilities:
Federal law (Health Insurance Portability and Accountability Act of 1996) imposes certain obligations and duties upon us as a covered health care provider with respect to your Protected Information. Specifically, we are required to:

- Provide you with notice of our legal duties and our policies regarding the use and disclosure of your Protected Information;
- Maintain the confidentiality of your Protected Information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your Protected Information unless under the law we are authorized to release your Protected Information without your authorization, in which case you will be notified within a reasonable period of time;
- Allow you to inspect and copy your Protected Information during our regular business hours;
- Act on your request to amend Protected Information within sixty (60) days and notify you of any delay which would require us to extend the deadline by the permitted thirty (30) day extension;
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods; and
- Abide by terms of this notice.

How Your Protected Information May Be Used and Disclosed:
Generally, your Protected Information may be used and disclosed by us only with your express written authorization. However, there are some exceptions to this general rule.

TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Care Coordination Purposes:
We may use or disclose your Protected Information for treatment purposes. During your care with Bee Well Healthcare, PLLC, it may be necessary for various personnel involved in your care to have access to your Protected Information in order to provide you with quality care. For example, pharmacists, suppliers of medical equipment or other health professionals that Bee Well Healthcare, PLLC uses in order to coordinate your care.

Payment Purposes:
Your Protected Information may also be used or disclosed for payment purposes. It is necessary for us to use or disclose Protected Information so that treatment and services provided by us may be billed and collected from you, your insurance company or other third party payer. It may also be necessary to release Protected Information to another health care provider or individual or entity, covered by the HIPAA privacy regulations, which has a relationship with you for their payment activities.

Health Care Operations:
Your Protected Information may also be used for health care operations, which are necessary to ensure the provider gives the highest quality of care. For example, your Protected Information may be used for quality assurance or risk management purposes. We may at any time remove information which could identify you from your record so as to prevent others from learning who the specific patients are. In addition, we may release your Protected Information to another individual or entity covered by the HIPAA privacy regulations that has a relationship with you for their fraud and abuse detection or compliance purposes, quality assessment and improvement activities, or review, evaluation or training of health care professionals or students.

Disaster Relief:
We may disclose your Protected Information to an organization assisting in disaster relief efforts; however, we will first ask your permission to disclose such information if possible. If seeking your permission is not feasible, we will disclose the information if in our professional judgment we determine the disclosure is in your best interest or that you would not have objected to the disclosure.

Special Circumstances:
Situations may arise which warrant us to use or disclose Protected Information without your consent or authorization. The law specifically allows us to use or disclose Protected Information without your consent or authorization in the following special circumstances:

Public Health Activities

We are allowed to use or disclose your Protected Information for public health activities and purposes. Examples of public health activities which would warrant the use or disclosure of your Protected Information include:

- Preventing or controlling disease, injury, or disability;
- Reporting births or deaths;
- Reporting the abuse or neglect of a child or dependent adult;
- Reporting reactions to medications or problems with products;
- Notifying individuals exposed to a disease that may be at risk for contacting or spreading the disease.

Health Oversight Activities

Your Protected Information may be used or disclosed to a health oversight agency for activities authorized by law. Examples of health oversight activities include audits, investigations, inspections, or judicial/administrative proceeding, which you are not the subject of. In most cases, the oversight activity will be for the purpose of overseeing the care
rendered by Bee Well Healthcare, PLLC or our agency's compliance with certain laws and regulations.

Judicial and Administrative Proceedings

If you are involved in a lawsuit or other administrative proceeding, we may release your protected information in response to a court or administrative order requesting the release. In some instances, we may also release Protected Information pursuant to a subpoena or discovery request but only if efforts have been made by the requestor to provide you with notice of the request and you have failed to object or the objection was resolved in favor of disclosure, or in the alternative, the requestor has obtained a protective order protecting the requested information.

Victims of Abuse or Neglect

Other than child and dependent adult abuse which is covered under public health activities, we may use or disclose your protected information to a protective services or social services agency or other similar government authority, if we reasonably believe you have been the victim of abuse, neglect or domestic violence as long as you agree to such disclosure and we feel it is necessary to prevent serious harm to you or other individuals. If you are incapacitated and unable to agree to such a disclosure, we may release your protected information for this purpose but only if failure to release it would materially and adversely affect a law enforcement activity and the information will not be used in any way against you.

Law Enforcement

We may also release your Protected Information to a law enforcement official for the following purposes:

- Pursuant to a court order, warrant, subpoena/summons or administrative request;
- Identifying or location a suspect, fugitive, material witness or missing person;
- Regarding a crime victim, but only if the victim consents or the victim is unable to consent due to incapacity and the information is needed to determine if a crime has occurred, non- disclosure would significantly hinder the investigation and disclosure is in the victim's best interest;
- Regarding an incident, to alert law enforcement that the individual's death was caused by suspected criminal conduct; or
- By emergency care personnel if the information is necessary to alert law enforcement of a crime, the location of a crime or characteristics of the perpetrator.

Coroner, Medical Examiners, Funeral Homes

Protected Information regarding a deceased individual may be released to a coroner or medical examiner for the purpose of identifying a deceased person, determining cause of death or other duties as authorized by law. Protected Information regarding a decedent may also be disclosed to funeral directors if necessary to carry out their duties.

Specialized Government Functions

Your Protected Information may be used or disclosed for a variety of government functions subject to some limitations. These government functions include:

- Military and veterans activities;
- National security and intelligence activities;
- Protective service of the President and others;
- Medical suitability determinations for Department of State officials;
- Correctional institutions and law enforcement custodial situations; or
- Provision of public benefits.

Organ Donation

Your Protected Information may be used or disclosed by us to entities engaged in the procurement, banking or transplantation of organs, eyes or tissues for the purpose of facilitating such donation and transplantation.

Worker's Compensation

We are allowed to disclose your Protected Information as authorized and to the extent necessary to comply with laws relating to workers' compensation or other programs providing benefits for work-related injuries or illness without regard to fault.

More Stringent Laws:

Some of your Protected Information may be subject to other laws and regulations afforded greater protection that what is outlined in this Notice. For instance, HIV/AIDS, substance abuse, and mental health information are often given more protection. In the event your Protected Information is afforded greater protection under federal or State law, we will comply with the applicable law.

Your Rights:

Federal law (Health Insurance Portability and Accountability Act of 1996) grants you certain rights with respect to your Protected Information. Specifically you have the right to:

- Receive notice of our policies and procedures used to protect your Protected Information;
- Request that certain uses and disclosures of your Protected Information be restricted provided, however, if we may release the information without your consent or authorization, we have the right to refuse your request;
- Access to your Protected Information provided, however, the request must be in writing and may be denied in certain limited situations;
- Request that your Protected Information be amended;
- Obtain an accounting of certain disclosures by us of your Protected Information for the past six years;
- Revoke any prior authorizations or consents for use or disclosures of Protected Information, except to the extent that action has already been taken; and
- Request communications of your Protected Information are done by alternative means or at alternative locations.

NOTICE:

You or your personal representative have the right to express complaints to Bee Well Healthcare, PLLC if you or your representative believe that your rights have been violated.

Bee Well Healthcare, PLLC encourages you to express any concerns you may have regarding your care.

Any complaints to Bee Well Healthcare, PLLC should be made in writing to

Bee Well Healthcare, PLLC
10214 N. Tatum BLVD Suite A 1600
Phoenix, AZ 85028
Office 480-694-7042
Fax 480-444-1478

You may also contact the Department of Health Services with the contact information provided

Arizona Department of Health Services

150 North 18th Avenue, Suite 450, Phoenix, AZ 85007
Office (602) 542-6635

Fax (602) 792- 0466
http://www.azdhs.gov/

Patient's Rights
(9 A.A.C. 10, Article 6, effective July 1, 2014)

1. Every patient is treated with dignity, respect, and consideration.

2. A patient is not subjected to:
    a. Abuse
    b. Neglect
    c. Exploitation
    d. Coercion
    e. Manipulation
    f. Sexual Abuse
    g. Sexual Assault
    h. Seclusion
    i. Restraint
    j. Retaliation for submitting a complaint to the Department or other entity.
    k. Misappropriation of personal and private property by the primary & palliative personnel members, employees, volunteers, or students.

3. A patient or the patient's representative:
    a. Except in an emergency, either consents to or refuses treatment;
    b. May refuse or withdraw consent for treatment before treatment is initiated;
    c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications.
    d. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to primary for identification and administrative purposes.
    e. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
        i. Medical Records
        ii. Financial Records
    f. Is informed of:
        i. The components of primary & palliative services provided by the agency
        ii. The rates and charges for the components of primary and palliative services before the components are initiated and before a change in rates, charges, or services.
        iii. The hospice's policy on health care directives
        iv. The patient complaint process.
    g. Is informed that a written copy of rates and charges, as required in A.R.S. 36-436.03, may be requested.

4. A patient has the following rights:
    a. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
    b. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
    c. To receive privacy in treatment and care for personal needs.
    d. To review, upon written request, the patient's own medical record according to A.R.S. 12-2293, 12-2294, and 12-2294.01
    e. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment.
    f. To participate or refuse to participate in research or experimental treatment
    g. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights.

CHRONIC CARE MANAGEMENT FAQs

What is it?

Chronic care management (CCM) services are generally non-face-to-face coordination services provided to patients who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient. These chronic conditions place the patient at significant risk for death, acute exacerbation/decompensation, or functional decline. CCM services are critical components of primary care that promote better health and reduce overall health care costs because they create a platform for a continuous relationship with a patient's care team. CCM can be initiated in a face-to-face visit with one of our providers during your Annual Wellness Visit, in a Preventive Physical Exam or in a regularly scheduled appointment.

What are examples of chronic conditions?

Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

What will it cost me?

We bill your insurance for these services. You will only incur a bill if your insurance does not cover the service, but most insurances do cover CCM. You may be responsible for a small co-pay in the event you do not have a secondary or supplemental insurance to your primary insurance.

What is available to me for this service?

We produce a comprehensive care plan for you that includes a list of your conditions, expected outcome and prognosis for each of the conditions, measurable treatment goals, symptom management, planned interventions and identification of the individuals responsible for each intervention, medication management, community and social services ordered, a description of how services of agencies and specialists outside the practice will be directed or coordinated and a schedule for periodic review and, when applicable, revision of the care plan. In this endeavor, we also work closely with home health and hospice teams to get you the best coordination of care possible.