BEEWELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

PATIENT INFORMATION

Fields with asterisk are required

Last name*: _____ **First name*:** _____ **Middle initial:** _____

Name you would like to appear on your health records: _____ **DOB*:** _____

Social Security#*: _____ **Drivers license #*:** _____ **Email address*:** _____

Home address*: _____ **APT #:** _____ **City*: State*: ZIP*:** _____

☐ **Home #*:** _____ ☐ **Most** **Mobile #*:** _____ (Please check the best number to use)

recent PCP*: _____ **Phone #:** _____ **Fax #:** _____

IF THE PATIENT IS LIVING IN AN ASSISTED LIVING FACILITY OR GROUP HOME*

Name of Facility*: _____ **Room #:** _____

Address*: _____ **City*: State*: ZIP*:** _____

POA CONTACT INFORMATION

Last name*: _____ **First name*:** _____ **Middle initial:** _____

Home address*: _____ **APT #:** _____ **City*: State*: ZIP*:** _____

☐ **Home #*:** _____ ☐ **Mobile #*:** _____ (Please check the best number to use) **Email**

Address*: _____ **Relationship to the patient*:** _____

Marital Status/Living arrangements*: _____

POA legal paperwork is required for us to speak to your POA about anything related to you or your treatment.

Please fax this information to 480.444.1478 PRIOR to your first appointment.

INSURANCE

Primary Insurer*:	**Name of Insured***
Insurance ID# / Group # / Other Information	
Secondary Insurer *	**Name of Insured***
Insurance ID# / Group # / Other Information	
Tertiary Insurer*	**Name of Insured***
Insurance ID# / Group # / Other Information	
Pharmacy Insurer*	**Name of Insured***
Insurance ID# / BIN # / PCN # / Group #/ Other information	
Preferred Pharmacy Address & Location #*	
Phone #*	**Fax #***

A COPY OF ALL YOUR INSURANCE CARDS IS PREFERRED AS NUMBERS CAN BE UNINTENTIALLY TRANSPOSED OR MISSED

BEEWELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

Personal Medical History – Constitutional e.g., fever, heat stroke, weight loss or gain, fatigue, etc. ☐ Yes ☐ No

Comments: _____

Ear/Nose/Throat – hearing loss, stuffy nose, earache, cough, dry mouth, trouble swallowing, etc. ☐ Yes ☐ No

Comments: _____

Heart (Cardiovascular) – high blood pressure, racing pulse, chest pain, unable to exercise, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Lungs (Respiratory) – congestion, wheezing, shortness of breath, productive or bloody cough, asthma ☐ Yes ☐ No

Comments: _____

Digestion (Gastrointestinal) – stomach upset, diarrhea, constipation, hernia, ulcers, cramps, acid reflux, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Muscles & bones (Musculoskeletal) – muscle pain, joint pain or swelling, stiffness, etc. ☐ Yes ☐ No

Comments: _____

Urological – painful or frequent urination, burning, impotence, incontinence, infections, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Gynecological – ovarian or uterine conditions, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Breast – cysts, fibroids, pain, numbness, lumps, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Neurological – numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Psychiatric – depression, anxiety, mood swings, insomnia, hallucinations, disorientation, memory, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

BEEWELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

Blood/Lymphatic – high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, swelling, etc. ☐ Yes ☐ No

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Skin – Itching, rash, infection, ulcer, tumors or growths, warts, excessive dryness, etc. ☐ Yes ☐ No

Comments: _____

Cancer – current diagnosis or history of ☐ Yes ☐ No

Do you see an oncologist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Comments: _____

Allergic/Immunologic – recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc. ☐ Yes ☐ No

Comments: _____

Hormones (Endocrine) – Diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc. ☐ Yes ☐ No

Comments: _____

If you are a diagnosed diabetic, please indicate if it is Type I or Type 2. ☐ Type 1 ☐ Type 2

Do you see a specialist for your condition? If yes, please provide the provider's name, phone number and when you last saw this provider. Name: _____ Phone #: _____ Date Last seen: _____

Year of diagnosis: _____ Last hemoglobin A1c: _____ Last percentage finding: _____

Comments: _____

Major Illness / Hospitalization admission & discharge / Skilled Nursing Facility admission & discharge: ☐ Yes ☐ No

Comments: _____

Date of Illness or Admission & Discharge: _____/_____

Surgeries: ☐ Yes ☐ No

Comments: _____

Date of Surgery & Admission & Discharge: _____/_____

Please indicate by checking the boxes below for details about any systemic disease:

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Hypertension ☐ Arthritis ☐ Other: _____

Comments: _____

PERSONAL SOCIAL HISTORY

Gender: ☐ Male ☐ Female

Have you ever been exposed to venereal disease or a sexually transmitted infection? ☐ Yes ☐ No

Tobacco use: ☐ Never ☐ Everyday use ☐ Intermittent use ☐ Former use ☐ Unknown ☐ Other: _____

Alcohol use: ☐ Never ☐ Everyday use ☐ Intermittent use ☐ Former use ☐ Unknown ☐ Other: _____

Recreational drug use: ☐ Never ☐ Everyday use ☐ Intermittent use ☐ Former use ☐ Unknown ☐ Other: _____

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

☐ Check here if you plan to send a separate medication list document

Medications: List ALL medications you are CURRENTLY taking. (Please include all herbals, vitamins, & supplements.)

Name of Medication	Dose	Frequency	Ordering Provider/Other Information

IF YOU HAVE MORE MEDICATIONS THAN WILL FIT IN THE BOXES ABOVE, PLEASE ATTACH A SEPARATE SHEET.

Allergies: Please list ALL allergies.

Allergy	Severity (scale of 1-10)	Reaction	Treatment Information

OPIOID PATIENT PRESCRIPTION SEARCH & CONSENT

The following Arizona Opioid Prescribing Guidelines were released in November 2014. These are a "voluntary consensus set of guidelines that promote best practices for prescribing opioids for acute and chronic pain." The guidelines were endorsed by a number of state organizations, including the Arizona Medical Association, the Arizona Hospital and Healthcare Association, and the Arizona Nurses Association.

Summary of guidelines: - Opioid medications should only be used for treatment of acute pain when the pain severity warrants that choice, and non-opioid pain medications or therapies do not provide adequate pain relief. - When opioid medications are prescribed for treatment of acute pain, the number dispensed should be no more than the number of doses needed. - When opioid medications are prescribed for acute pain, patient should be counseled that:

- Sharing with others is illegal.
- Medications should be stored securely.
- Medications should be disposed of properly when the pain has resolved to prevent non-medical use of medications.
- Opioids are intended for short-term use only.
- Driving or operating machinery should be avoided if a patient is sedated or confused while using opioids.

Long-acting opioids should not be used for treatment of acute pain, except in select opioid tolerant patients, and limited situations. - The continued use of opioids should be considered carefully, including assessing the potential for misuse

The provider should assess for risk of misuse, addiction, or adverse effects, and perform risk stratification before initiating opioid treatment. Also, the provider should obtain and document informed consent including discussion of risks, benefits, and conditions under which opioids are prescribed or discontinued.

On October 24, 2016, Governor Dough Ducey issued an executive order limiting all initial prescriptions of opioids to no more than a seven-day dose. Link to the Executive Order: http://azgovernor.gov/sites/default/files/prescription_opioid_initial_fill_limitation_e.o_0.pdf

As noted above, there is a 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."

_____ _____ _____

Patient's or POA's printed name8 **Patient's or POA's Signature*** **Date***

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

FREQUENTLY ASKED QUESTIONS ABOUT CHRONIC CARE MANAGEMENT (CCM)

What is Chronic Care Management (CCM)?
Chronic care management services involve non-face-to-face coordination provided to patients with two or more chronic conditions expected to last at least 12 months. These conditions significantly increase the risk of death, acute exacerbations, or functional decline. CCM plays a crucial role in primary care by fostering ongoing relationships with patients' care teams. It can be initiated during an Annual Wellness Visit, Preventive Physical Exam, or a scheduled appointment.

What are examples of chronic conditions?
Chronic conditions include Alzheimer's disease, arthritis (osteoarthritis and rheumatoid), asthma, atrial fibrillation, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), depression, diabetes, hypertension, and infectious diseases like HIV/AIDS.

What will it cost me?
We bill your insurance for CCM services. If your insurance does not cover the service, you may receive a bill. However, most insurances cover CCM. You may have a small co-pay if you lack secondary or supplemental insurance and Tricare 4 Life does not pay for CCM ultimately perhaps resulting in a $10 copay.

What is available to me for this service?
We develop a comprehensive care plan for you, including a list of your conditions, expected outcomes, treatment goals, symptom management, planned interventions, medication management, ordered community and social services, coordination with external agencies and specialists, and a schedule for periodic review and revision of the care plan. We collaborate closely with home health and hospice teams to ensure optimal care coordination.

Can I opt out of this service?
Yes, you can opt out by notifying us in writing that you do not want this service, but it is the best way to manage several chronic conditions because it enables all your providers to communicate effectively about your care.

To opt out, please send a fax or written communication indicating you do not want Chronic Care Management to the office at:

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

CALL: 480-694-7042
FAX: 480-444-1478

EMAIL: INFO@BEEWELLAZ.COM

FREQUENTLY ASKED QUESTIONS ABOUT CARE FOR PATIENTS ON HOSPICE OR IN NEED OF PALLIATIVE CARE

For those of our patients who join us already on hospice, or entering a hospice certification period subsequently, you should know we can still see you for other **non-hospice** related diagnoses while you are being cared for by a hospice nurse or physician. **Anytime** a patient enters Hospice, Medicare Part B is billed no matter what other Advantage plan you may have but this is ONLY while you are hospice. Should you be discharged from hospice, your Advantage insurance again becomes your primary insurance. You may just feel more comfortable being seen by us in **addition** to your hospice provider since we will know **all** your diagnoses rather than just your hospice diagnosis.

We also provide the medical portion of Palliative care. Palliative care is for people at any stage of illness. The illness is **NOT** required to be life-limiting. Patients seeking hospice are NOT seeking a cure for their illness. Palliative care patients can seek treatment to cure their illness or prolong their lives. Like hospice care, palliative care addresses a patient's physical, emotional, social and spiritual needs. We will take care of your physical needs, we can refer you to people who can help with your emotional, social and spiritual needs. To be clear, palliative patients are commonly seeking relief from pain, fatigue, nausea or the stress that comes with a serious illness or the side effects from medical treatment.

The above information is provided to make you informed of your options.

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO BEE WELL HEALTHCARE, PLLC

Last name*: _____ **First name*:** _____ **DOB*:** _____
Address*: _____

DO NOT FILL OUT BELOW
EXCEPT FOR YOUR SIGNATURE AT THE BOTTOM OF THIS PAGE

I authorize Bee Well Healthcare, PLLC to obtain from:

_____ Fax #: _____
Doctor or hospital name

Address: _____ City: _____ Zip: _____

Any information about my health and health care, including diagnosis, treatment, or examination rendered to me during the time period from: _____ to _____

CONFIDENTIALTY POLICY (Please read before signing)
Medical records are maintained to serve the patient and the health care team in accordance with all applicable legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The phrase "medical records" includes any protected health information (PHI), which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address, or fax number will require a separate authorization.

I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization. For the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing.

I understand this authorization is voluntary and may refuse to sign it.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

Patient or authorized representative signature*: _____ **Date*:** _____

Patient or authorized representative name*: _____ **Relationship to patient*:** _____

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name*: _____ **DOB*:** _____ **Phone*:** _____

Address*: _____ **City*:** _____ **State*:** _____ **ZIP*:** _____

I authorize the use or disclosure of the above-named individual's health information as described below, by:

BEE WELL HEALTHCARE, PLLC

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

☒ Complete health records Lab results/X-ray reports ☒ Medical exam Consultation reports ☒ Immunization record
☒ Lab results/X-ray reports ☒ Consultation reports ☐ Other: _____

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 health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

Bee Well Healthcare, PLLC

At the request of the patient or their POA.

The patient or their POA has been advised that they have a right to revoke this authorization at any time. He or she understands that if they revoke this authorization, they must do so in writing and present a written revocation to the health information management department. The patient or their POA also understand that the revocation will not apply to their insurance company when the law provides their insurer with the right to contest a claim under their policy. The patient or their POA understands that authorizing the disclosure of this health information is voluntary. The patient or their POA can refuse to sign this authorization. They need not sign this form to receive continued treatment. They understand that the provider may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. They further understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signature below demonstrates understanding of the paragraph above.

Signature of participant or representative*: _____ **Date*:** _____

Printed name of patient or representative*: _____

Description of personal representative's authority*: _____

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

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's or POA's printed name	Patient's or POA's Signature*	Date*

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

PATIENT FINANCIAL RESPONSIBILITY FORM / SELF-PAY WAIVER

Thank you for choosing Bee Well Healthcare, PLLC for your medical needs, we are committed to providing you the highest quality healthcare. We ask that you read, make the appropriate selection, and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian/POA) is ultimately responsible for the payment for treatment and care provided by Bee Well Healthcare, PLLC.

PLEASE CHECK ONE BELOW:

☐ Check here if you agree to the self-pay rate for services rendered, at time of service.

If you wish to be a self-pay / Cash pay patient, you agree to pay $200 for an initial visit and $100 for subsequent visits thereafter.

☐ Check here if you elect to use available medical insurance for visit coverage. Self-pay rates will not apply after date of service.

- We will bill your insurance for you; however, the patient is required to provide the most correct and updated information regarding insurance.
- In the event, insurance denies payment or balance remains beyond 90 days, patient will be financially responsible for the debt. Payment programs will be made available to help the patient and Bee Well Healthcare, PLLC mitigate balances.
- Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Copays are due at the time of service.
- Coinsurance, deductibles, and non-covered items are due after your insurance(s) have responded.
- Patients may incur, and are responsible for payment of additional charges, if applicable.

RELEASE OF INFORMATION: I authorize Bee Well Healthcare, PLLC to disclose and release to my insurance carrier(s), including Medicare, Medicaid, Medigap/Supplemental benefits providers, and private insurers, as applicable, any medical and treatment information needed for payment purposes for services rendered. I authorize use of this form for the release of information needed to process claims to all my insurance carrier(s) and its authorized agents. I authorize my provider/practice to act as my agent in helping obtain payment from my insurance companies.

ASSIGNMENT OF BENEFITS: I assign all payments, rights and claims for reimbursement of claims, costs and expenses allowable under my insurance plan(s) directly to my provider or practice for services rendered. I understand I will receive a statement for any balance due by me and I agree to make full payment upon receipt of the statement after insurance has met its obligation.

AGREEMENT OF RESPONSIBILITY: I understand that **COPAYMENT IS DUE AT THE TIME OF SERVICE** (coinsurance and deductibles may also be collected at the time of service). I understand I am financially responsible for charges not covered by my insurance company. I also agree to pay any outstanding balance as well as attorney fees and costs to **Bee Well Healthcare, PLLC** if this matter is referred to collection.

MEDICARE AUTHORIZATION: If a Medicare beneficiary, I understand my signature requests payment to be made and authorize the release of medical information necessary to pay claims. If 'other health insurance' is indicated in item 9 of the HCFA-1500 Form, or elsewhere on approved claim forms, or electronically submitted claims, my signature authorizes the release of information to insurance companies or its authorized agents. In Medicare-assigned cases, the physician or supplier agrees to accept the charge of determination of the Medicare carrier as the full charge, and I agree I am responsible for deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

By my signature below, I hereby authorize assignment of financial benefits directly to Bee Well Healthcare, PLLC and any associated healthcare entities for services rendered as allowable under standard third-party contracts.

I understand that I am financially responsible for charges not covered by this assignment.

I also accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/ or court costs, if such be necessary.

Printed Patient Name/POA Name*: _____ **Date***:_____

Patient/ Guardian Signature*: _____

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

NOTICE OF PRIVACY PRACTICES

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

At BEE WELL HEALTHCARE, PLLC ("Practice"), we understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive directly from one of our physicians. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice of Privacy Practices ("Notice") applies to all the records of your care generated by Practice.

This Notice will tell you about the ways in which Practice may use and disclose your protected health information ("PHI"). This Notice also describes your rights and certain obligations Practice has regarding the use and disclosure of PHI.

REGULATORY REQUIREMENTS.
The practice is required by law to maintain the privacy of your PHI, to provide individuals with notice of Practice's legal duties and privacy practices with respect to PHI, and to abide by the terms described in the Notice currently in effect.

RIGHTS.
You have the following rights regarding your PHI:

RESTRICTION.
You may request that Practice restrict the use and disclosure of your PHI. To request restrictions, you must make your request in writing to our Privacy Officer using the applicable Practice form. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

ALTERNATIVE COMMUNICATIONS.
You have the right to request that communications of PHI to you from Practice be made by particular means or at particular locations. For instance, you might request that communications be made at your work address, instead of your home address. Your requests must be made in writing using Practice's form and sent to the Privacy Officer. Practice will accommodate your reasonable requests.

INSPECT AND COPY.
Generally, you have the right to inspect and copy your PHI that Practice maintains, provided you make your request in writing to Practice's Privacy Officer. If you request copies of your PHI, we may impose a reasonable fee to cover copying and postage. If we deny access to your PHI, we will explain the basis for denial and your opportunity to have your request and the denial reviewed by a licensed health care professional (who was not involved in the initial denial decision) designated as a reviewing official. If Practice does not maintain the PHI you request and if we know where that PHI is located, we will tell you how to redirect your request.

AMENDMENT.
If you believe that your PHI maintained by Practice is incorrect or incomplete, you may ask us to correct your PHI. Your request must be made in writing, and it must explain why you are requesting an amendment to your PHI. We can deny your request if your request relates to PHI: (i) not created by Practice; (ii) not part of the records Practice maintains; (iii) not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, we will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and Practice's denial attached; and (iii) complain about the denial.

ACCOUNTING OF DISCLOSURES.
You generally have the right to request and receive a list of the disclosures of your PHI we have made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003). The list will not include disclosures made at your request, with your authorization, and does not include certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment and health care operations; (ii) made to you; (iii) for Practice's patient list; (iv) for national security or intelligence purposes; or (v) to law enforcement officials. You should submit any such request to Practice's Privacy Officer. Practice will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of the costs of providing the list.

RIGHT TO COPY OF NOTICE.
You have the right to receive a paper copy of this notice upon request. To obtain a paper copy of this notice, please contact the Privacy Officer at the address and contact information stated at the end of this notice.

BEEWELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.
Practice may use or disclose your PHI for the purposes described below **without obtaining written authorization from you**. In addition, Practice and the members of its medical and allied health professional staff who participate in the organized health care arrangement described below may share your PHI with each other as necessary to carry out their treatment, payment and health care operations related to the organized health care arrangement.

FOR TREATMENT.
Practice may use and disclose PHI while providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider.

FOR PAYMENT.
Practice may use and disclose PHI to bill and collect payment for the health care services provided to you. For example, Practice may need to give PHI to your health plan to be reimbursed for the services provided to you. Practice may also disclose PHI to its business associates, such as billing companies, claims processing companies and others that assist in processing health claims. Practice may also disclose PHI to other health care providers and health plans for the payment activities of such providers or health plans.

FOR HEALTH CARE OPERATIONS.
Practice may use and disclose PHI as part of its operations, including for quality assessment and improvements, such as evaluating the treatment and services you receive and the performance of staff and physicians in caring for you, patient surveys, provider training, underwriting activities, compliance and risk management activities, planning and development, credentialing and peer review activities, and health care fraud and abuse detection or compliance, and management and administration. Practice may disclose PHI to doctors, nurses, technicians, students, attorneys, consultants, accountants and others for review and learning purposes, to help make sure Practice is complying with all applicable laws, and to help Practice continue to provide quality health care to its patients.

AS REQUIRED BY LAW AND LAW ENFORCEMENT.
Practice may use or disclose PHI when required to do so by applicable laws and when ordered to do so in a judicial or administrative proceeding. Practice may also use or disclose PHI upon a properly documented and limited request from law enforcement agencies.

FOR PUBLIC HEALTH ACTIVITIES AND PUBLIC HEALTH RISKS.
Practice may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, or notifying a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

FOR HEALTH OVERSIGHT ACTIVITIES.
Practice may disclose PHI to the government for oversight activities authorized by law, such as audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities necessary for monitoring the health care system, government programs and compliance with civil rights laws.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS.
Practice may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

RESEARCH.
Under certain circumstances, Practice may use and disclose PHI for medical research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication with those who received another, for the same condition.

TO AVOID A SERIOUS THREAT TO HEALTH OR SAFETY.
Practice may use and disclose PHI to law enforcement personnel or other appropriate persons to prevent or lessen a serious threat to the health or safety of a person or the public.

SPECIALIZED GOVERNMENT FUNCTIONS.
Practice may use and disclose PHI of military personnel and veterans under certain circumstances. Practice may also disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities, and for the provision of protective services to the president or other authorized persons or foreign heads of state or to conduct special investigations.

DISCLOSURES TO YOU OR FOR HIPAA COMPLIANCE INVESTIGATIONS.
Practice may disclose your PHI to you or to your personal representative and is required to do so in certain circumstances described below in connection with your rights of access to your PHI and to an accounting of certain disclosures of your PHI. Practice must disclose your PHI to the secretary of the United States Department of Health and Human Services (the "Secretary") when requested by the Secretary in order to investigate Practice's compliance with privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996.

PATIENT LIST &/OR MARKETING.
Unless you object, Practice may use some of your PHI to maintain a list of patients it has served. This information may include your name, treatment facility, and the services Practice provided to you. This patient list and the information on it may be used for marketing purposes.

BEE WELL
HEALTHCARE

Patient Name: _____ DOB: _____ (Required on EACH page of packet)

DISCLOSURES TO INDIVIDUALS INVOLVED IN YOUR HEALTH CARE OR PAYMENT FOR YOUR HEALTH CARE.
Unless you object, Practice may disclose your PHI to a family member, other relative, friend, or other person you identify as involved in your health care or payment for your health care.

OTHER USES AND DISCLOSURES.
Other types of uses and disclosures of your PHI not described above will be made only with your written authorization, which with some limitations; you have the right to revoke your authorization in writing. If you revoke your authorization, Practice will no longer use or disclose PHI about you for the reasons covered in your written authorization. Please understand that Practice is unable to recover any disclosures already made with your authorization, and that Practice is required to retain records of the care provided to you.

RIGHT TO FILE A COMPLAINT.
At Practice, we value the relationships we develop with our patients, our patients' privacy, and the trust our patients' have in us. As such, we make every effort to remedy any issues or concerns you may have. You may submit any complaint regarding your privacy rights to:

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

CALL: 480-694-7042
FAX: 480-444-1478

EMAIL: INFO@BEEWELLAZ.COM

You also have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office for Civil Rights at:
Office for Civil Rights
U.S. Department of Health and Human Services

URL: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

PLEASE CONTACT THE PRIVACY OFFICER IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE OF PRIVACY PRACTICES OR YOUR PRIVACY RIGHTS.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
• Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers.
• Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that Bee Well Healthcare, PLLC has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below for a current copy of the *Notice of Privacy Practices* document.

Printed patient or POA name*: _____ **Relationship to patient*: _____**

Signature of patient or POA*: _____ **Date*: _____**

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