District Medical Group **MRN No._____**

PATIENT ADMISSION PACKET

Patient Identification and Financial Responsibility Acknowledgement

Client Name (Last, first, middle): _____

Date of Birth: _____ (Check One) ____Male ____Female

Race (check one) ____American Indian ____Alaska Native ____Asian ____ African American

____ Native Hawaiian ____Caucasian

Ethnicity (check one) ____Hispanic or Latino ____ Not Hispanic or Latino ____Decline

Language(s): _____

Address: _____

Street Address Apt # (if applicable) City State Zip

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

Pharmacy Name: _____Pharmacy Phone: _____

Pharmacy Address: _____

Street Address City State Zip

In case of a medical emergency or any other emergency, please list two emergency contacts below:

Name: _____ Phone: _____

Relationship

Name: _____ Phone: _____

Relationship

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

_____ _____

Name Relationship Name Relationship

_____ _____

Name Relationship Name Relationship

If patient is over the age of eighteen (18) does the patient have an advance directive? _____Yes _____No
If yes, please provide our office with copy. If no, would you like information on advance directives? ____Y ___N

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

Signature Patient/Parent/Guardian

DMG District Medical Group **MRN No._____**

Primary Care Physician (if Different) – Name, Address & Phone Number	

Do you have any religious or cultural beliefs that may affect your healthcare? ____yes ____No ifyes, please describe:

Methods of learning new material that I like best are:

____Verbal Instruction ____Written Instruction ____Visual (Pictures, videos etc.) ____Hand outs

Level of Education Completed:

____<6th Grade ____6th – 8th Grade ____9th Grade ____12th Grade ____1-4 Years of College ____> 4 years of College

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

Is there a secondary insurance company? ____Yes ____No if yes, please provide additional information to staff.

Financial Responsibility Acknowledgment – Please initial each paragraph.

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

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

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

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

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Print name of Patient/Parent/Legal Guardian

District Medical Group **MRN No._____**

Consent for Purpose of Information, Payment and Healthcare Operations

I consent to the use and disclosure of _____'s Protected Health Information by District Medical Group DMG for
Print Patient Name
the purpose of diagnosing, providing treatment, obtaining payment for health care bills or to conduct health care operations of the DMG clinic. I understand that the diagnosis or treatment by the DMG clinic providers may be conditioned upon the consent as evidenced by the authorizing signature and initials on this document.

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

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

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

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

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

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

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Printed Name of Patient/Parent/Legal Guardian

District Medical Group **MRN No._____**

Patient Record of Disclosures

In general the HIPAA privacy rule gives individuals he right to request a restriction onuses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications, or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

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

Home/Mobile Telephone: _____

_____ OK to leave message with detailed info

_____ Leavemessage with call-back number only

_____ Decline personal phone messages

Work Telephone: _____ Work Fax: _____

_____ O.K. to fax to this number

_____ O.K. to leave message with detailed info

_____ Leave message with call back number only

_____ Decline work phone messages

Written Communications:

Email: _____

_____ O.K. to send detailed email to this address

_____ O.K. to mail to my work/office address

_____ O.K. to mail to my home address

Patient Representative to whom information may be given:

Name: _____Relationship: _____ DOB: _____

Name: _____Relationship: _____ DOB: _____

Patient/Parent/Guardian Signature:

_____

Printed Name

DMG District Medical Group **MRN No._____**

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

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

Relationship to the patient: _____Today's date: _____

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

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

Name	Address	Phone Number

Family/Guardian/Decision Making

Who Lives at home with the patient?

Name	Relationship to Patient	Age

Is there a parent who does not live in the house? ___Yes ___No
If yes, what is their name? _____

Does your child have visits with this parent? ___Yes ___No

Will this parent ever bring the patient to appointments at CRS? ___Yes ___No

Will anyone who is not the parent or legal guardian bring your child to the clinic? ___Yes* ___No
*******If Yes, Please complete the authorization to consent for medical treatment of a child. Page 8********

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

Safety and Support

Are you afraid of anyone who lives in (or out of) your home? ___Yes ___No

Do you want to speak with a Social Worker today? _____Yes _____No

Does your child have a behavior problem for which you are not getting help? ___Yes ___No
If yes, what is your concern? _____
_____

CRS Staff Witness:_____ Date:_____

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

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

Community Resources

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

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

Education

Is your child in school yet? _____Yes _____No

Name of School	Grade

Does your child have an IEP? (Individualized Education Plan) or 504 plan? _____Yes _____No

Circle all of the services the child receives at school:

☐ *Regular Classes Special Education* ☐ *ResourcesHomeschool/Online school/Homebound instruction*

☐ *Physical Therapy (PT)* ☐ *Occupational Therapy (OT)* ☐ *Speech Therapy (ST)*

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

District Medical Group **MRN No._____**

General Consent for Treatment

Please initial each paragraph

_____ General consent: I consent to medical care at this facility. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.

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

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

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

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

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

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

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

_____ _____ _____ _____

Patient or Guardian signature Printed Name Relationship to Patient Date

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION

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

_____ _____ _____ _____

Patient or Guardian signature Printed Name Relationship to Patient Date

District Medical Group **MRN No._____**

AUTHORIZATION TO CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, _____Mother/Father of_____

Printed Name of Parent/Legal Guardian Child's Name

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

Do hereby authorize and appoint (please print):

Name:_____Relationship:_____Contact Number:_____

Name:_____Relationship:_____Contact Number:_____

Name:_____Relationship:_____Contact Number:_____

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

End date_____ or Event Name_____

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

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

(Please select preferred method of contact)

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

Parent/legal Guardian Signature: _____ Date:_____

CRS Staff Witness:_____ Date:_____

Notary Public

This form may be taken from the CRS clinic.

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

_____ _____

Notary Date

District Medical Group **MRN No._____**

DISTRICT MEDICAL GROUP
NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. OTHER USES AND DISCLOSURES

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

3. YOUR RIGHTS

i. **Right to this Notice:** Your may request a paper copy of this Notice of Privacy Practices from us at any time.

ii. **Right to request your medical information**: You may request access to the medical information about you that we have in our records. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

iii. **Right to request an amendment to your medicalinformation**: You may request an amendment of your medical information that you believe is incorrect or incomplete. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

iv. **Right to request a restriction of your medical information:** You may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You may also request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to a restriction that you may request. If we do agree to the requested restriction, we may not use or disclose your medical information in violation of the restriction unless it is needed to provide emergency treatment.
You may request that a health care item or service not be disclosed to your health plan for payment purposes or health care operations. We are required to honor your request if the item or service is paid out of pocket and in full. This restriction does not apply to the use or disclosure of your medical information related to your treatment.

v. **Right to request confidential communications from us by alternative means or at an alternative location.** You may request that we communicate with you in a way that is more confidential. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request.

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

4. CHANGES TO THIS NOTICE

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

5. QUESTIONS OR CONCERNS

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

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

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

Office for Civil Rights
US Department of Health and Human Services
90 7th Street, suite 4-100
San Francisco, AZ 941-03
Attn: OCR Regional Manage

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

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

PATIENT RIGHTS

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnoses;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To not be subjected to: Abuse, Neglect, Exploitation, Manipulation, Sexual Abuse, Sexual Assault, Restraint or Seclusion;
4. To not be retaliated against for submitting a complaint to the Arizona Department of Health or any other regulatory agency;
5. To not have private property misappropriated (taken or stolen) by any employee, volunteer or student at the outpatient treatment center;
6. To review, upon written request, the patient's own medical record according to Arizona Revised Statutes *12-229*, *12-2294*, and *12-2294.01*;
7. To receive a referral to another health care institution if the outpatient treatment center is unable to provide physical health services or behavioral health services for the patient;
8. To participate or have the patient's representative participate in the development of, or decisions concerning treatment;
9. To participate or refuse to participate in research or experimental treatment;
10. To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights;
11. Except in an emergency the patient has the right to consent to or to refuse treatment and may withdraw consent before the treatment is started;
12. Except in an emergency the patient will be informed of alternatives to a proposed psychotropic medication or surgical procedure and is informed of associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
13. To receive privacy in treatment and care for personal needs;
14. The patient will be informed on the outpatient treatment center's policy on advanced directives and the clinic's complaint and grievance process;
15. The patient has the right to consent or to refuse having a photograph taken, except when the patient is admitted for administrative identification procedures;

16. To be treated with consideration, respect, and dignity;
17. To send complaints or claims to members of clinical staff, or to outside entities or other individuals without limitation or retaliation;
18. To make fair, timely, and impartial complaints. To receive, upon discharge or transfer, recommendations for treatment; and
19. Except as otherwise permitted by law, the patient has the right to provide written consent for the release of information regarding the patient's medical or financial records.