Our web address is: http://www.pcofmesa.com
You can email us your concerns and questions through our website.

Welcome and thank you for choosing our practice! Included below is information to help you prepare for your visit.

For every appointment with our office, please check in 20 minutes prior to your Scheduled appointment time. This will allow us to ensure we have all the necessary information for each visit with your provider.

In an effort to provide you with the best possible care, our office will require:

First Appointment

VERY IMPORTANT: Please make sure your medical records and referral was provided by your Primary Care Physician prior to your appointment time.

It is your responsibility to obtain a referral through your primary care physician’s office. An authorization of care is required by your insurance carrier for your appointment with Pulmonary Consultants. Your Failure to do will result in charges being billed directly to you.

✓ Picture ID
✓ Insurance Card
✓ Referral from PCP
✓ Pharmacy Info (Name and Phone number)
✓ If your insurance requires a copay, please be prepared to pay At the time of your visit
✓ Completed New Patient Package
✓ Copies of your most recent imaging, lab and procedure results (Chest X Ray, CT Chest, PET Scan, etc.)
  * Please obtain the disk/film to bring to your appointment*
✓ Any pertinent Medical records that will assist in your visit
✓ If you are scheduled for a breathing related concern, please refrain From using a rescue inhaler/nebulizer 2 hours prior to appointment time
  As we may perform a Spirometry breathing test

Every Follow Up Appointment

✓ Copy of current medication list
✓ If your insurance requires a copay, please be prepared to pay
  At the time of your visit
✓ Copies of your most recent imaging, lab and procedure results (Chest X Ray, CT Chest, PET Scan, etc.)
  * Please obtain the disk/film to bring to your appointment*
✓ If you are scheduled for a breathing related concern, please refrain From using a rescue inhaler/nebulizer 2 hours prior to appointment time
  As we may perform a Spirometry breathing test

Complete Pulmonary Function Test

✓ Copy of current medication list
✓ Refrain from using a rescue inhaler/nebulizer 2 hours prior to appointment time

Thank you for the opportunity to be part of your health care team!

Pulmonary Consultants P.C.
PATIENT DEMOGRAPHIC FORM*

Social Security Number: _______________________________ E-mail: _______________________________

Name (last, first, middle): ________________________________________________________________

Primary Address: __________________________________ City __________ State _____ Zip ______

Secondary Address: __________________________________ City __________ State _____ Zip ______

Home Phone: ____________________________ Cell Phone: ______________________________

Email Address: ______________________________

Gender: _____ M _____ F ______________________ Date of Birth: ______________________________

Marital Status: S____ M____ D____ W ______ Ethnicity: i.e., Country of Origin:

Race: American Indian____ Asian____ Black____ White____ Pacific Islander____ Not Provided

Emergency Contact Info:
Name: ___________________________________ Phone: __________________ Relationship: _________

PHARMACY:

Pharmacy Name: ___________________________ Phone __________________________

Pharmacy Address: ______________________________

PHYSICIANS:

Primary Care Physician: ___________________________ Phone __________________________
Address: ________________________________________________

Referring Physician: ___________________________ Phone __________________________
Address: ________________________________________________
*Please bring a copy of your health insurance card, if applicable, with you to your visit

INSURANCES:

Primary Insurance Company: ____________________________

Name of Policy Holder: ____________________________ Date of Birth: ____________

Patient Relationship to Insured: __________________ Insured SSN: ____________

Secondary Insurance Company: ____________________________

Name of Policy Holder: ____________________________ Date of Birth: ____________

Patient Relationship to Insured: __________________ Insured SSN: ____________

Consent for Treatment & Insurance Assignment / Authorization

I hereby authorize Pulmonary Consultants, P.C., to furnish information to insurance carriers concerning my illness, and treatment. I hereby assign to the physicians ALL payments for medical services rendered to myself or dependent. I understand, I am responsible for ANY amount NOT covered by my insurance company. I am responsible for any unpaid amount and agree to pay court cost, including any attorney fees which are incurred in the collection process.

The patient or authorized representative recognizing the need for care consents to ALL or ANY services as ordered by the physicians, including lab procedure, medical treatment, minor or emergency surgical treatment, exam or other services rendered under specific instruction of the physician.

Signature of Responsible Party: ____________________________ Date: ____________
PULMONARY CONSULTANTS
NEW PATIENT MEDICAL HISTORY FORM

Patient Name: ____________________________  Birth Date: ____________
Referring Physician: ______________________  Today’s Date: ____________

PLEASE CHECK ANY CONDITION THAT REPRESENTS SIGNIFICANT PROBLEMS FOR YOU

☐ Fever     ☐ Weight Change     ☐ Frequent Colds     ☐ Hearing Loss
☐ Cough     ☐ Shortness of breath ☐ Anxiety     ☐ Runny/Stuffy Nose
☐ Cough With Phlegm  ☐ Fatigue     ☐ Difficulty Swallowing
☐ Hoarseness     ☐ Snoring     ☐ Memory Loss

PLEASE CHECK ANY CONDITIONS YOU HAVE BEEN DIAGNOSED WITH BELOW:

☐ Lung Nodule     ☐ Emphysema     ☐ Pulmonary Embolism     ☐ Hepatitis B
☐ Lung Cancer     ☐ Pulmonary Hypertension ☐ Heart Disease     ☐ Seizure Disorder
☐ Sarcoidosis     ☐ Pneumonia     ☐ Kidney Disease     ☐ Positive TB
☐ Pulmonary Fibrosis ☐ Chronic Bronchitis ☐ Macular Degeneration ☐ Lupus
☐ Asthma     ☐ Fluid On The Lungs ☐ Glaucoma Stroke ☐ Anemia
☐ COPD     ☐ Sleep Apnea ☐ Asbestos Exposure ☐ Hypertension
☐ Hyperlipidemia ☐ Cancer ☐ Rheumatoid Arthritis ☐ Osteoporosis
☐ Osteopenia ☐ Liver Disease ☐ Hypothyroidism ☐ Diabetes
☐ Congestive Heart Failure
ALLERGIES

Food Allergies: ________________________________________________

Drug Allergy and Reactions:
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

ENVIRONMENTAL ALLERGIES

☐ CATS  ☐ ANIMAL  ☐ POLLEN  ☐ TREES  ☐ DUST  ☐ SMOKE
☐ DOGS  ☐ DANDER  ☐ GRASS  ☐ MOLD  ☐ PERFUME  ☐ BLOOMING PLANTS
☐ CITRUS TREES  ☐ OLIVE TREES

VACCINATIONS

☐ Flu Vaccine  Date of Last Injection: _____________________________
☐ Shingles Vaccine  Date of Last Injection: _________________________
☐ Pneumonia 23 Vaccine  Date of Last Injection: _______________________
☐ Prevnar 13 Pneumonia Shot  Date of Last Injection: ________________
☐ DTAP  Date of Last Injection: _________________________________

PLEASE LIST ALL SURGERIES AND YEARS

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
PLEASE LIST ALL MEDICATION DOSAGE AND FREQUENCY BELOW


SOCIAL HISTORY

Alcohol Use - □ Never □ Occasionally □ Daily Type: ______________________________

Tobacco Use- □ Never □ Previously, but quit-year_____ Packs Per Day_______ for _____ years

Drugs Use- □ Never □ Occasionally □ Daily Type: ______________________________

Do you use illegal drugs?_______________

Do you use Marijuana?_______________

What is your occupation?__________________________

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Name of spouse or significant other:____________________________

Children: Number of Children__________________________________________

Where were you born?_______________________________________________

How long have you lived in Arizona?______________________________

Would you like access to your medical record online?__________________

Please list other doctors you visit

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________
FAMILY HISTORY

PLEASE INDICATE THE CURRENT STATUS OF YOUR IMMEDIATE FAMILY MEMBERS

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Date of Death</th>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>MOTHER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BROTHERS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SISTERS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRANT PARENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AUNT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNCLE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHILDREN</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ADDITIONAL COMMENTS:
# Authority To Use Or Disclose Health Information

**Patient Name:** ___________________________  
**Date of Birth:** ___________________________

**PLEASE RELEASE THE FOLLOWING INFORMATION:**

<table>
<thead>
<tr>
<th>Medication List</th>
<th>Any and/or All Lab Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most Recent Progress Note For Visit</td>
<td>Any and/or All X-rays or Imaging Reports</td>
</tr>
<tr>
<td>History and/or Physical</td>
<td>Other__________________________</td>
</tr>
<tr>
<td>Entire Medical Record</td>
<td></td>
</tr>
</tbody>
</table>

**THE PURPOSE OF THIS REQUEST IS FOR:**

<table>
<thead>
<tr>
<th>The Disclosure is at Patient Request</th>
<th>Government Agency/Police</th>
</tr>
</thead>
<tbody>
<tr>
<td>Further Medical Care</td>
<td>Attorney/Legal Investigation</td>
</tr>
<tr>
<td>Disability Determination</td>
<td>Personal Use (Patient)</td>
</tr>
<tr>
<td>Insurance/Release</td>
<td></td>
</tr>
</tbody>
</table>

I HEREBY AUTHORIZE:  
Pulmonary Consultants  
6750 E Baywood Avenue, Suite 401  
Mesa, AZ 85206  
Telephone: 480-835-7111  FAX: 480-889-9345

**TO DISCLOSE PROTECTED HEALTH INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:**

__________________________________________________________________________
__________________________________________________________________________

I understand that the information in my health records may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I 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.

This authorization will automatically expire within 12 months from the date signed below.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary, I need not sign this form to ensure healthcare treatment.

**Signature of Patient or Legal Representative**

**Date**

**If Patient is unable to consent by reasons of age, or some other fact, state reasons:**

__________________________________________________________________________

**Legally Authorized Representative**

**Date**  
**Relationship to Patient**

*Revised 11/2012*
TO RECEIVE MR

Authority To Use Or Disclose Health Information

Patient Name: ____________________________  Date of Birth: ____________________________

PLEASE RELEASE THE FOLLOWING INFORMATION:

☐ Medication List  ☐ Any and/or All Lab Work
☐ Most Recent Progress Note For Visit  ☐ Any and/or All X-rays, Imaging
☐ History and/or Physical  ☐ Reports
☐ Entire Medical Record  ☐ Other

THE PURPOSE OF THIS REQUEST IS FOR:

☐ The Disclosure is at Patient Request  ☐ Government Agency/Police
☐ Further Medical Care  ☐ Attorney/Legal Investigation
☐ Disability Determination  ☐ Personal Use (Patient)
☐ Insurance/Release

I HEREBY AUTHORIZE:

__________________________________________________________________________

__________________________________________________________________________

TO DISCLOSE PROTECTED HEALTH INFORMATION RELATIVE TO MY TREATMENT AND CARE TO:

Pulmonary Consultants
6750 East Baywood Avenue, Suite 401
Mesa, AZ 85208
Telephone# 480-835-7111  FAX: 480-969-9345

I understand that the information in my health records may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

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Signature of Patient or Legal Representative  Date

If patient is unable to consent by reason of age, or some other fact, state reasons:

__________________________________________________________________________

Legally Authorized Representative  Date  Relationship to Patient

Revised 11/2012
PULMONARY CONSULTANTS

OFFICE POLICIES

Thank you for choosing Pulmonary Consultants. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. The staff at Pulmonary Consultants Group strives to exceed expectations in care and service in order to make your experience with us as comfortable and stress-free as possible. Our goal is to provide quality medical care in a timely manner. In order to do so we have implemented an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care. Please feel free to contact our office if you have any questions regarding our policies.

OFFICE HOURS:

Our office is available Monday-Friday 8:00am to 5:00pm, and may be reached at (480)835-7111. If you need an appointment, prescription refill or test results, please call during regular business hours. If you reach us after hours please leave us a brief message along with your name, date of birth and phone number. We will get back to you next business day.

APPOINTMENTS:

When calling for an appointment, please provide your name, telephone number, chief complaint/reason for visit, as well as any updated contact and insurance information. We strive to give all of our patients the time that they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling become necessary on your appointment date. To ensure quality care, Pulmonary Consultants Group, does not treat patients we have not seen (i.e., we will not call in prescriptions or offer medical advice for patients prior to their initial visit). Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare can be determined.

RELEASE OF MEDICAL INFORMATION

I authorize Pulmonary Consultants, P.C., to receive or release medical records concerning myself to any physician, hospital, or agency involved in my care.

RELEASE OF ELECTRONIC MEDICAL INFORMATION

I authorize Pulmonary Consultants, P.C., to receive or release, through the CCHIT/HITECH software which meets or exceeds the Federal standard for encrypted electronic medical records concerning myself to or from any pharmacy. Physician, hospital or agency involved in my care.

ASSIGNMENT OF MEDICAL BENEFITS

I request payment under my insurance policy card which was presented and verified at the time of service be made directly to the provider listed on any claim for services furnished to me during the effective period of this policy and authorization. I authorize Pulmonary Consultants P.C. to release to Social Security Administration, intermediaries or managed carriers any information required for this claim or any related Medicare claim. I authorize the release of any information necessary to determine eligibility and/or benefits payable for the services rendered to me.
HIPPA POLICY

I have reviewed the posted HIPPA Policy of Pulmonary Consultants P.C.'s Health Information Portability and Accountability Act, and understand my health information will be protected by this act according to the written policy of Pulmonary Consultants, P.C. I may request to speak with the HIPPA Policy Officer at (480)835-7111, should there be any issues or concerns regarding this policy.

PAYMENT POLICY

Co-payments will be collected at the time of services, which are provided to me. Pulmonary Consultants accepts checks and debit cards, Visa or Master Card payment. I am ultimately responsible for all charges for medical services provided even if claim is submitted to another party for services which are provided to me. If Pulmonary Consultants is contracted with the insurance carrier, they will accept contractual rate as outlined within the terms of Pulmonary Consultants contract for the services billed. However, I will be responsible for any balances which are deemed patient responsibility, non-payable or non-covered by my insurance carrier which be billed accordingly. I am expected to make full payment upon receipt of a statement unless I have made a written payment arrangement with Pulmonary Consultants through their Billing Department upon receipt of the statement. Failure to make schedule payments will result in the transfer of my unpaid account to a collection agency.

NO SHOW - CANCELLATION

All Patients who fail to show for a scheduled appointment will be given ONE Warning regarding Pulmonary Consultants Cancellation and/or rescheduling Policy WITHOUT incurring a charge. However, after the patient has been counseled once, regarding their failure to show for a scheduled appointment, a fee of $50 will be charged to their account. This policy applies to all patients, both MEDICARE & Non-MEDICARE Patients as outlined by the Federal Guideline posted by CMS. Medicare & Non-Medicare Managed Care plans will not be billed, nor will they reimburse for these service charges, for which the patient is non-complaint. The $50 charge is the sole responsibility of the Patient irregardless of their health plan. No Show Appointments will be posted in the following manner to track the number of no show appointments which have been logged through the computer system.

99989- No Show Appointment / 1st Warning = No Charge

99990- No Show w/ Confirmed Appointment = $50

99991- No Show Appointment = $50

REFERRAL POLICY

I understand, it is my responsibility to obtain a referral through my primary care physician's office is one is required by my insurance carrier for my appointment with Pulmonary Consultants. My failure to do will result in charges being billed directly to me.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.

Signature of Responsible Party: _______________________________ Date: _____________________
HIPAA 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 we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers’ compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

• Most uses and disclosure of psychotherapy notes
• Uses and disclosure for marketing purposes
• Disclosures that constitute a sale of your protected health information.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.
YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – 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.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured Protected Health Information.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

HIPAA Privacy Rule Provided by AAPC Physician Services
Notice of Health Information Practices

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

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

What health information is available through Health Current?
The following types of health information may be available:

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

Who can view your health information through Health Current and when can it be shared?
People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning and population health services.

You may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form. Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

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

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

**How is your health information protected?**

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

**Your Rights Regarding Secure Electronic Information Sharing**

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. Contact your healthcare provider and you can get a copy within 30 days.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. Contact your healthcare provider and you can get a copy within 30 days. Please let your healthcare provider know if you think someone has viewed your information who should not have.

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

1. You may “opt out” of having your information available for sharing through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current. **Caution:** If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.

2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others. **Caution:** If that healthcare provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

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

**PATIENT NAME**

**SIGNATURE**