Pima Foot and Ankle Surgery

1601 N. Tucson BLVD., Suites 15
Tucson, AZ 85716
P: 520.209.1919

New Patient Forms Packet

Please review, sign, and date on the last page.

Consent for Treatment

I hereby grant permission to Infinity Health to provide routine evaluation and treatment services as may be deemed necessary or advisable for the diagnosis and/or care of the indicated patient below. I understand this consent shall remain valid so long as I am enrolled or until I withdraw consent.

I understand that all information gathered during my treatment at Infinity Health is confidential. However, confidential information may be disclosed without my consent in accordance with state and federal law. I understand that for purposes of my treatment, my treatment information may be discussed by other members of my integrated treatment team. Additionally, I understand that by signing this consent, I am giving permission for my insurance carrier to access information and records maintained by Infinity Health and/or its subcontracted providers concerning the provision of covered services.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you may gain access to information.

Infinity Health understands that your medical information and your health are personal. We are committed to protecting your medical information. Infinity Health creates a record of medical information about your care and services to provide you with quality care and to comply with certain legal requirements.

Infinity Health is required by law to:

- Ensure that medical information that identifies you is kept private
- Make certain that you are given notice of our legal duties and privacy practices with regards to your medical information

The following describes different ways we use and disclose your medical information. If you are receiving services for the evaluation of treatment of substance, use or Human Immunodeficiency Virus (HIV) conditions, specific rules apply to the use and disclosure of information related to those services.

For treatment: We may use your medical information to provide you with behavioral health services. We may disclose your information to the members of the treatment team to coordinate your ongoing care.

Individuals involved in your care: We may release your medical information to a family member actively involved in your care and treatment as allowed under Arizona State Law and in accordance with your insurance carrier and Infinity Health. This information is limited and will not be disclosed without first obtaining your written authorization.

Substance abuse health information: All medical information regarding substance use is kept strictly confidential and released only in conformance with the requirements of federal law (42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3) and regulation (42 C.F.R. part 2). Disclosure of any medical information referencing alohol or substance abuse may only be made with your written authorization. A general authorization for the release of medical or other information is not sufficient for this purpose.

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HIV Information: All medical information regarding HIV is kept strictly confidential and released only in conformance with the requirements of state law (A.R.S. 36-664). Disclosure of any medical information referencing HIV status may only be made with your written authorization. A general authorization for the release of medical or other information is not sufficient for this purpose.

Special Circumstances: Federal and state laws allow or require Infinity Health to disclose your medical information in certain special circumstances that include, but are not limited to:

- To prevent or control disease, injury, or disability
- To report births or deaths
- To report child abuse or neglect
- To report reactions to medications
- To notify people of recalls regarding medications they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting a disease
- To avert a serious threat to the health and safety of a person or the public
- To notify the appropriate government authority if we believe a member has been the victim of abuse, neglect, or domestic violence. We will make this disclosure when required by law.
- Health oversight activities: we may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the behavioral health system, government programs, and compliance with the civil rights laws.
- Lawsuits and disputes: if you are involved in a lawsuit or legal action, we may disclose your medical information in response to a valid court or administrative order, a valid subpoena, a discovery request, or other lawful process that complies with state law and Infinity as well as your insurance carrier policies and procedures.
- Law enforcement: we may not release your medical information to a law enforcement official except in response to a valid court order, subpoena, warrant, summons or similar lawful process that complies with state law and Infinity policies and procedures.
- Coroners, Medical Examiners, and Funeral Directors: We may release your medical information to a coroner or medical examiner. This may be necessary for the identification or to determine a cause of death. We may also release your medical information to a funeral director as necessary to carry out their duties.
- National Security and Intelligence Activities: We may release your medical information to authorized federal officials for intelligence, counter intelligence, and other national security activities authorized by law.
- As required by Law: We may disclose your medical information when required to do so by federal, state or local law.

Research: Banner may use or disclose information about you for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your information.

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Your rights regarding medical information about you:

- Right to access: You have the right to inspect and copy medical information that may be used to make decisions about your care. To request your medical information, make a written request of information to Infinity Health. Your request to inspect and copy your medical information may be denied in certain circumstances. If you are denied access to all, or part, of your medical information, you may request that denial be reviewed.
- Right to amend: If you feel that your medical information is incorrect or incomplete, you may ask us to amend the information. You must provide a reason that supports your request. We may deny your request if you ask us to amend information that: was not created by us, is not part of the medical information kept by or for Infinity or insurance carriers, is not part of the medical information which you would be permitted to inspect or copy or is accurate and complete.
- Right to request restrictions: You have the right to request a restriction on the medical information we use or disclose about you. If we do agree, we will comply with your request, unless the information is needed to provide you emergency treatment. To request a restriction, you must contact Infinity and make a request in writing. In the request, please provide us with information you want to restrict, and to whom you want restriction to apply to.
- Right to request confidential communications: You have the right to request that we communicate with you about matters in a certain way or at a certain location if you believe you will otherwise be endangered. To request confidential communications, please make a request in writing to Infinity Health. We will accommodate all reasonable requests. Your request must be specific must be specific and state how or where you wish to be contracted.
- Right to copy this Notice: You have the right to a paper copy of this Privacy Notice. You may ask us to give you a copy at any time.

Notice of Health Information Practices:

By signing below, you acknowledge receipt that you have read and understood the Notice of Health Information Practices regarding your provider's participation in the statewide Health Information Exchange (HIE), or you have previously received this information and decline another copy.

Changes to this Notice: Infinity reserves the right to change this Notice. Infinity reserves the right to make the revised notice effective for your medical information. We will post a copy of the current notice at the service site. The Notice will contain the effective date at the bottom of each page.

Complaints: If you believe your privacy rights have been violated, you may submit your complaint in writing to Infinity Health. If we cannot resolve your concern, you may submit your complaint to your insurance carrier privacy officer. You also have the right to file a written complaint with the United States Secretary of the Department of Health and Human Services. The quality of your care will not be jeopardized, nor will you be penalized for filing a complaint.

Other uses and disclosures: Other uses and disclosures of your medical information not covered by this notice will be made only with your written authorization. If you provide us with written authorization to use or disclose your medical information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, Infinity Health will no longer use or disclose your medical information for the reasons covered by the authorization. Infinity Health is unable to take back any disclosures already based on your authorization.

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Rights and Responsibilities

You have the right to:

- Be treated fairly and with respect regardless of race, ethnicity, religion, mental or physical disability, sex, age, sexual preference, or ability to pay.
- Participate in your treatment decisions and include any persons you wish in your treatment
- Have your protected health information kept private
- Receive your services in a safe place
- Make an advanced directive
- Agree to or refuse treatment services, unless the services are court ordered
- Get information in your own language or have it translated
- File a complaint without penalty
    - If you have a concern, grievance, or appeal and Infinity staff cannot quickly resolve the situation to your satisfaction, Infinity staff offer you the option of completing a Infinity Concern Form. Concern Forms are reviewed by the Practice Manager, who designates the appropriate staff to respond within ten (10) working days.
    - Infinity strives to provide quality care and exceptional services. If your concern has not been resolved, you have the right to file a grievance either orally or in writing, in accordance with ADHS/AHCCCS requirements to your health plan.
    - Infinity will notify you of further alternatives if you are dissatisfied with the complaint determination, including the option to contact ADHS/DBHS at 602-364-4558 or 1-800-867-5808.
    - Receive quality care
    - The same civil and legal rights as anyone else

Financial Responsibility Agreement

Thank you for allowing Infinity Health to assist you with your healthcare needs. In the interest of good healthcare practices, it is desirable to establish a payment policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible. As a courtesy to you, we will bill your insurance, if applicable. If there are any changes to your insurance, please let us know immediately so we can submit your claim properly. Insurance reimbursement is a contract between you, your employer and/or your insurance carrier. You are responsible for charges, or portions of charges that your insurance does not pay.

1. **Insurance:** We participate in most insurance plans. If you are not insured by a plan, payment is expected at the time of your scheduled appointment, unless a payment plan has been agreed upon. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Proof of Insurance:** All patients must provide photo identification card and insurance card before seeing their provider. Electronic copies will be kept securely within our electronic health record.
3. **Co-payments:** All co-payments and deductibles must be paid at the time of service. This arrangement in part of your contract with your insurance company.
4. **Non-payment:** If your account is over 90 days past due, you will receive a letter stating you have 20 days to pay your account in full. Partial payments through a payment plan may be negotiated with Infinity. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.
5. **No Show Policy:** If you fail to show to your scheduled appointment and do not contact Infinity Health to cancel/reschedule within 24 hours' notice, it will be considered a No Show, and you will be charged a $50.00 non-refundable fee.

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Thank you for understanding our payment policy.

By signing the agreement, you acknowledge that you have read and agree to the policy and our guidelines.

What is an Advance Directive? An Advance Directive is a written document, such as a Durable Mental Health Care Power of Attorney, in which you give instructions about your mental health care, what you want done or not done, if you can't speak for yourself.

What are Advance Directives for Health and Mental Health Care? These are documents you create that appoint someone else to make health care or mental health care decisions in the event you become incapacitated or incapable of making treatment decisions.

What do I do with my Advance Directive? When you create an Advance Directive, you remain in control of your health care decisions as long as you are able to communicate your wishes. If you are no longer able to make decisions for yourself, doctors and other health care providers are obligated to follow your wishes outlined in your Advance Directive according to the laws in the State of Arizona.

While it is optional, if you would like to make the instructions in this document an Advance Directive, please complete the information below and complete an Arizona Durable Mental Healthcare Power of Attorney form. This form is available at http://www.azag.gov/life_care/POA_MentalHealthCare.pdf

The signature below acknowledges understanding and receipt of the following:

- Consent to Treat
- Notice of Privacy Practices
- Patient Rights and Grievances
- Financial Responsibility

Patient Name: _____ Date: _____

Guardian / Agent: _____ Date: _____

Signature: _____ Date: _____

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HIPAA Privacy Authorization / Release of Information

Authorization for use or disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164).

Authorization:

I authorize the identified names below to either obtain or disclose my protected health information.

☐ **Previous Provider / Office.** ☐ **Family /Spouse, Friend, Agent, or Guardian.**

Name: _____

Phone:_____ Fax:_____ Address:_____

Please select one or both boxes below:

☐ Disclose Information ☐ Obtain Information

Please select what information is authorized to be disclosed below:

☐ All my health information ☐ Exclude any information related to _____

This authorization for release of information covers the period of healthcare from:

☐ From Specific Dates: _____ to _____ **OR** ☐ All Past, Present and Future periods

Purpose of Authorization is (check all that apply):

☐ Obtain my medical records. ☐ Release my medical records ☐ Both

Patient Name: _____ DOB: _____ Insurance ID #: _____

Guardian / Agent: _____ Date: _____ ROI Expires: _____

Signature: _____ Date: _____ ROI Expires: _____

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Authorization Extent & Additions

- I authorize the release of my complete health record (including records related to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse)
- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in full force and effect in perpetuity. unless services are terminated by any party at which time this authorization expires 90 days after services are terminated.
- I understand I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest claim. To revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back.
- I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- I understand that my treatment, payment enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.
- I consent to the use of my information for marketing purposes and understand I may be contacted with services, products or events that pertain to my condition or diagnoses.
- I or my appointed representative authorize communication with and the disclosing of health care related Information to chart span or other third parties.
- I understand that these companies may communicate with me, in relation to care and the services they offer. I understand that a payment may be made to Pima Foot and Ankle Surgery by said third parties for use of this information, but this does not mean my info is not being sold or provided to nonaffiliated third parties or vendors.

☐ I have read the above and certify that I understand and agree.

Patient Name: _____ DOB: _____ Insurance ID #: _____

Guardian / Agent: _____ Date: _____ ROI Expires: _____

Signature: _____ Date: _____ ROI Expires: _____