PATIENT REGISTRATION FORM

Updated 10.1.2020

PATIENT NAME: _____ **DATE OF BIRTH:** _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

Preferred method of contact (select one): ◯ Home Phone ◯ Cell Phone ◯ Work Phone

ADDRESS (THIS IS THE ADDRESS THAT WE WILL VISIT THE PATIENT AT):

_____

STREET CITY STATE ZIP CODE

EMAIL: _____

EMERGENCY CONTACT NAME: _____

PHONE: _____ ☐ Home Phone ☐ Cell Phone ☐ Work Phone

POWER OF ATTORNEY: _____ PHONE _____

ADDRESS: _____

STREET CITY STATE ZIP CODE

PEOPLE TO BE CONTACTED PRIOR TO APPOINTMENTS (optional): If you would like a specific person to be contacted before your appointment(s), please list them below.

_____

Name Relationship to patient Preferred method of contact: ☐ Phone ☐ Email

MAILING ADDRESS FOR PAYMENT: All Ponderosa Heart House Call LLC bill(s) and/or claim(s) should be sent to the following address:

_____

Address City State Zip Code

INSURANCE INFORMATION:

INSURANCE CARRIER: _____ POLICY#: _____

☐ PRIMARY ☐ SECONDARY

INSURANCE CARRIER: _____ POLICY#: _____

☐ PRIMARY ☐ SECONDARY

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____ LOCATION: _____

PRIMARY CARE PROVIDER: _____ PHONE NUMBER: _____

_____ _____

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME**

_____

DATE

Please complete all forms – sign and return to:

info@myheartmyhome.org or Fax (480) 597-1723

PONDEROSA HEART
HOUSE CALL CARDIAC CARE BUILT FOR THE HOME-BOUND

HEALTH CARE CONSENT FORM

UPDATED 10.1.2020

PATIENT NAME: _____ **DATE OF BIRTH:** _____

REVIEW. In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. Please sign at the bottom only after careful review and consideration.

CONFIDENTIALITY. I understand that no information regarding services performed shall be released without my express consent except as follows: I authorize that copies of my records may be sent to another location if I seek additional treatment at that location. I understand that, in addition to authorized Advanced Practitioner herein stated to be either a Physician Assistant (PA) or Nurse Practitioner (NP), the supervising/collaborating physician(s) shall have full access to my treatment records. I understand that appropriate medical review may be conducted to further the safety and efficacy of my Advanced Practitioner's services. I understand my Advanced Practitioner may also provide limited patient information to various third-party vendors to provide database development and maintenance services, referral services or marketing research services. I understand that photographs may be taken to document treatment results, but they will not be released or used otherwise without my specific written consent. My advanced practitioner will maintain file copies of all records for a minimum of seven years.

SERVICES. Collectively the Cardiac Services offered in the home and the Cardiac Services and procedures not offered in the home are referred to herein as the "Cardiac Services." Ponderosa Heart House Call ("PHHC") provides the following cardiac care services: Cardiac consultations (in-person and/or via telehealth), cardiac disease and medication management, Diagnostic testing - ECG, Holter/event monitoring/cardiac outpatient telemetry monitoring, ABI, transthoracic echocardiography, upper/lower extremity arterial and lower extremity venous imaging, pacemaker/defibrillator management and remote monitoring, abdominal aortic duplex scan, and anticoagulation management.

Cardiac services not offered in the home: Cardiac related surgical or interventional procedures (not limited to): cardiac catheterizations, balloon angioplasty, coronary artery /carotid artery/ peripheral vascular angiography/angioplasty or stenting, ASD/PFO closures, valvuloplasty, transcatheter aortic valve replacement (TAVR), pacemaker/defibrillator implantation, loop recorder implantation, electrical cardioversion, cardiac electrophysiology ablation, sclerotherapy, endovascular radiofrequency venous ablations, endovenous laser treatment (ELVT), or Enhanced External Counter-Pulsation (EECP), cardiac stress testing, or transesophageal echocardiography.

DISCLOSURE OF MEDICAL HISTORY. I agree that I will disclose a full and accurate personal medical history, including any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications.

MATERIAL RISKS OF TREATMENT PROCEDURES: I understand that the medical provider, medical personnel and other assistants participating in the patient's care will rely upon my documented medical history (or if I am the patient representative, medical power of attorney or guardian) as well as other information obtained from me, the patient, the family or others having knowledge regarding the patient, in determining the course of treatment for my/the patient's condition.

(a) All medical treatment involves risks. Risks associated with your PCP and/or Cardiac(s) include but are not limited to bruising, bleeding, heart attack, stroke, irregular heart rhythm's (arrhythmias), allergic reactions to medications, kidney damage, infection, blood clots.

(b) Following or as part of your consultation please ask your Advanced Practitioner and/or attending medical provider if you would like additional information regarding the nature or consequences of these risks, and their likelihood of occurrence.

INFORMATION AND RISK. While the PCP and/or Cardiac Services are routinely performed in clinicians' offices, or in the home as described above, without incident, there are certain risks associated with providing the PCP and/or Cardiac Services in the home. I understand that, while the Advanced Practitioner are responsible for providing me with information about the PCP and/or Cardiac Services and for answering my questions about them, it is not possible to enumerate each and every risk for every service or procedure utilized in modern health care. If I have further questions or concerns regarding the PCP and/or Cardiac Services, I agree to ask the Ponderosa Heart House Call for more information.

ROUTINE PROCEDURES. I acknowledge and understand that during the course of PHHC providing PCP and/or Cardiac Services to me various types of routine diagnostic and treatment procedures ("Procedures") may be utilized, which are considered ordinary and necessary techniques for the services provided.

CONSENT. Having discussed the matter with the PHHC provider to my satisfaction I hereby authorize and give voluntary consent to PHHC and its healthcare professionals to provide me (or if I am the patient representative, medical power of attorney or guardian) with one or more of the above Cardiac Services, which may require a continuing course of PCP and/or Cardiac Services or related medical action. I consent to and authorize the persons participating in and responsible care to utilize PCP and/or Cardiac Services that they deem reasonably necessary or desirable in the exercise of their professional judgment, including those Procedures that may be unforeseen or not known to be needed at the time this Consent is obtained. This Consent shall also extend to the treatment of all conditions which may arise during the course of such Cardiac Services and Procedures, including those conditions which may be unknown or unforeseen at the time this Consent is obtained.

APPOINTMENT REMINDERS VIA EMAIL OR TEXT. I consent to PHHC sending text messages to my mobile device or emails to my email address, as designated by me, in compliance with applicable privacy policies and requirements, to remind me about upcoming appointments. No such contact will be deemed unsolicited. I may be contacted at the cell phone number currently on file with PHHC. I may opt out of PHHC text or email message communications at any time by following the opt-out instructions provided to me via text or email.

NO CONSENT TO ELECTRONIC MESSAGE.

☐ By checking this the box, I do **not** give my consent to PHHC to send text messages to my mobile device for the purpose of reminding me about upcoming appointments. (_____patient/patient representative initials)

SCOPE OF SERVICES AND SUPERVISION. I understand that, as required by law, the Advanced Practitioner which provide the PCP and/or Cardiac Services are subject to the supervision of a licensed physician who may observe and supervise the care of the Advanced Practitioner as required by law but is not required to participate in face-to-face patient care.

DIGITAL IMAGES. I understand that digital and other images may be recorded to document the patient's care and I consent to such recordings. I understand that PHHC will retain the ownership rights to these digital and other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner in PHHC electronic health record and kept for the time period required by law and/or outlined in PHHC policy.

NO GUARANTEE OF TEST RESULTS OR TREATMENT OUTCOME. I understand that the practice of medicine is not an exact science and that no guarantees or assurances are made to me concerning the outcome and/or result of any Cardiac Services.

WARRANTIES AND DISCLAIMERS. PHHC shall provide the PCP and/or Cardiac Services as described to the patient in consultation. While PHHC has the discretion to perform or provide additional medical services as it deems necessary it has no duty to so. PHHC disclaims and shall have no duty to provide any other service or benefit not described to the patient and approved by PHHC.

LIMITATION OF LIABILITY. PHHC shall not be responsible for, and shall not pay, any amount of incidental, consequential or other direct or indirect damages, whether based on lost revenue, lost profits, loss of goodwill or otherwise, regardless of whether I was advised of the possibility of such losses in advance, or for any compensation, exemplary, punitive or damages except as set forth herein. In no event shall the liability of PHHC or its principals and agents hereunder exceed the amount paid by you, the undersigned, for our PCP and/or Cardiac Services regardless of whether your claim is based on contract, tort, strict liability, product liability or otherwise. In any case, your sole remedy shall be a refund of our service fees or as explicitly described in any written warranty we may provide to you.

WRITTEN MODIFICATION. This Agreement may be modified only by a written amendment signed by both parties. The prevailing party in any dispute as determined by the arbitrator, shall be entitled to an award of reasonable costs and attorney's fees. In the event arises out of this agreement or its formation the matter shall be heard by one arbitrator under the commercial rules of arbitration and the auspice is of the American Arbitration Association. Any award shall be final and may be entered as a judgment in the records of any court of competent jurisdiction.

ENITRE AGREEMENT. This agreement is the entire agreement between the parties. It replaces and supersedes any oral agreement between the parties, as well as any prior writings. No party to this Agreement is relying on any representation or understanding not expressly stated herein.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE

PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME

DATE

FINANCIAL CONSENT AND AUTHORIZATION

Updated 9.1.2020

PATIENT NAME:_____ **DATE OF BIRTH:**_____

A. PAYMENT RESPONSIBILITY. The undersigned acknowledges responsibility to pay for all care that I receive in accordance with regular rates and terms of Ponderosa Heart House Call LLC. I allow Ponderosa Heart House Call LLC to bill my insurance for the services rendered. If my insurance provider or health benefit plan does not cover the full cost of such care, then I must pay the remaining balance. If payment obligations can't be met, then a payment arrangement must be made with Ponderosa Heart House Call LLC for payment to be paid in full within 60 days from the date of service.

B. FOR MEDICAL BENEFICIARIES. The undersigned certifies and authorizes to release information and payment request that the information given by me in applying for payment if under Medicare, Medicaid, or any other insurance carrier is correct. I authorize the release of all records required to act on this request.

C. RELEASE AGREEMENT. The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, Ponderosa Heart House Call LLC may disclose portions of the undersigned records; including any medical records to any person, corporation, or other entity liable for all, or any portion of the facility charges. This includes, but not limited to insurance companies, health care service plans, and workers compensation carriers.

D. ASSIGNMENT OF BENEFITS. The undesigned, in consideration of the services provided to the patient by PHHC I hereby assign and transfer to PHHC and other appropriate health care providers all health care benefits payable and related rights, including my rights to appeal any denial of benefits or limitation of coverage existing under the insurance policies or benefit plans that I have identified or will identify in connection with the patient's medical care. I authorize and direct the insurance company or benefit plan to pay all such benefits to Ponderosa Heart House Call LLC, and I appoint Ponderosa Heart House Call LLC to act as my authorized representative in requesting an appeal from my insurance company or benefit plan regarding any denial of payment. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by my insurance company or benefit plan, unless otherwise provided in the terms of an agreement between Ponderosa Heart House Call LLC and the insurance company or benefit plan.

E. CERTIFICATION. The certifies that undersigned has received and read the above information by the patient, patient's legal representative or their duly authorized to be the patient's general agent to execute this agreement and consent and accept its terms.

_____ _____

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME**

_____

DATE

PONDEROSA HEART
HOUSE CALL CARDIAC CARE BUILT FOR THE HOME-BOUND

Chronic Care Management (CCM) Consent

Updated 9.1.2020

PATIENT NAME:_____ **DATE OF BIRTH:**_____

Your health is very important to Ponderosa Heart. In alignment with our dedication to keep you as healthy as possible with a focus to keep you out of the hospital and minimize the costs and inconvenience of unnecessary visits to doctors, labs, or urgent care facilities -- You are eligible for a Chronic Care Management. CCM involves managing chronic conditions effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness. This includes a non-face-to-face component of care that involves the creation of a patient-centered plan of care, medication monitoring, management of care transitions, electronic care coordination and exchange of health information with other health care providers as necessary, while providing you (and/or your caregiver) 24/7 access to your care team.

YOU WILL RECEIVE:

- A dedicated Care Team that is familiar with your conditions with 24/7 access (by you or your caregiver) to around-the-clock services to your Care Plan your using our secure medical portal in the event you require care when we are not available.
- Actively help you manage all your medications
- Coordinate visits with your providers, facilities, labs, radiology, and/or other medical services
- Provide a personalized and comprehensive care plan management
- Assist with scheduling preventive care services, many of which are covered by insurance

Only one provider can bill for this service for you. Please let us know if you have entered into a similar agreement with another provider or practice. You may discontinue this service at any time and for any reason. Your signature is required to end CCM services, so please notify us if you choose to discontinue the service, we will provide it only through the last day of the calendar month of your decision and provide you with a CCM revocation form.

I consent to allow my advanced practitioner and their designees to perform CCM on my behalf. I understand that Ponderosa Heart House Call will bill my insurance for this service, and that I am responsible for any copayment or deductible. I understand that I can revoke this permission at any time by notifying Ponderosa Heart House Call in writing.

I agree to participate in the Chronic Care Management program. ◯ Yes ◯ No

_____ _____

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME**

_____

DATE

COVID-19 Screening Questionnaire

updated 10.1.2020

PATIENT NAME:_____ **DOB:**_____

You anticipating to participate in **routine** medical evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

- While our practice complies with Arizona Department of Health Services (AZDHS) and the Centers for Disease Control and Prevention (CDC) infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
- Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the COVID-19. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself - please be truthful and candid in your answers.

PATIENT/PATIENT REPRESENTATIVE _____ DATE _____

Please answer the following screening questions:

Have you been tested for COVID-19? _ ◯ YES ◯ NO

If yes when_____?

Was it a positive test ? ◯ YES ◯ NO

Within the last 14 days have you:

Lost your sense of taste or smell? ◯ YES ◯ NO

Traveled outside of the country? ◯ YES ◯ NO

Traveled outside the state of Arizona? ◯ YES ◯ NO

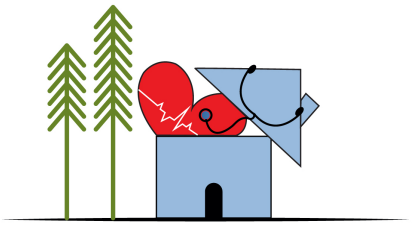
Experienced headaches? ◯ YES ◯ NO

Been short of breath? ◯ YES ◯ NO

Had a cough? ◯ YES ◯ NO

Had a Fever? ◯ YES ◯ NO

Been around anyone whom may have had or did have COVID-19? ◯ YES ◯ NO



MEDICAL HISTORY FORM

Updated 9.1.2020

PATIENT NAME: _____ **DATE OF BIRTH:** _____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY):

- ☐ AIDS/ HIV
- ☐ Alzheimer's
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arrythmia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joint(s)
- ☐ Atrial Fibrillation
- ☐ Asthma/COPD
- ☐ Bipolar
- ☐ Blood Clots
- ☐ Blood Disease
- ☐ Blood transfusions
- ☐ Bruise easily
- ☐ Cancer
- ☐ Carotid Artery Disease
- ☐ Chemotherapy
- ☐ Chest Pain
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Coronary Artery Disease
- ☐ Dementia
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Diarrhea
- ☐ Headaches
- ☐ Genital Herpes
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives of Rash
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pacemaker or Defibrillator
- ☐ Parathyroid Disease
- ☐ Psychiatric Condition
- ☐ Radiation Treatment
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
- ☐ Spina Bifida
- ☐ Stents in Heart How Many? ____
- ☐ Stents in Legs How Many? ____
- ☐ Stomach/Intestinal Disease
- ☐ Stomach Ulcers
- ☐ Stomach Bleeding
- ☐ Stoke
- ☐ Swelling in Limbs
- ☐ Tuberculosis
- ☐ Stomach Ulcers
- ☐ Ulcer/Wounds on Leg

PAST SURGICAL HISTORY:

HOSPITALIZATION: REASON: DATE:

_____

_____

_____

_____

_____

FAMILY HISTORY:

RELATIONSHIP: STATUS OR CONDITION:

MOTHER: _____

FATHER: _____

CHILDREN: _____

SIBLING(S): _____

GRANDMOTHER(S): _____

GRANDFATHER(S): _____

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Current Smoking – How Many Years? _____

☐ Former Smoking – Year Quit _____

☐ Alcohol Use – Year Quit _____

☐ Drug Use – Which Drug(s) _____

☐ Current Exercise

# of Children: _____

Occupation: _____

Education: _____

CURRENT MEDICATIONS:

NAME OF DRUG DOSE (STRENGTH AND FREQUENCY)

_____

_____

_____

_____

_____

NAME OF DRUG DOSE (STRENGTH AND FREQUENCY)

_____

_____

_____

_____

_____

MEDICATION ALLERGIES:

_____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective 6.18.2020 - Updated 9.1.2020

PATIENT NAME:_____ **DATE OF BIRTH:**_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information also known as The Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please review it carefully. If you have questions about this notice or to obtain a paper copy of this notice please contact (480) 795-1515 or info@myheartmyhome.org

Our Obligations - We are required by law to:
Maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice that is currently in effect

How we may use and disclose health information:
The following describes the ways we may use and disclose health information that identifies you ("Health information"). Except for the purposes described below we will use and disclose health information only with your written permission. You may revoke such permission at any time in writing.

For treatment. We may use and disclose health information for your treatment and to provide you with treatment related healthcare services. For example, we may disclose health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For payment. We may use and disclose health information so that we or others may bill and receive payment from you, and insurance company, or a third-party for the treatment and services you received. For example, when they give your health plan information about you so they will pay for your treatment.

For healthcare operations. We may use and disclose health information for healthcare operations purposes. These disclosures are necessary to make sure that all of our patients receive quality care and to operate, and manager office. For example, we may use and disclose information to make sure that the care he received is of the highest quality. We may also share information with other entities that have a relationship with you (for example your health plan) for their healthcare operation activities.

Appointment reminders, treatment alternatives, and health related benefits and services. We may use and disclose health information to contact you to remind you that you have an appointment with us. We also may use and disclose health information to tell you about treatment alternatives or health related benefits and services that may be of interest to you.

Individuals involved in your care or payment for your care. When appropriate, we may share health information with a person who is involved in your medical care for payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition to disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose health information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help him identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any health information.

Special Situations:
As required by law. We will disclose health information when required to do so by local, state, or federal law.

To avert a serious threat to health or safety. We may use and disclose health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, we made only to someone who may be able to help prevent the threat.

Business associates. We may disclose health information to our business associates that perform functions on our behalf to 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 are not allowed to use or disclose any information other than as specified in our contract.

Organ and tissue donation. If you are an organ donor, we may use or release health information to organizations that handle organ procurement or other entities engage in procurement, banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation and transplantation.

Military and veterans. If you are a member of the Armed Forces, we may release health information as required by military command authorities. We may also release health information to the appropriate foreign military authority if you're a member of a foreign military.

Workers compensation. We may release health information for Worker's Compensation or similar programs. These programs for my benefits for work related illnesses or injuries.

Public health risks. We may disclose health information for public health activities. These activities generally include disclosures to prevent or control disease injury or disability. Report births and deaths, report child abuse or neglect, report reactions to medications or problems with products, notify people of recalls of products they may be using, a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, in the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health oversight activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Data breach notification purposes. We may use or disclosure of protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Laws and disputes. If you are involved in a lawsuit or a dispute, we may disclose health information in response to a court or administrative order. We also may disclose health information in response to a subpoena, discovery request, or other lawful processes by someone else involved in the dispute, but only if efforts have been made to tell you about the request to obtain an order protecting the information requested.

Law Enforcement. We may release health information if asked by law-enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person (3) about the victim of a crime even if under certain very limited circumstances we are unable to obtain the persons agreement (4) about a death we believe may be the result of criminal conduct (5) about criminal conduct on our premises and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical examiners, and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example to identify a deceased person or to determine the cause of death. We also may release health information to funeral directors as necessary for their duties.

National security and intelligence activities. We may release health information to authorize federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective services for the President and others. We may disclose health information to authorize federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law-enforcement official. This release would be necessary: (1) for the institution to provide you with healthcare (2) to protect your health and safety or the health and safety of others, or (3) the safety and security of the correctional institution.

Your Rights:
You have the following rights regarding health information we have about you:

Right to inspect and copy. You have a right to inspect and copy health information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this health information, you must make your request in writing to Ponderosa Heart House Call. 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 cost 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 Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in a denial of your request, and we will comply with the outcome of the review.

Right to get notice of a breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to amend. If you feel that health information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as

long as the information is kept by or for our office. To request an amendment, you must make your request, in writing to Ponderosa Heart House Call.

Right to an accounting of disclosures. You have the right to request a list of certain disclosures we made of health information for purposes other than treatment, payment and healthcare operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing to Ponderosa Heart House Call.

Right to request restrictions. You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make a request in writing to Ponderosa Heart House Call. We are not required to agree to your request unless you were asking us to restrict the use and disclosure of your protected health information to a health plan for payment or healthcare operations purposes and such information you wish to restrict pertain salute to the healthcare item or service for what you have paid us "out of pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-pocket payments. If you had out of pocket (or another words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that you're protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or healthcare operations, and we will honor that request.

Right to request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request in writing to Ponderosa Heart House Call. Your request my specify how or where you wish to be contacted. We will accommodate reasonable requests.

Write you a paper copy of this notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, contact Ponderosa Heart House Call at (480) 795-1515 or info@myheartmyhome.org

Changes to this notice:
We reserve the right to change this notice and make the new notice apply to health information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page in the top right-hand corner.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with our office or with the secretary of the department of health and human services. To file a complaint with our office, contact Ponderosa Heart House Call at (480) 795-1515. All complaints must be made in writing. You will not be penalized for filing a complaint.

Your written authorization is required for other uses and disclosures:
The following uses and disclosures of your protected health information will be made only with your written authorization:
(1) Uses and disclosures of protected health information for marketing purposes and (2) Disclosures that constitute a sale of your protected health information.
Other laws and disclosures of protected health information not covered by this notice or the laws that applies to us we made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation and we will no longer disclose protected health information under the authorization, but disclosure that we made in reliance on your authorization before you vote it will not be affected by the revocation.

The undersigned patient or legally authorized representative ("Patient Representative") of the patient acknowledges that he or she has been offered a copy of Ponderosa Heart House Call notice of HIPAA privacy practices on a date indicated below.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME**

DATE

MEDICAL RECORDS RELEASE FORM

UPDATED 9.1.2020

PATIENT NAME:_____ **DATE OF BIRTH:**_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or summary or narrative of my protected health information, to the clinician, person, facility, and/or entity listed below.

THE INFORMATION YOU MAY RELEASE SUBJECT TO THIS SIGNED RELEASE FORM IS AS FOLLOWS:

☐ Complete Record(s)	☐ Progress Note(s) - 3 most recent	☐ Radiology Report(s)
☐ Pathology Report(s)	☐ Lab Report(s)	☐ Operative Report(s)
☐ Hospital Report (s)	☐ Treatment Record(s)	☐ Coronary Angiogram(s)
☐ Vascular Report (s)	☐ Medication Record(s)	☐ Peripheral Angiogram(s)
☐ History & Physical	☐ Ultrasound Report(s)	☐ Other (specified below)

Other: _____

_____

_____

_____

_____

Please release my protected health information to the following clinician, person, facility, and/or entity listed below:

Ponderosa Heart House Call
Address: 115 S. Alto St., Suite 3
Prescott, AZ 86303
Phone: (480) 795-1515
Fax: (480) 597-1723

_____ _____

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **PATIENT/ PATIENT REPRESENTATIVE PRINTED NAME**

_____

DATE