Dignity Health Medical Group

Welcome!

Dear Patient:

Welcome to Dignity Health Medical Group (DHMG) Arizona. DHMG is the academic employed physician group of Dignity Health in Arizona. DHMG is comprised of more than 200 physicians, nurse practitioners, physician assistants, and certified nurse midwives, as well as over 500 support staff who cover a wide variety of specialties. With 26 practice sites and four hospitals interspersed throughout the valley, we are able to provide more than 20 subspecialty services to the Greater Phoenix Metropolitan area.

As a part of the Dignity family, DHMG shares the mission and values of Dignity Health, furthering the healing ministry of Jesus, with a focus on innovative clinical care and pursuit of excellence through scholarly activities. Our vision is to be the top performing, physician led, professionally managed integrated academic medical group providing our communities with the highest quality of care.

At DHMG, we employ providers that are recognized as AZ top docs in Phoenix Magazine. We also have providers within DHMG that are continuously ranked at the top for patient satisfaction and quality. Our providers are all board certified—or working towards their certification—in order to meet nationally recognized standards for education, knowledge, experience, and skills. Additionally, our exceptional providers work together to train future physicians which encourages them to remain proficient in the most cutting-edge medical knowledge and training, further allowing them to provide high quality care in an array of medical specialties, above and beyond that of a traditional clinician.

Dignity Health Medical Group Primary Care Clinics are recognized as Patient Centered Medical Home (PCMH) certified. Patient-Centered Medical Home emphasizes the use of systematic, patient-centered, coordinated, evidence-based care that supports access, communication and patient involvement. It provides a system of care in which a team of health professionals work together with patients, families and/or caregivers to meet all of your health care needs, from the point of scheduling, to the patient's arrival, through the visit and after for continued care. It is a trusting partnership between a doctor-led health care team and a patient.

Please review and complete the attached forms prior to your scheduled appointment.
We are excited to welcome you to the Dignity Health Medical Group family.

Bruce Bethancourt, MD
Chief Medical Officer, DHMG

Dignity Health Medical Group

Adult Demographics

PATIENT INFORMATION

Last Name		First Name	Middle	
Social Security Number	Date of Birth	Legal Gender ☐ Male ☐ Female ☐ Nonbinary	Marital Status	
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other ☐ Decline to Answer				
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to state		Language	Preferred Language for Health Care Information	
Mailing Address		City	State	Zip
Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Secondary Contact Number ☐ Home ☐ Cell ☐ Work ( )	Preferred Notify Method: ☐ Home ☐ Cell ☐ Work Other: ( )		
E-Mail Address		Employer		
Emergency Contact:		Relationship to patient	Emergency Contact Number:	

RESPONSIBLE PARTY'S INFORMATION (IF OTHER THAN PATIENT)

Last Name	First Name	Middle	Relationship to Patient	
Date of Birth		Primary Contact Number ☐ Home ☐ Cell ☐ Work ( )		
Mailing Address		City	State	Zip

FAMILY AND FRIENDS ACCESS (OPTIONAL)

I permit Dignity Health to share my appointment date/time, and/or billing with any individuals listed below:

Full Name:	Full Name:	Full Name:
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:

INSURANCE INFORMATION

Primary Insurance Carrier	Worker's Comp Injury ☐ Yes ☐ No	Insurance Billing Address:	
Policy/Group Number:	Subscriber Full Name:		Subscriber Date of Birth:
Secondary Insurance Carrier		Insurance Billing Address:	
Policy/Group Number:	Subscriber Full Name:		Subscriber Date of Birth:

Dignity Health Medical Group

PATIENT NAME: ______________________
MRN: ______________________
DOB: ______________________

_____ **CANCELLATIONS, LATE PATIENTS, AND NO SHOWS:** Our goal at Dignity Health Medical Group is to maximize the time your provider spends with you and minimize your wait time. In order to do so, we have a standardized policy for no shows, cancellations, and late arrivals;

- **Cancellation:** We require 24 hour notice of cancellation for any appointments.
- **Late:** You will be considered late if you arrive 15 minutes after scheduled appointment time.
- **No Show:** If you do not arrive for a scheduled appointment and do not provide the office notice within at least 24 hours you will be considered a no show.
  - No show #1- Documented
  - No show #2- Warning letter mailed out to patient
  - No show #3- Discharged from office

_____ **FAMILY AND FRIENDS:** You have the option to list 3 individuals which you give permission to know about appointment dates, times, and/or billing information. These individuals may NOT give consent for any in office procedures, immunizations, etc.

_____ **MEDICATION REFILLS:** Please contact your preferred pharmacy to request medication refills. Once the request has been received, refills will be completed within 3 business days.

_____ **FINANCIAL RESPONSIBILITY:** This may include co-payments, co-insurance and services not covered or paid by your insurance carrier. This financial responsibility also applies if your insurance carrier is not contracted with Dignity Health Medical Group. **It is your responsibility to ensure that all services rendered by Dignity Health Medical Group on your behalf are paid in full within thirty (30) days of the statement date**

We do not change billing codes once they have been submitted to your insurance company.

Depending on your insurance coverage at the time of your visit to the clinic, you may be asked to make a deposit on your account prior to seeing a physician. Deposits will be applied toward charges incurred but may not represent payment in full for services. Additional charges may be warranted by use of x-ray, supplies, and/or more complex services as required for care.

It is important that you bring proof of insurance each time you visit the clinic. Failure to do so may result in your not being seen or being required to make a full payment at the time services are rendered. Please make every effort to let us know if your insurance carrier (primary or secondary insurance) or your personal information (home address, employer, and phone number) has changed since your last visit.

We understand that insurance coverage can be confusing and we are committed to helping you with any questions you may have. **Please feel free to call Patient Billing Services directly at 602.406.3860 or toll free at 877.877.8311.**

Dignity Health Medical Group

PATIENT NAME: ______________________

MRN: ______________________

DOB: ______________________

_____ **TELECOM AGREEMENT:** You agree that by signing below you consent and request that Dignity Health Medical Group, its affiliates, and those acting on its/their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include those concerning the patient's care, scheduling, reminders, prescriptions, advertisements or telemarketing messages concerning our benefits and services. Calls can be made to any number you provide or we obtain even if listed on a national or state Do Not Call registry. You understand that consent is not a condition of care.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

_____ **TELEHEALTH OR TELEMEDICINE VISITS:** If patient participates in a Telehealth or Telemedicine visit, then consent from patient to receive telehealth services will be acquired virtually by provider at time of visit and documented as part of the Visit Note.

_____ **HEALTH INFORMATION EXCHANGE (HIE) STATE PARTICIPATION ACKNOWLEDGEMENT:** I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Dignity Health's participation in Health Current, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy.

I have read and understood the above.

____ ______________________

Guarantor/Responsible Party or Patient Signature | Date

Dignity Health Medical Group

PATIENT NAME: ______________________

MRN: ______________________

DOB: ______________________

Health Assessment

ALLERGIES/REACTIONS:

MEDICATIONS: INCLUDING SUPPLEMENTS, LIST NAME OF MEDICATION, DOSE AND FREQUENCY.

Name	Dose	Frequency

Medical Illness:

- ☐ Adrenal tumor/mass
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Clots
- ☐ Blood Pressure High/Low
- ☐ Bone Infections
- ☐ Bowel Problems
- ☐ Cancer*
- ☐ Chicken Pox
- ☐ Colon Polyps
- ☐ Concussion
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Gallstones
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lung Disease
- ☐ Lymphatic disease
- ☐ Mononucleosis
- ☐ Neurological Disorder
- ☐ Pancreatic tumor/mass
- ☐ Parkinsons
- ☐ Pituitary tumor/mass
- ☐ Pneumonia
- ☐ Prostate Enlargement
- ☐ Psychiatric Problems
- ☐ Seasonal Allergies/ Hay Fever
- ☐ STD______________
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumor/Mass
- ☐ Tuberculosis/Exposure
- ☐ Ulcers
- ☐ Valley Fever
- ☐ Other: ______________________

Surgeries:

- ☐ Appendix
- ☐ Back Surgery
- ☐ Breast Biopsy
- ☐ Cardiac
- ☐ Colon Polyps
- ☐ Gall Bladder
- ☐ Hemorrhoid
- ☐ Hernia (Umbilical or Inguinal)
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Knee Surgery
- ☐ Ovarian
- ☐ Prostate
- ☐ Shoulder Surgery
- ☐ Skin Biopsy
- ☐ Splenectomy
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Vasectomy
- ☐ Other: ____________________

Cancer History*:

- ☐ Breast
- ☐ Colon
- ☐ Lung
- ☐ Prostate
- ☐ Ovarian
- ☐ Skin
- ☐ Stomach
- ☐ Other: ______________________

Dignity Health Medical Group

PATIENT NAME: ______________________
MRN: ______________________
DOB: ______________________

Health Assessment

Please complete the following information regarding the patient's biological family.
If the biological family history is unknown please check here: ☐

FAMILY HISTORY

Problem	Biological Mother/Type	Biological Father/Type	Biological Siblings/Type
Developmental Delays			
Diabetes			
Cardiac Problems			
Kidney Disease			
Thyroid Problems			
Stroke			
Liver Disease			
High Cholesterol			
Seizures/Epilepsy			
Heart Murmur			
Psychiatric Illness			
Cancer/Type			
Gastric Reflux			
Arthritis			
Other			

Obstetrical History:
Pregnancies___________ # Deliveries____________
Miscarriages ___________ # Abortions____________
Contraception/Type:______________________________
Menarche (Age Menstruation Began)______________
Date of Last Menstrual Period ___________________

Clinicians you see: Please include name, specialty and phone number.
____
____
____

Vaccination(s) & Date:
- ☐ Tetanus ____________________
- ☐ TDAP (Tetanus/Diphtheria/Pertussis) ____________________
- ☐ Hepatitis A ____________________
- ☐ Hepatitis B ____________________
- ☐ MMR ____________________
- ☐ Varicella ____________________
- ☐ Shingles ____________________
- ☐ Other: ____________________

Pharmacy Information*:
Name:__________________ Phone: ___________ Location:___________________ Mail Order Pharmacy:______________________________
If multiple, please use space to list any/all preferred pharmacies

Preferred Lab:
Name:____

Do you have an Advanced Directive in Place (Living Will and/or Medical Durable Power of Attorney)? ☐ Yes ☐ No

FOR OFFICE USE ONLY

Date:	Medical Record #

Advanced Directives: ☐ Patient refused
☐ Scanned in Chart ☐ Pt Completed AD at Home ☐ Provided AD Informational Brochure ☐ Pt Requested More Information

Dignity Health Medical Group

Annual Screening Questionnaire

PATIENT NAME: ___________________________

MRN: ___________________________

DOB: ___________________________

PREVENTATIVE CARE

Date of last Flu Vaccine:		(Ages 65+) Pneumonia Vaccine (yr/type):	
(Ages 50+) colorectal cancer screening (type/yr/result):	Type: Year: Result:	(Ages 65+) Bone Density:	Date:
Do you see an OB/GYN? ☐ Yes ☐ No ☐ N/A		If yes, name:	
Mammogram (Ages 50+):	Results:	Date of last:	Location:
Pap smear: ☐ Yes ☐ No ☐ N/A		Date of last:	Have you had an abnormal pap smear? ☐ Yes ☐ No

SOCIAL HABITS

Have you ever used tobacco/nicotine products? ☐ Yes ☐ No	If so, what kind?
Current tobacco/nicotine user? ☐ Yes ☐ No	How many years?
Date quit tobacco/nicotine, if applicable:	Current user: interested in quitting? ☐ Yes ☐ No
Have you ever used THC (marijuana or CBD) products? ☐ Yes ☐ No	If so, what kind?
Current THC (marijuana or CBD) user? ☐ Yes ☐ No	How many years?
Date quit THC (marijuana or CBD), if applicable:	Current user: interested in quitting? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No	If so, what kind?
How much/How often?	Current user: interested in quitting? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No	If so, how often?
Do you use caffeine? ☐ Yes ☐ No	If so, how often?
Do you drink soda or other sugar-sweetened beverages? ☐ Yes ☐ No	If so, how often?
Do you use illicit drugs? ☐ Yes ☐ No	If so, what kind?
How much/How often?	Current user: interested in quitting? ☐ Yes ☐ No

FALL RISK ASSESSMENT – AGES 65 AND OLDER

Have you had a fall in the past year?	☐ Yes ☐ No
If yes, how many falls:	☐ 1 w/o injury ☐ 1 w/ injury ☐ 2+ (w/wo injury)
Are you unsteady walking, or, do you request assistance?	☐ Yes ☐ No
Do you use any assistive device (i.e: cane, walker, wheelchair)?	☐ Yes ☐ No Type:________________

DEPRESSION SCREENING PHQ-9 (PLEASE CIRCLE THE APPROPRIATE NUMBER TO YOUR RESPONSE)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
			Total =	

How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult
Do you currently have problems getting food, transportation, or affordable housing?	☐ Yes ☐ No *Staff: If answer is "Yes" please provide the full 10 SDOH form to patient.
Do you have problems with obtaining your prescriptions?	☐ Yes ☐ No

Dignity Health Medical Group

PATIENT NAME: ____________________

MRN: ____________________

DOB: ____________________

JOINT NOTICE OF PRIVACY PRACTICES FOR HEALTH INFORMATION (NPP) ACKNOWLEDGMENT FORM

Effective April 14, 2003, the law requires that Dignity Health Medical Group give every patient a copy of its Notice of Privacy Practices for Health Information. We will give you a copy at the time of first treatment and if we change our notice, thereafter at the next treatment visit. By signing below, the patient acknowledges receipt of such, or if you are the patient's personal representative, or authorized agent, or involved in patient's medical care, you acknowledge receipt of such.

____________________ ____________________

Acknowledgment Signature Date

____________________ ____________________

If not by patient, print name Relationship to Patient

For Official Use

I provided a copy of the NPP to the patient (or personal representative) but was unable to obtain his or her written acknowledgment of receipt of such for the following reasons:

____

____

I have attempted to provide to the patient (or personal representative) a copy of the NPP, but was unable to do so for the following reasons:

____

____

Signature of Medical Group Representative: ____________________ Date: ____________________

Print Name: ____________________ Department: ____________________

Dignity Health Medical Group

Joint Notice of Privacy Practices for Medical Information

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.

WHO MUST FOLLOW THIS NOTICE?

We (the facility) provide you (the patient) with health care by working with doctors and many other health care providers (referred to as we, our or us). This is a joint notice of our information privacy practices. The following people or groups will follow this notice:

- any health care provider who comes to our locations to care for you. These professionals include doctors, nurses, technicians, physician assistants and others.
- all departments and units of our organization, including skilled nursing, home health, clinics, outpatient services, mobile units, hospice, and emergency department.
- our employees, students and volunteers, including regional support offices and affiliates.
- The third party business partners working on our behalf to help provide you with technology tools and assist us with healthcare operations.

OUR PLEDGE TO YOU

We understand that medical information about you is private and personal. We are committed to protecting it. Hospitals, doctors and other staff make a record each time you visit. This notice applies to the records of your care at the facility, whether created by hospital staff or your doctor. Your doctor and other health care providers may have different practices or notices about their use and sharing of medical information in their own offices or clinics. We will gladly explain this notice to you or your family member. We are required by law to:

- keep medical information about you private.
- give you this notice describing our legal duties and privacy practices for medical information about you.
- notify you as outlined in state and federal law if a breach of unsecured medical information about you has occurred.
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND SHARE YOUR MEDICAL INFORMATION

This section of our notice tells how we may use medical information about you. In all cases not covered by this notice, we will get a separate written permission from you before we use or share your medical information. We will ask you for permission in writing before we use or share your medical information for any of the following reasons:

- marketing an item or service that is not related to treatment for you or when we are paid to market to you.
- special notes about you made by therapists and counselors that are not part of your medical record.
- the sale of your medical information.

You can later cancel your permission by notifying us in writing.

We will protect medical information as much as we can under the law. Sometimes state law gives more protection to medical information than federal law. Sometimes federal law gives more protection than state law. In each case, we will apply the laws that protect medical information the most.

Dignity Health is a large health system. We may use or share medical information about you (in electronic or paper form) with hospital personnel, including doctors, at any Dignity Health hospital or facility for treatment, payment

and health care operations. Please contact the Facility Compliance Office (at the address at the bottom of the notice) for a list of all Dignity Health facilities.

EXAMPLES:

Treatment: We will use and share medical information about you for purposes of treatment. An example is sending medical information about you to your doctor or to a specialist as part of a referral.

Payment: We will use and share medical information about you so we can be paid for treating you. An example is giving information about you to your health plan or to Medicare.

Health Care Operations: We will use and share medical information about you for our health care operations. Examples are using information about you to improve the quality of care we give you, for disease management programs, patient satisfaction surveys, compiling medical information, de-identifying medical information and benchmarking.

Appointment Reminders: We may contact you with appointment reminders.

Internet Based Products and Services: Working with third party, we may o er you internet based products or services allowing you to

- schedule appointments
- reduce wait times in our emergency rooms
- help you find a physician or offer you access to your medical information

Treatment options and health-related benefits and services: We may contact you about possible treatment options, health-related benefits or services that you might want.

Fund-raising Activities: We may use limited information to contact you for fundraising. We may also share such information with our fundraising foundation. You may choose to opt out of receiving fund-raising requests or contacts.

Research: We may share medical information about you for research projects, such as studying the effectiveness of a treatment you received. We will usually get your written permission to use or share medical information for research. Under certain circumstances we may share medical information about you without your written permission. These research projects, however, must go through a special process that protects the confidentiality of your medical information.

Facility Directory: Unless you tell us otherwise, we may list your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation in our directory. We will give this information (except your religious affiliation) to anyone who asks about you by name. Your religious affiliation will be given only to appropriate clergy members.

Public Health: We may disclose your health information as required or permitted by law to public health authorities or government agencies whose official activities include preventing or controlling disease, injury, or disability. For example, we must report certain information about births, deaths, and various diseases to government agencies.

We may use your health information in order to report to monitoring agencies any reactions to medications or problems with medical devices. We may also disclose, when requested, information about you to public health agencies that track outbreaks of contagious diseases or that are involved with preventing epidemics.

Required by Law: We are sometimes required by law to report certain information. For example, we must report assault, abuse, or neglect. We also must give information to your employer about work-related illness, injury or workplace-related medical surveillance. Another example is that we will share information about tumors with state tumor registries.

Public Safety: We may, and sometimes have to share medical information about you in order to prevent or lessen a serious threat to the health or safety of a particular person or the general public.

Health Oversight Activities: We may share medical information about you for health oversight activities where allowed by law. For example, oversight activities include audits investigations or inspections. The activities are necessary for government review of health care systems and government programs.

Coroners, Medical Examiners and Funeral Directors: We may share medical information about deceased patients with coroners, medical examiners and funeral directors to identify a deceased person, determine the cause of death, or other duties as permitted.

Organ and Tissue Donation: We may share medical information with organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Agencies: We may use or share medical information about you for national security purposes, intelligence activities or for protective services of the President or certain other persons as allowed by law. We may share medical information about you with the military for military command purposes when you are a member of the armed forces.

We may share medical information with the Secretary of the Department of Health and Human Services for investigating or determining our compliance with HIPAA.

Judicial Proceedings: We may use or share medical information about you in response to court orders or subpoenas only when we have followed procedures required by law.

Law Enforcement Arizona & Nevada: We may share medical information about you with police or other law enforcement personnel where permitted or required by state and federal law. For example, if the police present a search warrant or court order, we must produce the information requested.

Law Enforcement California: We may share medical information about you with police (or other law enforcement personnel) without your written permission:

- If the police bring you to the hospital and ask us to test your blood for alcohol or substance abuse
- If the police present a search warrant
- If the police present a court order
- To report abuse, neglect, or assaults as required or permitted by law
- To report certain threats to third parties
- If you are in police custody or are an inmate of a correctional institution and the information is necessary to provide you with health care, to protect your health and safety, the health and safety of others or for the safety and security of the correctional institution.

Family Members, Personal Representative, and Others Involved in Your Care: Unless you tell us otherwise, we may share medical information about you with friends, family members, or others you have named who help with your care or who can make decisions on your behalf about your healthcare.

Disaster Relief Purposes: We may use or share medical information about you with public or private disaster organizations so that your family can be notified of your location and condition in case of disaster or other emergency. We may also use it to help in coordination of disaster relief efforts.

Electronic Sharing and Pooling of Your Information: We may take part in or make possible the electronic sharing or pooling of healthcare information. This helps doctors, hospitals and other healthcare providers within a geographic area or community provide quality care to you. If you travel and need medical treatment, it allows other doctors or hospitals to electronically contact us about you. All of this helps us manage your care when more than one doctor is involved. It also helps us to keep your health bills lower (avoid repeating lab tests). And finally it helps us to improve the overall quality of care provided to you and others. We are involved in the Affordable Care Act and may use and share information as permitted to achieve national goals related to meaningful use of electronic health systems.

We also may make your information available to health plans, doctors, hospitals, and health care providers through the electronic health information exchange(s) [HIE] identified below. If you do not want your information to be available in a particular HIE, you can "opt out" by going to the HIE's website and follow the instructions to opt-opt.

Health Current (formerly HINAz) https://healthcurrent.org/hie-participants/patient-rights-process/. If you do choose to opt out, the HIE will not allow any HIE participants, including emergency medical providers, to access your information electronically through the HIE.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

Requesting Information about You:

In most cases, when you ask in writing, you can look at or get a copy of medical information about you in paper or electronic format. You may also request that we send electronic copies directly to a person or entity chosen by you. We will give you a form to fill out to make the request. You can look at medical information about you for free. If you request paper or electronic copies of the information we may charge a fee. If we say no to your request to look at the information or get a copy of it, you may ask us in writing for a review of that decision.

Correcting Information about You:

If you believe that information about you is wrong or missing, you can ask us in writing to correct the records. We will give you a form to fill out to make the request. We may say no to your request to correct a record if the information was not created or kept by us or if we believe the record is complete and correct. If we say no to your request, you can ask us in writing to review that denial.

Obtaining a List of Certain Disclosures of Information:

You can ask to receive a list of the disclosures we have made of your medical information for the last six years. Your request must be in writing and state the time period for the listing. The first request in a 12-month period is free. We will charge you for any additional requests for our cost of producing the list. We will give you an estimate of the cost when you request the additional list.

Restricting How We Use or Share Information about You:

You can ask that medical information be given to you in a confidential manner. You must tell us in writing of the exact way or place for us to communicate with you. You also can ask in writing that we limit our use or sharing of medical information about you. For example, you can ask that we use or share medical information about you only with persons involved in your care. Any time you make a written request, we will consider the request and tell you in writing of our decision to accept or deny your request. We are legally required to agree to only one type of restriction request: if you have paid us in full for a health procedure or item for which we would normally bill your health plan, we must agree to your request not to share information about that procedure or item with your health plan.

All written requests or requests for review of denials should be given to our Facility Compliance Office listed at the end of this notice.

CHANGES TO THIS NOTICE

We may change our privacy practices from time to time. Changes will apply to current medical information, as well as new information after the change occurs. If we make an important change, we will change our notice.

We will also post the new notice in our facilities and on our Web site at: www.DignityHealth.org/privacy. You can ask in writing for a copy of this notice at any time by contacting the Dignity Health Compliance Office. If our notice has changed, we will give you a copy of the notice the next time you register for treatment.

DO YOU HAVE CONCERNS OR COMPLAINTS?

If you think your privacy rights may have been violated, you may contact the Dignity Health Compliance Office Hotline at 800.443.1986 or by email at privacy.office@dignityhealth.org. Finally, you may send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights. Our Facility Compliance Office can provide you the address. We will not take any action against you for filing a complaint.

St. Joseph's Medical Center
Dignity Health Compliance Office
Dignity Health Compliance Office Phone: **800.443.1986**
Dignity Health Compliance Office Fax: **415.591.6279**

Version effective: January 22, 2018

MGF106
DHAZE4968
7/2018

Dignity Health Medical Group

Helpful Information about Your Provider Visit

1. **Please bring the following items to your appointment:**
   - Photo ID
   - Insurance Card
   - Co-Payment (if any)
   - Current medication list
   - Any records/results requested for your appointment

2. **Arrival Instructions**
   Please ensure your clinic arrival time is 15-30 minutes before you will meet with the provider to allow time for parking and completing paperwork.

3. **Obtaining Insurance Prior Authorization and Referrals**
   Many insurance plans require a mandatory prior authorization before a specialist can be seen. Please check with your insurance company to see if this is required on your plan before you come for your appointment. Your provider's office will have a staff member who handles prior authorizations and will be able to answer any of your questions. Authorization must be received prior to your scheduled appointment. Failure to receive prior authorization/referral may result in the need to reschedule your appointment to a later date. Please contact your insurance company for more information.

4. **Telephone Communications**
   Calls to 602.406.DHMG are answered from 7 a.m.-6 p.m., Monday thru Friday. Our team is equipped to handle general questions and can direct calls as appropriate. Additionally, our answering service is here to assist you after hours and on weekends or holidays. If necessary, the on-call provider can be contacted. For a life-threatening medical emergency, please call 9-1-1 immediately to activate your local Emergency Medical Service.

5. **Written Communications**
   Please do not fax any time-sensitive communication or urgent medical advice questions to the office.

6. **Electronic Communications**
   Dignity Health Medical Group uses an electronic patient portal. During the scheduling of your appointment, will be asked to provide an email address for enrollment purposes. Please discuss the procedure for secure electronic communications with your individual doctor or medical assistant.

7. **Medical Questions**
   Please call the office directly to discuss any concerns about your medical condition or if you have questions about your medications or laboratory results. If your call is of an urgent nature, please call the main number and inform the staff that you need urgent assistance.

   REMEMBER, for a true medical emergency do not wait for a return call from the office. Instead, call 9-1-1 to activate your local Emergency Medical Service.

8. **Appointment Reminder**
   You will receive an automated message via text, email and/or telephone call to remind you of your appointments. Please listen to the message and select one of the following message options:
   - Confirmation of your appointment
   - Cancellation of your appointment and reschedule request
   - General clinic information including address and hours of operation
   - Request to not receive future appointment reminders

   If you do not wish to receive an appointment reminder, please contact the front office staff.

9. **Cancellation of Scheduled Appointments**
   Should you need to cancel and reschedule an appointment, we ask that you kindly notify us as soon as possible and not later than 24 hours prior to the appointment so we can reschedule you in a timely manner and offer the open slot to another patient. If you are late for your appointment, you may have to be rescheduled. Multiple

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cancellations with less than 24 hours notice or failure to show will impact our ability to care for you.

10. **Pharmacy Refills**
For refills on medications prescribed by a doctor from this office only, please ask your pharmacy to fax a refill request to our office directly. It is important that you do not run out of your prescribed medications. Please plan ahead for refills and allow 3 business days for faxed refill requests to be processed and returned to the pharmacy. Keep in mind that prescriptions for certain controlled substances require a hard copy prescription that cannot be called in or faxed. It is the policy of our doctors not to refill controlled substance prescriptions for our practice partners; therefore, you must obtain these prescriptions from your specific provider.

11. **Test Ordering and Results**
Your doctor may order diagnostic tests as part of your evaluation and care. Some insurance companies require prior authorization and approval before your test can be scheduled. Your doctor will submit orders for these tests and the staff within our Referrals and Authorization Department will send required documentation to obtain authorization from your insurance company prior to scheduling any test(s). Questions about this process can be directed to 602.406.3464 (DHMG). Upon receipt, office staff will arrange the delivery of results; most results can be expected within 3 weeks of testing and are available on the patient portal.

12. **Medical Records**
We are unable to share your medical records without a signed release from you. If you need a copy of your medical records from Dignity Health Medical Group, you will need to sign an authorization request; select records are also available via the patient portal.

    You may also pick up a hard copy of your medical records, please note that a fee for this service may be incurred. If you require copies of your medical records, please contact us at 602.406.8988. Upon receiving your signed request, a copy of your records will be mailed within 2 weeks. Please ask our office staff if you have any questions.

    Please note that in order for us to obtain records from other physician offices, additional forms may need to be completed and signed.

    If you need records from a Dignity Health hospital—including lab tests or radiology results—please call the hospital directly and ask to be connected to the Health Information Department.

13. **Billing Inquiries**
Fees for services are due and payable at the time of your visit, including insurance co-payment. Patients are responsible for any services deemed "not-covered" by your plans. If you have questions about a bill you received that was generated from our office and doctor's visit or procedure performed here, please contact our Billing Department at 866.621.7272.

14. **Prompt Pay Discount**
If you don't have insurance or for uncovered services, you have an option to pay cash at the day of your appointment for a reduced fee. This program is called the Prompt Pay Discount. For more information on this program and to see if you qualify, please contact the main office.

15. **Patient Satisfaction Survey**
Here at Dignity Health Medical Group, we strive to provide an exceptional patient experience. One to four weeks after your visit, please expect to receive a survey via email or mail inquiring about your visit.Your response is confidential and we appreciate your feedback. We strive to provide a service where you will strongly agree that Dignity Health Medical Group delivers exceptional patient care.

If you have any questions, please speak with your provider or one of our staff members.

We look forward to providing healthcare for you and your entire family!

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