DMG
District Medical Group

MRN No._____

PATIENT ADMISSION PACKET

Patient Identification and Financial Responsibility Acknowledgement

Client Name (Last, First, Middle): _____

Email Address: _____

Date of Birth: _____ (Check One) ☐ Male ☐ Female

Race (check one) ☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American
☐ Native Hawaiian ☐ Caucasian

Language(s): _____

Ethnicity (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Address: _____
Street Address Apt # (if applicable) City State Zip

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

Pharmacy Name: _____Pharmacy Phone: _____

Pharmacy Address: _____
Street Address City State Zip

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

_____ Phone: _____
Name Relationship

_____ Phone: _____
Name Relationship

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

_____ _____
Name Relationship Name Relationship

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

I certify that this information is true to the best of my knowledge. _____
Signature Patient/Parent/Guardian

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Do you have any religious or cultural beliefs that may affect your healthcare? ____Yes ____No
If yes, please describe: _____
_____

Methods of learning new material that I like best are:

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

Level of Education Completed:

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

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

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

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Financial Responsibility Acknowledgment

Initials

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

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

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

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

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Print name of Patient/Parent/Legal Guardian

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Consent for Purpose of Information, Payment, and Healthcare Operations

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

Initials

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

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

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

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

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

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

_____ _____

Signature of Patient/Parent/Legal Guardian Date

_____

Printed Name of Patient/Parent/Legal Guardian

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Patient Record of Disclosures

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

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

Home/Mobile Telephone: _____

_____ OK to leave message with detailed info

_____ Leave message with call-back number only

_____ Decline personal phone messages

Work Telephone: _____ Work Fax: _____

_____ O.K. to fax to this number

_____ O.K. to leave message with detailed info

_____ Leave message with call back number only

_____ Decline work phone messages

Written Communications:

Email: _____

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

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

_____ O.K. to mail to my home address

Patient Representative to whom information may be given:

Name: _____ Relationship:_____ DOB: _____

Name: _____ Relationship:_____ DOB: _____

_____ _____

Patient/Parent/Guardian Signature Printed Name

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Consent for Treatment

Initials

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

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

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

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

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

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

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

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

_____ _____ _____ _____

Patient or Guardian signature Printed Name Relationship to Patient Date

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION

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

_____ _____ _____ _____

Patient or Guardian signature Printed Name Relationship to Patient Date

MRN No._____

District Medical Group Behavioral Health Department
Consent to Treatment

Welcome to DMG Behavioral Health Services. We provide a variety of behavioral health services to support you, your child, and your family. Our staff consists of Psychiatrists, Psychologists, Licensed Clinical Social Workers and Licensed Counselors. We provide assessment, individual and family therapy, and medication treatment to help with a variety of problems such as:

- Anxiety/fears related to medical conditions & treatment
- Depression
- Coping with chronic medical illness
- Behavioral or anger problems
- Self-esteem and identity issues
- Psychosocial issues
- Screening for learning disabilities & cognitive functions

The Behavioral Health Department cannot share information about you or your child with anyone outside of District Medical Group unless we have your written permission. Behavioral health records are locked in the Electronic Medical Record (EMR) and can only be accessed by staff associated with you or your child's medical care. When a language interpreter is required he or she will also follow these confidentiality guidelines.

There are some things we cannot keep private, such as reports of abuse or suspicion of abuse, neglect, danger to self or others, or information requested by a court of law (e.g. a valid subpoena or law suit). If we suspect that you or your child is being abused, neglected or otherwise in danger, we must report it to the authorities. If we are told that a person is going to do serious harm to themselves or to others, we must also report that to the authorities.

At times, when working with an adolescent it is in the best interest to keep some information private between the therapist and the adolescent. However, we will tell the parent/guardian and/or the authorities about things such as self-harm, suicidal behavior, harm to others, abuse or neglect.

Minors: Decisions about psychiatric, other behavioral health, and medical care must be made by a child's legal guardian(s), who must be physically present to provide consent, have an opportunity to be fully informed of the evaluation process, be provided with an opportunity to ask questions and in order for identity to be verified. In the situation of a parental separation or divorce (except in the case of one parent having sole physical and legal custody), both parents must consent, in writing, to the psychiatric evaluation. Both parents are invited and encouraged (as they are able) to participate in the process of evaluation and treatment. If one parent retains sole physical and legal custody, this parent must provide legal documentation of this in order for the psychiatric evaluation to occur as scheduled. Both parents, regardless of custody, have a legal right to medical records.

The Behavioral Health Department is open during these business hours: 7:00 am – 6:00 pm Monday – Thursday and 7:00am to 5:15pm on Friday. If you need assistance after hours, you may contact:

Children's Rehabilitative Behavioral Health phone line at…… (602)512-3055
The Desert Horizon Adult phone line at…… (602)336-4441
Child phone line at …… (602)336-4332
24 Hour Maricopa Crisis Line…… (602)222-9444 or (800)631-1314
In case of an emergency, you will need to call 911, or go to an emergency department

I am aware that I am entitled to:
1. Modify my consent to treatment at any time.
2. A fair explanation of the treatment I am to receive and the purposes of that treatment.
3. An answer to my inquiries concerning treatment.
4. Revoke my consent to treatment at any time.

I have had an opportunity to read, discuss and ask questions about this information.

_____	_____	_____
Patient/Parent/Guardian Signature	Signature Date	Printed Name
_____	_____	
Signature of Representative	Date	

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Desert Horizon Integrative Medicine

Acknowledgment of Receipt

At the time of admission, I have been provided with the following information

1. A list of client rights (MH-211);
2. A copy of the Refund Policy and Procedure;
3. A copy of the Billing Policy and Procedure that includes;
    a. Notice of fees: $ 60 fee for each Employee Completed Form that include, but not limited to:
        i. FMLA Forms
        ii. Disability Forms
        iii. Adoption Forms
        iv. Other forms requiring manual completion
        Please note: Forms may or may not be completed upon the first visit.
    b. Any ancillary forms will require a fee of $30.
    c. Notice of fees: $ 25.00 for the first 25 pages per each request for medical records, $.50 for every additional page after 25 pages (except to treating physicians and health insurance carriers). Allow 7-10 business days for completion.
    d. Client responsibilities pertaining to their insurance coverage and outstanding charges.
4. A copy of the No Show/Cancellation Policy and Procedure that applies to no shows and/or late cancellations (less than 24 hours-notice):
    a. NS fee of $ 60 will apply for med management (M.D.) appointments;
    b. NS fee of $ 120 for therapy appointments
    c. NS fee of $25 for family practice appointments
5. A copy of the Termination Policy and Procedure including, but not limited to:
    a. Multiple cancellations and/or no shows;
    b. Non-payment;
    c. Refusal to comply with recommended treatment;
    d. Services are beyond the scope of services of the outpatient clinic
    e. Inappropriate behavior.
6. A copy of the Medication Policy. *Please note in the policy that all medication refill requests are required to be made by the client. Desert Horizon will not accept medication refill requests from a pharmacy.*
7. The current telephone number and addresses of:
    a. The Office of Behavioral Health Licensure;
    b. The Department's Division of Behavioral Health Services;
    c. The human rights advocates provided by the Department of the Department's designee (if applicable);
    d. The Arizona Department of Economic Security Office of Adult Protective Services (if applicable);
    e. The Arizona Department of Economic Security Office of Child Protective Services (if applicable); and
    f. The local office of the Regional Behavioral Health Authority.
8. A copy of HIPAA Notice of Privacy Practices.

I acknowledge receipt of all documents listed above by my signature set forth below. I understand that it is my responsibility to read all policies and procedures provided to me.

_____ _____ _____/_____/_____

Signature of Client/Parent/Legal Guardian Printed name Date