Doctor On Call
Phone & Fax | 480-900-3556
info@doctoroncall.biz

Continuation of Treatment
Non Solicitation

I, _____ (patient name), wishes to continue receiving medical care from provider, Jessica Moody PA, and/or a provider of Doctor On Call corp [DOC], as my Primary Care Provider. I have made this decision independently without any solicitation.

PATIENT NAME: _____ DOB: _____
POA/GUARDIAN NAME: _____

The undersigned (the "Patient and/or Power of Attorney (POA)") confirms that he/she has requested Doctor On Call corp [DOC] to begin providing their medical care on an "unsolicited" basis. In order to induce DOC to accept this request, the Patient and/or POA represents and warrants to DOC as follows, and understands that DOC is relying on such representations and warranties in connection there with:

1. The request is being placed at the initiative and direction of the Patient/POA.
2. The request was not solicited or recommended, either orally or in writing, by DOC, or any of its medical providers or employees, at any time.
3. The Patient and/or POA understands that neither DOC, nor any of its medical providers or employees, have made any recommendation to the Patient and/or POA.
4. The Patient and/or POA has made the decision to change their Primary Care Provider ("PCP") to DOC at their own free will.
5. The Patient and/or POA made the decision to change their PCP to DOC by their own research and information, or on recommendation and information obtained from a source other than DOC staff. None of DOC's medical providers or employees had any input into the Patient and/or POA decision to change the patient's PCP.

The Patient and/or POA first learned about DOC from:

- ☐ Research
- ☐ Recommendation from a friend/family/medical provider/Assisted Living Facility staff member
- ☐ Other _____

Patient Name (printed): _____ DOB: _____

Patient/POA/Fiduciary Name (signed): _____ Date: _____

POA/Fiduciary Name (printed)(if different from patient): _____

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Financial Policy

Please read carefully, initial each paragraph, and sign at the bottom.

Fees and Payment Policy:

____ Payment is required at the time of your visit. If you are unable to make your co-payment at the time of your visit, your appointment may need to be rescheduled.

____ While filing insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.

____ Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and the services you intend to receive are covered.

____ In order for us to file a claim, you must present a CURRENT copy of your insurance at each visit and communicate changes in your personal information.

____ Not all services are a covered benefit in all policies, so it is especially important that you understand the provisions of your individual policy. Insurance companies select certain services that they will not pay for. Therefore, we cannot guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility.

____ Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on coverage by insurance companies. To request a diagnosis change solely for the purpose of securing reimbursement from an insurance carrier is considered fraud and will not be done by our office.

Miscellaneous Charges:

____ Non-Sufficient Funds (NSF) checks are subject to a $30.00 fee (in addition to fees from your bank).

We accept cash, checks, and major credit cards. There is a 3% credit card transaction fee. Additional fees may apply to special financing arrangements and bad debt collections.

By signing this Financial Policy, you, the guarantor, acknowledge that you have read, understand, and accept the above financial policy and responsibilities.

Patient Name (printed): _____ DOB: _____

Patient/POA/Fiduciary Name (signed): _____ Date: _____

POA/Fiduciary Name (printed)(if different from patient): _____

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HIPAA
NOTICE OF PRIVACY PRACTICES

We, the members of Doctor On Call corp [DOC], are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions regarding this notice, please contact our office by phone, fax, or mail. Our contact information is listed above.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient’s request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction.

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PAYMENT

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

HEALTHCARE OPERATIONS

We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request.

IMPORTANT NOTE:
Under the law, we must also disclose your protected health information when required to investigate or determine our compliance with the requirements under Section 164.500.

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USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

- The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or
  disclose your protected health information for marketing purposes.
- We may not sell your protected health information without your authorization.
- We may not use or disclose most psychotherapy notes contained in your protected health information.
- We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.
- You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR PRIVACY RIGHTS

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

1. You have the right to inspect and have a copy of your protected health information (additional fees may apply).
   - Pursuant to your written request, you have the right to inspect or have a copy of your protected health information, whether in paper or electronic format. The records will be provided within 30 days of request.
   - Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.
2. You may request copies of your medical records.
   - There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees.
3. You have the right to request a restriction of your protected health information.

- You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations.
- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.
- Your request must state the specific restriction requested and to whom you want the restriction to apply.

4. You have the right to request to receive confidential communications.
   - You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
5. You have the right to request an amendment to your protected health information.
   - You may ask us to correct health information about you that you think is incorrect or incomplete. We may say “no” to your request, but we will tell you why in writing within 60 days.
6. You have the right to receive an accounting of certain disclosures.
   - You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, and healthcare operations; required by law for up to six years prior to the date of the request.
7. You have the right to receive notice of a breach.
   - We will notify you if your unsecured protected health information has been breached. We will also notify you about the steps we have made to secure your protected health information post-breach and to resolve the breach.
8. You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically.
   - We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Patient Printed Name	Patient DOB
Patient/POA/Fiduciary Printed Name	Relationship of POA/Fiduciary
Patient/POA/Fiduciary Signature	Date signed

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Medical Record Release Authorization

Patient Name _____ Date of Birth _____
Home Phone _____ POA Phone _____
Address _____ City/State/Zip _____

A) I hereby authorize records FROM:
Name _____
Address _____
Phone Number _____
Fax Number _____

B) To be released TO:
Name _____
Address _____
Phone Number _____
Fax Number _____

Date Range: From _____to_____
or

- ☐ Past 1 year
- ☐ Past 3 years

- ☐ Physicians Office Notes
- ☐ Immunizations
- ☐ Operative/Procedure Reports
- ☐ Cardiology/EKG Reports
- ☐ Lab/Path Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Collaboration Notes and Records
- ☐ Other _____

Records Format:

- Records should always be delivered via secure fax, secure email, EHR transfer, or postal services.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. **Subject to Fees

This authorization will expire one year from the above date unless I specify an expiration date: (Expiration date of authorization) *PLEASE READ Fee Information: Doctor On Call corp [DOC] reserves the right to charge the fee schedule as set by the State of Arizona. **A $20.00 handling fee, $0.50 per page and postage may be invoiced to you** from DOC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DOC for your records. In the case of continuity of care, we may transfer a minimal portion of your records directly to a physician as a courtesy.

_____ _____
Patient or Patient Representative | Signature Date

_____
Patient | Printed Name

_____
Patient Representative/POA/Fiduciary | Printed Name

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Notice of Privacy Practices Acknowledgement Form

Patient Name: _____ DOB: _____

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

> How this office will use and disclose your protected health information Your privacy right with regard to your protected health information This office's obligations concerning the use and disclosure of your protected health information Release of Medical Information:

My preferable method of contact is:
Phone: _____ ___Home ___Cell
May we leave a detailed message? ___Yes ___No
Email: _____

You may discuss my medical information with:
Name: _____ Relationship:_____
Name: _____ Relationship:_____
Name: _____ Relationship:_____

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available upon request.

_____ _____
Patient or Patient Representative | Signature Date

_____
Patient | Printed Name

_____
Patient Representative/POA/Fiduciary | Printed Name