Outpatient Patient Information

Patient Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Social Security #: _____

Insurance Information

Primary Insurance: _____ Insurance Phone #: _____

Medicare #/ID #: _____ Group #_____

Subscriber Name (if different from self): _____

Subscriber DOB: _____

Secondary Insurance: _____ Insurance Phone #: _____

ID#: _____ Group #: _____

Subscriber name (if different from self): _____

Subscriber DOB: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

Physician Information

Referring Physician: _____ Physician Phone #: _____

OUTPATIENT REHABILITATION
PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical record.

Patient Name: _____ DOB:_____ Date:_____

Reason For Therapy Referral:_____

Date of Onset of Injury/Condition:_____

Have you had previous therapy for this injury/condition?_____

Is this injury/condition work related? _____ If so, has it been reported to your employer? _____

Medical History:

Do you have currently or have you had in the past any of the following:

Diabetes	Yes	No		Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No		Sensitivity to cold	Yes	No
Circulatory Disorders	Yes	No		Dizziness	Yes	No
Heart Disease	Yes	No		Seizures	Yes	No
Heart Attack	Yes	No		Headaches	Yes	No
Stroke/TIA	Yes	No		Cancer	Yes	No
Pacemaker	Yes	No		Visual Problems	Yes	No
Metal Implants	Yes	No		Allergies	Yes	No
Kidney Problems	Yes	No		Previous Surgeries	Yes	No
Hernia	Yes	No		Back Injuries	Yes	No
Nervous Disorders	Yes	No		Other injuries	Yes	No
Are you Pregnant?	Yes	No		Other Illnesses	Yes	No
Breathing Difficulties	Yes	No		Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No		Neurological Problems	Yes	No
Weight Loss	Yes	No		DVT/Pulmonary Embolism	Yes	No
COVID-19	Yes	No		COVID-19 Vaccine	Yes	No

If you answered **YES** to any of the above, please explain and give appropriate dates:

_____

_____

_____

Medications:

Are you currently taking any medications? (Check one) _____ **Yes** _____ **No**

If **YES**, please list the medications, dosage and for what condition.

Medication Name	Dosage	Condition

Therapy Communication Preferences

_____ _____

Patient Name Date

SHARING YOUR INFORMATION WITH CAREGIVERS, FAMILY AND OTHER VISITORS: It is our policy not to release confidential medical information regarding your treatment to caregivers, family members (other than the authorized representative), or other visitors unless we can reasonably infer from the circumstances that you do not object to sharing your information (for example, if a family member or other visitor is present while we are providing care, we will assume, unless you object, that the person is entitled to receive information regarding your treatment).

List which caregivers, family members, or other visitors may have limited verbal updates regarding your treatment when you are not present:

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Therapy Representative Date

Authorization for Payment Options

I understand that Auto Draft is an automatic bank account or credit card withdrawal system for paying my co-payments on the days that outpatient therapy is provided. I further understand that the decision of whether to participate in the Auto Draft program is **voluntary**, and I am under no obligation whatsoever to do so, as co-payments can be taken care of manually prior to each session.

(Please initial your choice(s) from the options listed below)

_____ I authorize ***Phoenix Mountain Therapy*** and my financial institution to deduct from my bank account the co-payment amount that is determined by my insurance provider for according to my rehabilitation benefits on the day that rehabilitation services are rendered.

_____ I authorize ***Phoenix Mountain Therapy*** and my financial institution to deduct from my credit card the co-payment amount that is determined by my insurance provider for according to my rehabilitation benefits on the day that rehabilitation services are rendered.

_____I authorize ***Phoenix Mountain Therapy*** and my financial institution to deduct from my bank account or my credit card any private balance due which is greater than 60 days in arrears.

_____I authorize ***Phoenix Mountain Therapy*** to process this payment for Dates of Service _____ (Month/Year) and going forward.

First Name: _____ Last Name: _____

Phone Number: _____

Mailing Address:_____

Financial Institution: _____

Financial Institution Address: _____

Please Check One: _____ Checking Account _____ Savings Account _____ Credit Card

Routing Number: _____ Account Number _____

Credit Card Number: _____ Exp. Date: _____

Credit Card Type: _____ Three Digit Security Code: _____

I may revoke this Authorization at any time, by providing notice to the Facility (Attention: Outpatient Clinic Director), in writing, thirty (30) days before I intend the revocation to be effective.

Today's Date: _____

Print Name: _____ Signature: _____

Patient Acknowledgements Signature Form

_____ **Financial Responsibility:** I acknowledge my obligation to pay for all therapy services provided by Phoenix Mountain Therapy. I understand that I am ultimately responsible for the payment of my account, and the clinic will not engage in negotiating settlements for any disputed insurance claims. As a courtesy, the clinic will submit claims to my insurance provider. I acknowledge that co-payments and patient responsibility are required at the time of service, and any remaining balance, after insurance has made an initial payment, will be due immediately upon receipt. I further understand that fees are due and payable for services that are rendered to me and agree to pay such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements are made with the Administration Department should this account be referred to an attorney or collection agency, I agree to cover reasonable attorney fees, legal costs, and collection expenses in addition to the balance owed.

_____**Treatment Consent:** I give my consent to undergo any evaluations and treatments prescribed or recommended by my physician or their designated substitute.

_____**Draft No Show/Late Cancellation Policy:** In order to ensure we can provide the best possible care to all patients and manage clinic and staff resources accordingly, we assess a $X no-show/late cancellation fee for any scheduled therapy visits that are not cancelled within 24 hours before the scheduled appointment time. This fee will be charged to the payment method on file.

_____**Home Health Service Agreement**: I am currently not receiving Home Health Services. I understand that I cannot participate in outpatient therapy while I am receiving Home Health Services and will be accountable for payment if both are being received at the same time.

_____ **Hospice Care:** I am not currently under Hospice care. I understand that I should disclose if I am under Hospice care to allow collaboration of the therapy professionals and your physician to ensure that your treatment is covered under the appropriate diagnosis.

_____**Authorization for Release of Information:** Phoenix Mountain Therapy is authorized to disclose, in line with clinic policy, any professional and clinical information needed to process my medical claims by authorized third-party agents or agencies, based on the medical records created during my treatment. The clinic is released from any legal responsibility that may result from sharing this information.

_____**Assignments and Authorization to Pay Insurance Benefits:** I assign and authorize payment to be made directly to the clinic for services rendered, not to exceed the clinic's standard charges for this treatment period. I understand that I am responsible for any charges not covered or paid by my insurance.

_____**Assignments and Authorization to Bill Medicare (IF APPLICABLE):** I assign and authorize payment to be made directly to this clinic for services rendered, not to exceed the facility's standard charges for this treatment period. I acknowledge that I am financially responsible for 20% of the Medicare Part B services.

Telehealth Acknowledgment: My signature below confirms that I understand and approve the use of telehealth services for evaluations and/or treatments as determined by my clinician. I recognize that services provided through telehealth will be billed in accordance with the requirements set by my insurance provider.

Acknowledgment of Receipt of Notice of Privacy Practices: My signature below confirms that I have received a copy of the Clinic/Agency's Notice of Privacy Practices, revised on March 1, 2016. I understand that refusing to sign does not prevent the clinic/agency from using or disclosing my health information as allowed by law.

Acknowledgment of Patient Rights: My signature below confirms that I have been informed about the policy on patient rights, received a copy of my patient rights, and been informed about the complaint process.

Financial Agreement Acknowledgement: My signature below confirms that I acknowledge receipt of the financial agreement. The patient and responsible party certify that they have read the entire agreement, fully understand its terms and conditions, and agree to abide by them. The responsible party, or any individual signing on behalf of the patient, affirms they are authorized to do so. By signing, both the patient and responsible party accept all the terms of this agreement and commit to fulfilling its obligations. No representations have been made by the facility or its staff beyond those outlined in this agreement.

Acknowledgment of Advanced Directives: My signature below confirms that I have been informed about the clinic's policy on advanced directives and have been offered a copy of this policy.

By signing below, patient and/or responsible part is agreeing to all of the above and is acknowledging that they have received digital copies of the above documents and may request printed copies at any time.

Patient or Responsible Parties Name:

(If form is completed by responsible party/POA, please provide a copy of POA paperwork to the front desk).

_____

Printed

_____ _____

Signature Date

Phoenix Mountain Therapy

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Name of Beneficiary: _____ HIC #::_____

Date(s) of Service: _____ Provider #:_____

SECTION I (Employment)

A. Are you currently working? Yes No No, Never Employed

Date of Retirement, if applicable:_____

Employer:_____ Insurance Co:_____ Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

B. Are you covered by an Employer Group Health Plan? Yes No

Employer:_____ Insurance Co:_____ Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

C. Is your spouse currently working? Yes No No, Never Employed

Date of Retirement, if applicable:_____

Employer:_____ Insurance Co:_____ Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

D. Are you covered under an employed spouse or family member: Yes No

Employer:_____ Insurance Co:_____ Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

SECTION II (Disability)

A. Are you entitled to Medicare Benefits SOLELY because of a disability? Yes No

If yes, date of disability:_____ Describe Disability:_____

SECTION III (Accident/Injury)

A. Was your illness/accident related to a WORK injury, past or present? Yes No

Employer:_____ Insurance Co:_____ Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

Name of Workers Compensation Carrier:_____ Attorney:_____

B. Was your illness/injury related to an AUTOMOBILE accident? Yes No

Date of accident:_____ Location:_____

How did accident occur:_____

Automobile medical or no-fault insurance:_____ Claim/Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

C. Was your illness/injury related to an accident, OTHER than an automobile accident? Yes No

Date of accident:_____ Location:_____

How did accident occur:_____

Automobile medical or no-fault insurance:_____ Claim/Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

Can payment be made by third party liability insurance: Yes No

Third party liability or attorney:_____

Address:_____ City:_____ State:_____ Zip: _____

SECTION IV (VA/Black Lung)

A. Are you entitled to any Veteran's Administration Benefits for a service related illness or injury? Yes No

VA Plan Name:_____ Claim/Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

B. Are you entitled to any Black Lung Benefits? Yes No

Black Lung Policy Name:_____ Claim/Policy #:_____

Address:_____ City:_____ State:_____ Zip: _____

SECTION V (End Stage Renal Disease (ESRD))

A. Are you entitled to Medicare ONLY because of End Stage Renal Disease (ESRD)? Yes No

If yes, did you have self dialysis training or a kidney transplant 3 months prior to Medicare Entitlement?

Yes No

Date of first dialysis or kidney transplant:_____

B. Are the services to be paid by a program such as a government research grant? Yes No

OBTAIN BENEFICIARY OR OTHER REPRESENTATIVES' SIGNATURE IF POSSIBLE. IF UNABLE TO OBTAIN A

SIGNATURE, PLEASE INDICATE HOW THE INFORMATION WAS OBTAINED.

Beneficiary/Resp. Party Signature (Optional):_____ Date: _____

Facility Witness Signature:_____ Date: _____

Phoenix Mountain Therapy Financial Agreement

PHOENIX MOUNTAIN THERAPY RESPONSIBILITIES

1. Phoenix Mountain Therapy shall provide services and materials as described in Section 2 below, in compliance with the orders of the Patient's physician. Administration of treatments shall be ordered by the Patient's physician.
2. Phoenix Mountain Therapy shall provide the following prescribed services to Patient (circle all that apply): Occupational Therapy, Physical Therapy, Speech Therapy)
3. Additional services may be provided by Phoenix Mountain Therapy upon receipt of subsequent orders from the Patient's physician. Any such services provided by Phoenix Mountain Therapy shall be subject to all the terms of conditions and obligations of this Agreement. Phoenix Mountain Therapy welcomes all persons without regard to race, color. national origin. religion sex or qualified handicaps.

PATIENT/RESPONSIBLE PARTY RESPONSIBILITIES

1. Patient and Responsible Party agree jointly and severally to assume and be liable for all charges of whatever nature incurred by or on behalf of Patient for the services described herein and to pay such charges as they become due.
2. Patient and Responsible Party further agree that, if any of the services rendered by Phoenix Mountain Therapy to Patient, are covered by insurance, or benefits under either Title XVlll or Tile XIX of the Social Security Act (Medicare/Medicaid), is nevertheless the joint and several obligation of Patient and Responsible Party to pay all charges incurred by or on behalf of Patient. Patient and Responsible Party further agree that any co-insurance or deductible obligation under Medicare, Medicaid or private insurance must be paid directly to Phoenix Mountain Therapy by Patient and Responsible Party.
3. Patient and Responsible Party further agree that any charges which are not made IN FULL when due or no later than 30 days shall be subject to a late charge of 1.5% monthly, (18%) percent per annum until paid. Should it become necessary for Phoenix Mountain Therapy to refer Patient's delinquent account to an attorney for collection, Patient and Responsible Party agree to pay in addition to all sums due all reasonable attorney's fees, court costs and all other reasonable costs of collection.

PATIENT'S CERTIFICATION

1. Patient certifies and warrants that all information submitted on behalf of Patient for purposes of applying for or receiving benefits under Title XVIII or XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Responsible Party warrants that all information they have supplied to Phoenix Mountain Therapy is correct and true and further agree to hold harmless and indemnify Phoenix Mountain Therapy from and against any and all loss, damage, cost. expenses, or liability resulting from Patient's or Responsible Party's submission of false or incorrect information to Phoenix Mountain Therapy.
2. Patient authorizes any health care Phoenix Mountain Therapy or doctor to furnish Phoenix Mountain Therapy and/or or the Social Security Administration. its fiscal intermediary or carrier all requested information from Patient's medical or financial records. Patient further authorizes Phoenix Mountain Therapy to disclose all or any part to Patient's medical or financial records to any person or entity which is or may be liable under contract to Phoenix Mountain Therapy, to Patient or to a family member or to the employer of Patient to pay all or a portion of the costs or care provided to Patient including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carrier, welfare fare of Patient's employer. Patient

further authorizes Phoenix Mountain Therapy to disclose all or any part of Patient's medical or financial records to any independent auditor of Phoenix Mountain Therapy.

3. Patient requests and hereby authorizes that payment for any authorized benefits be made directly to Phoenix Mountain Therapy on Patients behalf Phoenix Mountain Therapy does not make any assurance of any kind whatsoever that Patient's care will or can be covered by Medicare/Medicaid or any private insurance, and the Patient and Responsible Party hereby release Phoenix Mountain Therapy, its agents, servants, and employees from any liability or responsibility in connection with the Patient's and/or Responsible Party's potential claim of coverage under Medicare/Medicaid and/or private insurance program.

RESTRICTIONS AND LIABILITIES

1. Patient and Responsible Party hereby release Phoenix Mountain Therapy from any and all harm, liability. injury or loss suffered by Patent while outside the physical confines of Phoenix Mountain Therapy and/or the supervision and contract of Phoenix Mountain Therapy's staff.
2. Phoenix Mountain Therapy shall have no liability for injuries of any kind suffered by Patient while under its care. except where the injury is caused by the negligence of Phoenix Mountain Therapy or its regular staff or as required by law. If Patient discontinues or suspends treatment before the attending physician has so ordered, or if Patient fails to follow a prescribed regimen of activity, treatment or therapy, Patient and Responsible Party agree to assume all responsibility for any result which may follow Patient's action.
3. Phoenix Mountain Therapy is not responsible or liable for any injury to Patient caused by Phoenix Mountain Therapy visitors attempting to assist to treat Patient in anyway. For the safety of Patient and others, only the Patient and Patient's guardian, if a minor, are permitted into patient treatment areas of Phoenix Mountain Therapy.
4. Phoenix Mountain Therapy is not liable or responsible for any personal belongings brought into and left in Phoenix Mountain Therapy by Patient. except as required by law.

MISCELLANEOUS

1. Where Patient is eligible for Medicaid benefits and/or where Phoenix Mountain Therapy is precluded under state or federal law in requiring that a Responsible Party act as guarantor for Patient. the term "Responsible Party", as used herein. shalt be deemed to mean "Patient Agent". The Patient Agent is responsible for assuring that any of Patient's own funds, over which such Patient Agent exercises any management or control, and which constitutes the Patient's share of costs or liability to Phoenix Mountain Therapy, shall be paid to Phoenix Mountain Therapy as such liability is incurred.

Notice of Privacy Practices

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

YOUR RIGHTS

When it comes to your health information, you have certain rights. You have the right to:

- **Get an electronic or paper copy of your medical records**
  - o You may ask to see or obtain an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this
  - o We will provide a copy or a summary of your health information and may charge a reasonable, cost-based fee for doing so

- **Ask us to correct your medical records**
  - o You may ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
  - o We may deny your request and will provide you a reason in writing

- **Request confidential communications**
  - o 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
  - o We will comply with all reasonable requests

- **Ask us to limit what we use or share**
  - o You may ask us **not** to use or share certain health information for treatment, payment or our operations. We may deny your request if we believe it may affect your care
  - o If you pay for a service or health care item out of pocket in full, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will comply with your request unless a law requires us to share that information

- **Get a list of those with whom we have shared your information**
  - o You may request a list (accounting) of the times and to whom we have shared your health information for six (6) years prior to the date you ask.
  - o We will include all the disclosures except for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free and may charge a reasonable, cost-based fee if you request additional lists within twelve (12) months.

- **Get a copy of this privacy notice**
  - o You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly

- **Choose someone to act for you**

o If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information
o We will verify the person has this authority and may act for you before we take any action

❖ **File a complaint if you feel your rights have been violated**
o You may complain if you feel we have violated your right by contacting us using the information below. We will not retaliate against you for filing a complaint.
- *Our Compliance Hotline at **1-866-256-0955** which is available 24 hours per day, 7 days per week.*

o You may file a complaint with the U.S Department of Health and Human Services Office for Civil Rights by sending a letter to:
- **200 Independence Avenue, S.W. Washington, D.C 20201, calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.**

YOUR CHOICES

For certain health information, you may tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

❖ **In these cases, you have both the right and choice to tell us to:**
o Share information with your family, close friends, or others involved in your care
o Share information in a disaster relief situation
o Include your information in a directory

❖ **In these cases, we may not share your information unless you give us written permission:**
o Marketing purposes
o Sale of your information
o Most psychotherapy notes

❖ **In the case of fundraising**
o We may contact you for fundraising efforts, but you may tell us not to contact you again

OUR USES AND DISCLOSURES OF YOUR INFORMATION

We may use or share your health information for treatment, to obtain payment, and/or to operate our business.

❖ **Treat you**
o We may use your health information and share it with other professionals who are treating you

- *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

❖ **Run our organization**

o We may use and share your health information to run our practice, improve your care, and contact you when necessary

- *Example: we use health information about you to manage your treatment and services.*

❖ **Bill for your services**

o We may use and share your health information to bill and receive payment for health plans or other entities

- *Example: We give information about you to your health insurance plan to obtain payment for your services*.

We are allowed or required to share your information in other ways – usually in ways that contribute to public good, such as public health, safety, and research. We must meet many conditions in the law before we may share your information for these purposes. For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

❖ **Help with public health and safety issues**

o We may share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to a person's health or safety

❖ **Do research**

o We may use or share your information for health research with your written permission

❖ **Comply with the law**

o We may share information about you if state or federal laws require it, including with the Department of Health and Human Services (DHHS)

❖ **Respond to organ and tissue donation requests**

o We may share health information about you with organ procurement organizations or other entities engaged in the procurement, banking, or transplantation for the purpose of facilitating organ and/or tissue donation

❖ **Work with a medical examiner or funeral director**

o We may share health information with coroners, medical examiners, or funeral directors as necessary to carry out their duties

❖ **Address workers' compensation law enforcement and other government requests**

o We may use or share health information about you:

- For Workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

❖ **Respond to lawsuits and legal actions**

o We may share health information about you in response to a court or administrative orders, or in response to a subpoena

OUR RESPONSIBILITIES

❖ We are required to maintain the privacy and security of your protected health information
❖ We are required to notify you promptly in the event your information is compromised
❖ We must follow the duties and privacy practices described in this notice and give you a copy of it on request
❖ We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
❖ For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Changes to the Terms of This Notice

We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website.

THIS NOTICE DESCRIBES THE RIGHTS YOU HAVE AS A PATIENT IN OUR PRACTICE. PLEASE REVIEW THEM CAREFULLY.

Patients Have a Right to:

- Be treated with dignity, respect, and consideration
- Not be subjected to abuse, neglect, exploitation, coercion, manipulation, sexual abuse or assault, restraint or seclusion (subject to R9-10-1012(B)), retaliation for submitting a complaint to the Department or another entity, or misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student
- Not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis
- Receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities
- Receive privacy in treatment and care for personal needs
- Review, upon written request, the patient's own medical record
- Receive a referral if the outpatient treatment center is not authorized or able to provide certain health services needed by the patient
- Participate or have the patient's representative participate in the decisions concerning treatment
- Refuse treatment to the extent allowed by law
- Receive assistance by the patient's representative or other individual in understanding, protecting, or exercising the patient's rights

Administrators Shall Ensure that:

- A patient or the patient's representative either consents to or refuses treatment, except in an emergency
- A patient or the patient's representative may refuse or withdraw consent before treatment is initiated
- A patient is informed of alternatives to a proposed psychotropic medication or surgical procedure and
- associated risks and possible complications of a proposed psychotropic medication or surgical procedure, except in emergencies
- A patient or the patient's representative is informed of the outpatient treatment center's policy on health care directives and the patient complaint process
- A patient consents to a photograph before taken, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes
- A patient provides written consent to release information in the patient's medical record or financial records, except as otherwise permitted by law

Patient Responsibilities:

- Providing us with honest, complete information about matters that relate to your care
- Showing respect and consideration for the rights of fellow patients, our staff and our property
- Complying with the rules of our facility, including our visitor and smoke-free environment policies
- Patient Comment or Complaint Process:
- Ask to speak with the center's Site Manager
- Any patient or patient's representative has to right to report any concerns to:

Arizona Department of Health Services
Medical Facilities Licensing

150 N. 18th Avenue, Ste. 450
Phoenix, AZ 85007
(602) 364-3030