UMBRELLA
MOBILE PRIMARY CARE & BEHAVIORAL HEALTH

Dear Valued Patient/POA,

Thank you for allowing Umbrella Primary Care and Behavioral Health to participate in your medical care as your Primary Care, Palliative Care, Psychiatry, or Behavioral Health Provider.

To Start the Enrollment Process, We Will Need:

- **The attached registration form completed and signed,**
- **A copy of your most current insurance card,**
- **A complete list of your current medications,**
- **Name and phone number of your current PCP and Specialists so that we can request medical records, if necessary.**

If you need assistance with completing the New Patient Registration Form, or have questions regarding our services, please don't hesitant to contact our office to speak with one of our intake coordinators.

Once the registration is received by our office we will verify insurance, and contact you, or your designee, to go over coverage and schedule an appointment.

Note: We try to process all new patients within 72 hours and have them seen within seven (7) business days. However, delays can occur if our intake office needs more information, or your insurance requires a one-time prior authorization. That said, if you have a serious concern and need to be seen quickly, please let our office know so we may accommodate you as best we can.

If you have any questions, please feel free to contact our Office.

Sincerely,

Umbrella Healthcare Solutions
Phone: 602-362-2983
Fax: 480-565-4552

Umbrella Healthcare Solutions, 9225 N 3rd St, Suite # 203, Phoenix, AZ 85020 | T: (602) 362-2983 | F: (480) 565-4552

Last Name:_____ **First Name:**_____

Facility Name:_____ ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Address:_____

Date-of-Birth: _____ **Gender:** ____ **Social Security Number:** _____

Race (*leave blank to decline*): ☐ **American Indian/Alaska Native** ☐ **Black/African American** ☐ **Asian** ☐ **Hawaiian/Pac. Islander** ☐ **Caucasian** ☐ **Other**

Ethnicity *(leave blank to decline)*: ☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

Home Phone:_____ **Cell Phone:**_____

Email:_____ **Fax Number:**_____

Preferred Contact: **Home Phone** **Cell Phone** **Text Message** **Email**

INSURANCE INFORMATION

Primary Policyholder Information

Primary Insurance

Insurance Name:_____
Policy #:_____
Group #:_____
Policyholder:_____

Secondary Insurance

Insurance Name:_____
Policy #:_____
Group #:_____
Policyholder:_____

FINANCIAL INFORMATION

Name:_____ Relationship:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Cell Phone:__

INFOMRATION RELEASE AUTHORIZATION & EMERGENCY CONTACT INFORMATION

I authorize the release of my healthcare information to:
Medical POA -primary:_____
Primary Phone:_____
Medical POA -secondary:_____
Secondary Phone:_____
Emergency Contact:_____
Emergency Contact Phone:_____

CURRENT PHYSICIANS/SPECIALISTS

	Name	Phone
Primary Care		
Cardiology		
Pulmonology		
Nephrologist		
Urologist		
Psychiatrist		

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PAST MEDICAL HISTORY

Last Name:_____ First:_____ DOB:_____

Please check ALL boxes that apply.

IMMUNE SYSTEM
- ☐ Seasonal Allergies
- ☐ Low Immune System
- ☐ Other_____

BLOOD DISORDERS
- ☐ Hemolytic Anemia
- ☐ Iron Deficiency Anemia
- ☐ Other_____

CANCERS
- ☐ Bone Cancer
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Melanoma
- ☐ Renal Carcinoma
- ☐ Skin Cancer
- ☐ Thyroid Cancer
- ☐ Other_____

CARDIAC
- ☐ Blood Clot
- ☐ Heart Attack (MI)
- ☐ Heart Failure (HF)
- ☐ Heart Valve Disease
- ☐ High Blood Pressure (HTN)
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Irregular Heart Beat (Tachycardia/Bradycardia)
- ☐ Atrial Fibrillation (A-Fib)
- ☐ Atrial Flutter
- ☐ Peripheral Vascular Disease
- ☐ Coronary Artery Disease (CAD)
- ☐ Other_____

ENDOCRINE/HORMONE
- ☐ Diabetes, Type I
- ☐ Diabetes, Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other_____

GASTROINTESTINAL
- ☐ Cirrhosis (liver)
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Gallbladder Disease
- ☐ Hepatitis Type_____
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Reflux (GERD)
- ☐ Stomach Ulcer
- ☐ Other_____

KIDNEY/URINARY TRACT
- ☐ Acute Renal Failure
- ☐ Chronic Renal Failure
- ☐ Kidney Stones
- ☐ Urinary Reflux
- ☐ Other_____

LUNGS/PULMONOLOGY
- ☐ Asthma
- ☐ COPD
- ☐ Chronic Bronchitis
- ☐ Pulmonary Embolism
- ☐ Pulmonary Hypertension
- ☐ Pulmonary Edema/Effusion
- ☐ Emphysema
- ☐ Other_____

MENTAL HEALTH HISTORY
- ☐ Anxiety
- ☐ Post-Traumatic Stress Disorder
- ☐ ADD
- ☐ Obsessive-Compulsive
- ☐ Schizophrenia
- ☐ Bipolar
- ☐ Depression
- ☐ Substance-Related Addiction
- ☐ Other_____

MUSCLE/BONE/TISSUE
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Other_____

NEUROLOGY
- ☐ Alzheimer's Disease
- ☐ Stroke
- ☐ Dementia
- ☐ Headaches
- ☐ Parkinson's Disease
- ☐ Seizure Disorder
- ☐ Traumatic Brain Injury (TBI)
- ☐ Multiple Sclerosis
- ☐ Other_____

SKIN
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other_____

OTHER
- ☐ Glaucoma
- ☐ Sleep Apnea
- ☐ Other_____

ADDITIONAL HEALTH HISTORY TO NOTE

HOSPITALIZATION
Hospital Name:_____

Reason:_____

Date:_____

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PAST MEDICAL HISTORY

Last Name:_____ First:_____ DOB:_____

Please check ALL boxes that apply.

ADVANCED DIRECTIVES

Living Will

☐ Yes On File ☐ None

DNR

☐ Yes On File ☐ No

Organ Donation

☐ Yes On File ☐ No

TOBACCO/ALCOHOL

Tobacco

☐ Nonsmoker
☐ Current Use
- ☐ Cigarettes:____/day
  ____years smoked
- ☐ Cigars:____/day
  ____years smoked

☐ Past Use

Alcohol

☐ Non-Drinker
☐ Current Alcoholic
☐ Past History of Alcoholism
☐ Current Drinker
☐ Frequency
☐ Rare ☐ Social ☐ Regular
_____Times/Week

SURGICAL HISTORY (WITH YEARS)

_____

_____

_____

FAMILY HISTORY

MOTHER:_____

FATHER:_____

MEDICATIONS	DOSAGE

KNOWN ALLERGIES:_____

_____

General Consents & Acknowledgements

Authorizations: I authorize ***Umbrella Healthcare Solutions (UHCS)*** to provide treatment, services, and procedures which may include, but are not limited to primary care, palliative care, psychiatry, behavioral health, labs, imaging consults, medical and minor surgical treatments, or procedures under the instructions of UHCS providers. I understand this consent will remain valid as long as I am enrolled with UHCS. I understand by signing this consent form, I am authorizing any member of the UHCS clinical team and my insurance payer to access my information and records, as needed.

Consent for Chronic Care Management: I authorize Umbrella Healthcare Solutions (UHCS) to provide me with Chronic Care Management. This is available to all Medicare Beneficiaries with two or more chronic conditions. This program will provide you with care coordination and will work closely with all the parties involved to ensure you receive the highest level of care possible. We will work to reduce hospitalizations/associated costs and eliminate any gaps in care. By participating in this program, you are allowing the UHCS CCM Team to monitor your conditions, provide care oversight and update the medical provider as needed should there be any changes of condition. We will submit a claim to Medicare, or your insurance company once we have provided 20 minutes of non-face-to-face care per month. Only one provider can bill for this service, please notify UHCS if there is another provider that is providing you with this service. I understand the I may opt out of these services. **Opt. Out**: By initialing here, I do not want to receive services: ____.

Consent for Palliative Care: I authorize Umbrella Healthcare Solutions (UHCS) to provide me with Palliative Care. Palliative care services are offered by our primary care providers and is a resource for anyone living with a serious illness, such as heart failure, chronic obstructive pulmonary disease, cancer, dementia, Parkinson's disease, a combination of illnesses, and many others. Palliative care not only improves the quality of life of patients and their families, reducing mental and physical distress and discomfort, but also can help patients live longer and avoid hospitalization. We will submit a claim to Medicare, or your insurance company, for your palliative visit. Palliative visits are in addition to your routine, or sick visits and provides the patient added time with our Providers. I understand I may opt. out of these services. **Opt. Out**: By initialing here, I do not want to receive services:___.

Consent for Communication: I understand that if I email, text, video chat, cell phone, or facsimile UHCS providers and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email are not secure communication methods; for example, unencrypted messages could be intercepted. As such, I expressly waive the UHCS's obligation to guarantee confidentiality with respect to such correspondence using such means of communication. I acknowledge that all such communications may become part of my medical records.

Assignment of Benefits: I hereby authorize assignment of the medical insurance benefits I am due to UHCS for application to bills for medical services and supplies received. I further authorize UHCS to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due UHCS and not received from my insurance carrier(s). I understand UHCS is submitting claims on my behalf as a courtesy. I shall not revoke this assignment for any reason.

Explanation of Benefits (EOB)

You will receive an EOB from your insurance company for services you received. The EOB is not a bill. The EOB informs you on what your insurance will pay and what you need to pay. Your eligibility to receive care is determined prior to your visit. However, we are limited by the information the insurance company provides and you may need to contact them directly if you see any discrepancies in the EOB. General

Statements: Each month you will receive a statement for your portion of any bill that is due within 30 days of receipt. Unpaid balances may result in the discontinuation of services until balances are either paid, or payment arrangements have been made.

Medication Refill Policy: Prescriptions should be obtained at your regularly scheduled physician appointments and medications will not be automatically refilled. Refills will be scheduled based upon the most recent fill date by your pharmacy. It will be necessary for you to make an appointment for any prescription changes as this will not be done over the phone. There are times when you may have prescription needs between appointments, please be aware that no prescriptions will be refilled after normal business hours. Please allow 72 hours for processing of any prescription request. Please note that some prescriptions require prior authorization, and the processing of the prescription will be delayed.

Scheduling Agreement: I acknowledge the I may be scheduled for in-office (Behavioral Health Only), in-home, and/or telehealth services. For UHCS staff to schedule you in a timely manner and allow for timely follow-up appointments, it is your responsibility to communicate when you are unable to keep your scheduled appointments. Patients that have 3, or more no-shows with the practice, or any provider may be discharged from the practice.

Patient Name:_____ **DOB:**_____

Signature:_____ **Date:**_____

Relationship to Patient: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I ask that any requested records be sent to:
Umbrella Healthcare Solutions, 9225 N 3rd St., #203, Phoenix, AZ 85020
Telephone: 602-362-2983 | Fax: 480-565-4552

Purpose of Release

- ☐ Appointment/Continuation of Care
- ☐ Changing Physician(s)
- ☐ Other:_____

Information to be Released

- ☐ Demographics Sheet
- ☐ Office Notes/H&P
- ☐ Laboratory Tests
- ☐ X-Rays/Scans

I authorize the release of photocopies of the above-noted medical records in your possession to be released to Umbrella Healthcare Solutions (UHSC), its employees, or agents. I understand that the information in my health record may include information relating to behavioral, mental, or physical conditions/services in which I have received.

Participation with Health Current: UHSC is enrolled with Health Current, Arizona's Health Information Exchange (HIE)**,** that allows participating providers, first responders, hospitals, labs, community behavioral health and physical health providers, post-acute cares, etc. to securely share patient information and records.

HIE Disclaimer: Patients have the right to request a copy of their health information that is available through Health Current, Arizona's health information exchange (HIE). Patients also have a right to request a list of the persons who have accessed their health information through the HIE in the last three years. If you want to request any of this information, please complete and return this form to your healthcare provider. You will receive a response to the request within 30 days. Please note, Health Current may https://healthcurrent.org/ only send data to an address within the United States of America or its territories. If you are filling out this form for another person, the references to "I" and "my" in this form refer to that other person.

Opt Out: By initialing here, I do not want any of my information shared through Health Current_____.

I have given my consent freely and without coercion. I understand I may revoke this authorization at any time by providing UHSC notification in writing. I understand that the revocation will not apply to information that has already been released in response to this signed authorization. I understand that a photocopy/ facsimile of this authorization is considered acceptable in lieu of the original.

Signature:_____ **Date:** _____

Printed Name:_____ **Relationship:**_____

PATIENT NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments

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

If you have any questions about this notice or if you need more information, please contact:

Umbrella Healthcare Solutions
Attn: Owen Owens, PhD, MHA
9225 N 3rd St., #203, Phoenix, AZ 85020
Phone: (602) 362-2983
Email: oowens@umbrellahcs.com

ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at **Umbrella Healthcare Solutions.** We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply withcertain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

WHAT IS PROTECTED HEALTH INFORMATION ("PHI")

PHI is information that individually identifies you. We create a record or get from you or from another health care provider, health plan, your employer, or a healthcare clearinghouse that relates to:

- Your past, present, or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your healthcare.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- **Treatment.** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHImay be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician orother health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and under taking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **Health Care Operations.** We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that youhave an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors**. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research.** We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiativesamongst **Umbrella Healthcare Solutions** providers. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contactany individual.
- **As Required by Law.** We will disclose PHI about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessaryfor those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injuryor disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example,audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, governmentprograms, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuit sand Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
- **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**
- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Payment for Your Care.** Unless you object in writing, you can exercise your rights under HIPAA that your health care provider does not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
- **Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We may disclose your PHI as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

Your Written Authorization if Required for Other Uses and Disclosures

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy.** You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to **30 days** to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If wedo deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request,and we will comply with the outcome of the review.
- **Summary or Explanation.** We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Electronic Copy of Electronic Medical Records.** If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request your record will be provided in a readable hard copy form.
- **Receive Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12- month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or health care operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure; and to whom you want the restriction to apply.
- **Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing, and you must specify how or where we are to contact you.
- **Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by contacting Umbrella Healthcare Solutions.

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create orreceive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the **Umbrella Healthcare Solutions**, Privacy Officer, at the address listed at thebeginning of this Notice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Humans Services, 200 Independence Ave., S.W., Washington, D.C.20201. Call (202)619-0257(or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/,for more information.

Umbrella Healthcare Solutions
9225 N 3rd St., Suite 203
Phoenix, AZ 85020
Tel: (602) 362-2983
Fax: (480) 565-4552

Scope of Services
PATIENT RIGHTS & RESPONSIBILITIES

As a healthcare service provider, we have an obligation to protect the rights of our patients. Patients also have certain responsibilities. Both are included below. The Practice or the Your family or your designee may exercise these rights for you if you are unable to exercise them for yourself.

As a patient you have the right to:

1. Competent, individualized health care without regard to race, color, creed, sex, age, national origin, handicap, ethical/political beliefs, ancestry, religion or sexual orientation or whether or not an advance directive has been executed.
2. Exercise your rights. In the event you have been judged incompetent, your family or guardian has the right to exercise your rights.
3. In the case of a patient who has not been adjudged incompetent, any legal representative may exercise the patient's rights to the extent permitted by law.
4. Be free from verbal, physical, psychological, and sexual abuse or harassment of any form including corporal punishment or physical or chemical restraints and to be treated with consideration, respect and full recognition of your dignity and individuality, including privacy in treatment and care for personal needs.
5. Participate, either yourself or your designated representative, in the consideration of ethical issues that arise in your care.
6. Have your property treated with respect.
7. Be admitted for service only if the Practice can provide safe, professional care at the level of intensity needed.
8. Expect all personnel caring for you will be current in knowledge, appropriately licensed or certified as applicable and have completed a training program or competency evaluation regarding his/her respective areas of employment.
9. Be informed that you may participate in the development of your plan of care or treatment, the periodic review and update, discharge plans, appropriate instruction, and education in the plan of care and be informed of all treatments the Practice is to provide, the disciplines needed to provide your care, and the frequency of visits/shifts to be furnished and to be advised of any change in the plan of care before the change is made.
10. Know when and how each service will be provided and coordinated, the Practice ownership, name and functions of any person and affiliated Practice personnel providing care and services.
11. Choose care providers, to communicate with those providers and to reasonable continuity of care.
12. Be fully informed, orally and in writing, at the time of admission and in advance of care provided, a statement of services available by the Practice, care and treatment provided by the Practice and related charges. This must include those items and services for which you may be responsible for reimbursement, eligibility for third party reimbursement, coverage available under Medicare, Medicaid and any other federal program of which the home health Practice is aware. The Practice will advise you of changes orally and in writing as soon as possible, but no later than thirty (30) calendar days from the date that the Practice becomes aware of a change.
13. Be informed about the nature and/or purpose of any procedure that will be performed including information about both the potential benefits and burdens to the patient, as well as who will perform the procedure.
14. Be taught and have your family members taught the treatment plan, so that you can, to the extent possible, assist yourself
15. and your family or other designated party can also understand and assist you.
16. Request information regarding the diagnosis, prognosis and treatments including alternatives to care risk(s) involved. This information will be given in a language or format so that you and your family members can readily interpret and understand so that informed consent may be given.
17. Refuse any/all treatment to the extent permitted by law after being fully informed of and understanding the possible consequences of such action, without relinquishing any other portions of the treatment plan, except where medical contraindication of partial treatment exists.
18. Review all of your health records during normal business hours with prior approval of management, unless contraindicated in the clinical record by the physician.
19. Be referred elsewhere when denied services for any reason and upon request, given a written explanation regarding the denial.
20. Privacy including confidentiality of all record communications, personal information and to transfer to a health care facility, as required by law or third-party contracts. You shall be informed of the policy and procedure regarding disclosure of your clinical records.
21. Receive the care necessary to assist you in attaining optimal levels of health, and if necessary, cope with death. To know that a patient does not receive experimental treatment or participate in research unless he / she gives documented voluntary informed consent.
22. Know that Do – Not – Resuscitate orders shall not constitute a directive to withhold or withdraw medical treatment other than CPR. Withdrawal of life sustaining treatment is done only after the physician has ordered it and the family / significant other is notified.
23. Be informed of the procedures for submitting patient complaints with respect to patient care, that is, or fails to be furnished or regarding the lack of respect for property by anyone who is furnishing services on behalf of the Practice with suggested changes in services without coercion, discrimination, reprisal or unreasonable interruption of services.
24. Be provided with updates and state amendments on individual rights to make decisions concerning medical care within 90 days from the effective date of changes to state law.
25. Be informed of the procedure for submitting a written complaint / grievance to the home health Practice. All complaints / grievances are to be referred to the Chief Operating Officer for resolution.
26. Receive prompt and reasonable response regarding complaint / grievance. Administrator or designee will document the grievance/complaint within three (3) calendar days of receipt of the complaint. The Administrator or designee must complete the investigation and documentation within 30 calendar days after the Practice receives the complaint unless the Practice documents reasonable cause for delay.

Umbrella Healthcare Solutions
9225 N 3rd St., Suite 203
Phoenix, AZ 85020
Tel: (602) 362-2983
Fax: (480) 565-4552

Patient Rights & Responsibilities *(continued)*

As a patient you are responsible for:

1. Confirm scheduled appointments with a member of our staff prior to the appointment date. All unconfirmed appointments will be automatically rescheduled. If an appointment is confirmed and a provider arrives at your home without you being present, you are considered a no-show. There is a $100.00 no-show fee, and all no-shows will require that another appointment be made, which may take 1-2 weeks for the appointment date. No-shows may also impact our ability to refill prescriptions. Repeated no-shows may impact our ability to ensure your care and you may be discharged from the practice.
2. Late cancellations are appointments cancelled same day for appointments that have been confirmed. Late cancellations may result in your being billed $50.00. Multiple cancellations may result in your being discharged from the Practice.
3. Provide updated insurance and contact information as the information changes. We must have your current insurance and contact information for us to provide you with care services.
4. Maintain ongoing appointments to prevent the disruption of care services. Patients receiving controlled substances as part of their care will need to have been seen in the last 30-days for prescription refills. The office will make every effort to schedule your appointments but missing an appointment may delay medication refills.
5. Be available and allow staff to enter your residence for all services, which may include, primary care services, behavioral health services, home-health services, labs, imaging, and other services being provided as part of your treatment plan. Failure to complete these services may have an impact on your future appointments, which may be rescheduled until the necessary service is provided.
6. If receiving home-based care, prepare your home for a home visit by having a clean area for the appointment, remove all pets from the care area, cease smoking during the appointment, and be prepared for a health screening before our providers enter your home.
7. Be free from the influence of illegal drugs, or alcohol during the appointment. This includes the removal of any paraphernalia from the care area. If you are under the influence of illegal drugs or alcohol when your visit occurs, your appointment may be rescheduled. If the appointment is rescheduled, we'll make every effort to get you rescheduled to prevent interruptions in care. If you are receiving medication management, your medication refills may be delayed until the provider can see you when you are free from the influence of illegal drugs or alcohol.
8. Patients are required to have all medication bottles available for each appointment. If you have been prescribed a medication from another provider outside this practice, the medication will be reviewed by the provider for inclusion into your care plan. The provider may decline to fill the medication and require that you continue to see the prescribing provider for refills and medication management.
9. All medication refills must be requested during normal working hours. Refills will not be completed on the weekends and may take up to 72-hours for processing. As a reminder, please review all medications with the provider during your appointments to prevent any delays in our processing your medication refills or new prescriptions that may be needed.
10. All patients that receive controlled substances are subject to a random urinary drug screening for the continuation of medication management. In the event a non-prescribed drug is identified, or if a prescribed drug isn't present, the practice may review the treatment plan, cease to provide services, and refer you for substance abuse treatment.
11. It's requested to have care givers and Medical Power of Attorney holders present for the appointment, whenever possible. Power of Attorney documents are required and must be presented to the Practice.
12. It is a patient obligation to follow-up with specialists for ongoing specialty care and management. As behavioral health, geriatric, & palliative care providers, we are unable to provide medication and management for services that the practice doesn't provide. Specialists include cardiology, pain management, pulmonary, and a variety of others.
13. At times, you may choose to go against medical advice. Should this occur, your health record will be noted, and your care plan may change. Depending on the severity, you may be discharged from the practice.
14. Should you be discharged from the practice, you'll receive written communications, and we'll provide you with 30-days of transitional care. Please find another provider during this time as our services will terminate at the end of the 30-days.
15. All communications must be respectful and courteous. We understand that healthcare services can be confusing and create frustration. However, please remember that we are here to help you meet your medical needs. Should you become agitated and disrespectful to our providers or staff you may be asked to call back later, or you may be rescheduled for a later time.

We make every effort to respond to all inquiries, grievances, or complaints. Please contact our Chief Operating Officer if you have an inquiry, grievance, or complaint at (602) 362-2983, 9225 N 3rd St., Suite 102, Phoenix, AZ 85020.

Should we be unable to resolve your concern, you may also contact the Arizona Department of Health Services at (602) 542-1025, 150 N 18th Ave, Phoenix, AZ 85007.

Most recent inspection results and fee schedules are available upon request.