Welcome to Vanguard Mobile Physicians!

Thank you for being a part of our growing practice. We are so excited to get to know you and your loved ones better. We take pride in having strong relationships with our patients and hope to provide them the best possible care in the near and long-term.

Vanguard Mobile Physicians started from the idea that all people deserve quality health care services delivered in the privacy and comfort of their own homes. Now that people are living longer it is proven that their quality of life and happiness can be improved by having necessary medical services delivered to them without the hassle of urgent care facilities and emergency rooms or the wait of a traditional doctor's office.

This packet contains all of the necessary forms required to become a new patient of Vanguard Mobile Physicians as well as what to expect on our initial and follow up visits and general information about our practice.

Included in this Welcome Packet

- What to expect on your initial and follow up visits
- About Vanguard Mobile Physicians and Practitioner Profile
- Patient Forms

Forms included in this Welcome Packet

- Previsit Questionnaire
- Insurance Release Form
- Medical Release Form
- Credit Card Authorization
- Photography Consent
- Advance Beneficiary Notice (Medicare Patients Only)
- Notice of Privacy Policy

Please note new patients must fill out all forms completely before our initial home visit. Please fax or mail to the address below. ALSO PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD (FRONT AND BACK).

Vanguard Mobile Physicians
1840 E University Dr Suite 6 • Mesa, AZ 85203
Phone: 480-268-2670 • Fax: 480-268-2671
Website: www.azhousecalls.com • Email: info@azhouseacalls.com

What to Expect

Vanguard Mobile Physicians employs Nurse Practitioners (NPs) and Doctors to give quality care to adult patients in the comfort of their own home.

During our Initial Visit We Will:

- Perform a thorough medical and social history
- Perform a thorough physical examination
- Review your current list of medications
- If warranted, discontinue medications that may not necessarily be needed. Our goal is to have our patients on the least amount of medications possible so there will be the least amount of interactions.
- Order baseline lab work. We like to have these so if in the future our patient gets sick(we will do our best so this doesn't happen), then we have something to use as comparison. If warranted we may add additional laboratory orders depending on medications.
- Develop a plan of care with patient and/or caregiver
- Fill or refill any medications if needed
- set up a future visit to review progress and lab work.
- Review contact information. Our practice prides itself in having the patient/caregiver be an active part of the caring process. Therefore, each patient will receive a pass code in which they can access their medical records through our secure online system.

During our Follow up Visits We Will:

- Review what was done at previous visit.
- Discuss any concerns of the patient or caregiver.
- Physical exam
- Add to ongoing plan of care and discuss with patient and caregivers.
- Refill any medications or order any new ones.
- Set up future visit(s).

If you have any questions please don't hesitate to contact us. We believe the best care is given when there is an open line of communication. If you reach our voicemail and you feel it is an urgent matter that needs to be discussed please say so in your message and we will get back to you as soon as possible. We are thrilled to be a part of your care team!

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About Vanguard Mobile Physicians

Vanguard Mobile Physicians employs Nurse Practitioners (NP) to give quality care to adult patients in the comfort of their own home.

What Is a Nurse Practitioner?

A nurse practitioner (NP) is a registered nurse (RN) who has completed advanced education (a minimum of a master's degree) and training in the diagnosis and management of common medical conditions, including chronic illnesses. Nurse practitioners provide a broad range of health care services. They provide some of the same care provided by physicians and maintain close working relationships with physicians. An NP can serve as a patient's regular health care provider.

A Nurse Practitioner's Duties Include the Following:

- Collaborating with physicians and other health professionals as needed, including providing referrals
- Counseling and educating patients on health behaviors, self-care skills, and treatment options
- Diagnosing and treating acute illnesses, infections, and injuries
- Diagnosing, treating, and monitoring chronic diseases (e.g., diabetes, high blood pressure)
- Obtaining medical histories and conducting physical examinations
- Ordering, performing, and interpreting diagnostic studies (e.g., lab tests, x-rays, EKGs)
- Prescribing medications
- Prescribing physical therapy and other rehabilitation treatments
- Providing prenatal care and family planning services
- Providing well-child care, including screening and immunizations
- Providing health maintenance care for adults, including annual physicals

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Our Practitioner Profiles

Megan L. Spears, RN, BSN, MSN, ANP
Adult Nurse Practitioner

Megan Spears is the founder of Vanguard Mobile Physicians, LLC and a founding member of Vanguard Mobile Physicians. Megan is an Adult Nurse Practitioner and has been specializing in home based health care since 2007. Megan's focus areas include all aspects of adult medicine and she has a special interest in geriatric care including treating including geriatric depression.

Before specializing in home based health care, Megan had 8+ years of health care experience including orthopedic and neurological care as well as emergency room and trauma care.

Megan received her Bachelors and Masters Degree from Arizona State University in 2004 and 2007 respectively. Megan is also a member of the American Academy of Nurse Practitioners, American Academy of Home Care Physicians, and a member of the Arizona Independent Nurse Practitioner Consortium.

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New Patient Form: Previsit Questionnaire

Thank you for completing this form before your visit. It will allow your doctor to perform the most complete evaluation possible when you arrive for your appointment. Your time and effort is much appreciated.

General Patient Information

Date form completed: _____

Name of patient: _____

Patient Social Security #_____

Patient Lives in ☐ Private Home ☐ Assisted Living Facility (Provide Facility Information Below)

Facility Name: _____ Facility Phone: _____ Facility Fax: _____

Address: _____

City: _____

State: _____

ZIP Code: _____

Patient Phone: _____

Date of birth: _____

Gender: ☐ Male ☐ Female

Who filled out this form?

☐ Self ☐ Other (please give name below)

Name: _____

Phone number: _____

Relationship of the person to the patient?

☐ Spouse ☐ Child ☐ Friend ☐ Other (specify):_____

Who has been your primary care doctor?

Name: _____

Address: _____

Phone number: _____

Fax Number: _____

Insurance Information

Insurance Provider _____ Acct # _____ Group # _____

Secondary Insurance _____ Acct #_____ Group # _____

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Additional Patient Information

Hospice Information

Is Patient Currently on Hospice or Has Patient Even been admitted to Hospice?

☐ Yes ☐ No

If yes please fill out below

Hospice Name: _____

Address: _____

Phone: _____

Fax: _____

Pharmacy Information

Pharmacy Name: _____

Address: _____

Phone: _____

Fax: _____

Medication List

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Referral Source

Who referred you to our Practice?

_____

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Medical History

Which medical conditions do you have now or have you had in the past? Please check all that apply

EYE & EAR
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss/hearing aid
- ☐ Other (specify): _____

HEART
- ☐ Heart attack, year: _____
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Aortic stenosis
- ☐ Heart valve problem
- ☐ Angina
- ☐ High cholesterol
- ☐ Pacemaker
- ☐ Atrial fibrillation
- ☐ Irregular heartbeats (arrhythmias)
- ☐ Other (specify): _____

KIDNEY & URINARY TRACT
- ☐ Frequent bladder infections
- ☐ Kidney disease
- ☐ Enlarged prostate
- ☐ Urinary incontinence
- ☐ Kidney stones
- ☐ Other (specify): _____

LUNGS
- ☐ Asthma
- ☐ COPD/emphysema
- ☐ Bronchitis
- ☐ Recurrent pneumonias
- ☐ Other (specify): _____

GASTROINTESTINAL TRACT
- ☐ Heartburn/reflux/GERD
- ☐ Ulcers
- ☐ Irritable bowel
- ☐ Liver disease/cirrhosis
- ☐ Hepatitis
- ☐ Gallbladder disease
- ☐ Colon polyps
- ☐ Diverticulosis
- ☐ Bleeding problems
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Other (specify): _____

GLANDS
- ☐ Thyroid overactive (high)
- ☐ Thyroid underactive (low)
- ☐ Diabetes
- ☐ Other (specify): _____

NERVOUS SYSTEM
- ☐ Dementia or Alzheimer's disease
- ☐ Parkinson's disease
- ☐ Stroke
- ☐ Epilepsy or seizures
- ☐ Neuropathy/nerve damage ?
- ☐ Depression
- ☐ Anxiety
- ☐ Other (specify): _____

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BONES & JOINTS	OTHER HEALTH PROBLEMS
☐ Gout ☐ Lower back pain ☐ Osteoporosis ☐ Arthritis (indicate location): ☐ Hip ☐ Knee ☐ Shoulder ☐ Back ☐ Hands ☐ Fractured bone (indicate location): ☐ Hip ☐ Spine ☐ Wrist ☐ Other (specify): ☐ Other (specify): _____	☐ Thrombosis/blood clots: ☐ In the leg ☐ In the lung ☐ Syncope (loss of consciousness) ☐ Hernia ☐ Anemia ☐ Sexual function problems (specify): _____ ☐ Cancer: ☐ Breast ☐ Prostate ☐ Colon/Rectum ☐ Lung ☐ Skin ☐ Lymphatic ☐ Other (specify):

Please Note Surgeries

☐ Heart bypass Date: _____ ☐ Heart stent placement Date: _____ ☐ Heart valve replacement Date: _____… ☐ Pacemaker Placement Date: _____ ☐ Defibrillator/ICD placement Date: _____ ☐ Tonsils Removed Date: _____	☐ Appendix Removed Date: _____ ☐ Gallbladder Removed Date: _____ ☐ Knee Replacement Date: _____ ☐ Hysterectomy Date: _____ ☐ Hip repair due to fracture Date: _____ ☐ Cataract Date: _____

Other Surgeries and Dates: (Please list below.)

_____

_____

_____

Patient or POA Signature:_____

Date: _____

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New Patient Form: Insurance Release Form

- I hereby authorize Vanguard Mobile Physicians to directly bill Medicare or Medicaid(AHCCS) and my insurance company to make direct payments to Vanguard Mobile Physicians
- Billing Charges claimed under Vanguard Mobile Physicians may also be billed under the entity of Vanguard Mobile Physicians, LLC or Healthy Tomorrows, LLC
- Vanguard Mobile Physicians may obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies provided.
- I am aware that Medicare does not pay for preventative medicine, routine physicals, or routine screening tests.
- I am also aware that I am responsible for any deductible, co-payment or any amount that is not covered by my insurance(s) and that I am ultimately responsible for my bill. I have requested medical services on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.
- I hereby authorize Vanguard Mobile Physicians Release any information necessary to insurance carriers regarding my illness and treatments
- I hereby authorize a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Patient or POA Signature:_____

Date: _____

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New Patient Form: Medical Release Form

May Vanguard Mobile Physicians release medical information to specified persons other than you?

Yes _____ No_____

If yes, please specify to whom this information may be released and the Authorized Person's Relationship to You

_____
_____
_____
_____
_____
_____

- I understand that as part of my continuing healthcare, my healthcare provider maintains medical records in his/her office, which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.
- I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.
- I understand that this document is a part of my permanent medical record, and that I may make changes regarding the disclosure of my health information at any time and that I need to notify my healthcare provider in writing of these changes.

Patient or POA Signature:_____

Date: _____

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New Patient Form: Credit Card Authorization

Since it's difficult to contact POA's or relatives at times when payment is due, we require a credit card number on file to charge for payment balances. Many secondary insurers do not automatically crossover after Medicare payment is approved. Occasionally, secondary insurers will consider medical house calls a "non-covered" charge.

I understand that Vanguard Mobile Physicians will charge my credit card for unpaid balances for home visits. These unpaid amounts may include:

1. Unpaid 20% (by secondary insurer) if Medicare pays 80%; or No secondary coverage
2. Medicare denials that cannot be quickly resolved.
3. Annual Deductibles for Primary or Secondary insurer.
4. Travel Fees (if applicable)
5. Secondary insurers that do not automatically cross-over from Medicare: It is the patient's (POA) responsibility to get reimbursed the 20% from these insurers. A paid invoice can be mailed after credit card charges are completed, only if requested by patient or POA.

Any disputes regarding insurance coverage is the patient's or POA responsibility.
Vanguard Mobile Physicians does NOT dispute individual insurance coverage with insurance companies. Payment for house calls is the responsibility of the patient or POA.

Thank you in advance for your understanding so we can continue to provide this valuable medical service.

Patient Name: _____
Name on Card:_____
Address: _____
Phone Number: _____
Credit Card (please circle): Visa Mastercard AMEX Discover
Credit Card #: _____
Expiration Date:_____
CCN#:_____
Patient or POA Signature:_____
Date: _____

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New Patient Form: Advance Beneficiary Notice (Medicare Patients Only)

Patient's Name:
Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services. We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your healthcare provider recommended it. Right now, **Medicare probably will not pay for these and possible other Items or Services:**

Some Diabetic supplies	Durable Medical equipment	Foot Care
Hearing Aides	Cholesterol Screening if already done within a 5 yr period	Bone Density Testing if certain criteria is not previous established
Certain laboratory workups	Lab draws	Travel fees
Safety equipment	Medical Supplies	Vitamins and supplements

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

• Ask us to explain, if you don't understand why Medicare probably won't pay.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _ _____

Date Signature of patient or person acting on patient's behalf

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare. OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

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New Patient Form: Photography Consent

I hereby authorize the use of photos to use as an identifier (such as headshots) and of any dermatological conditions to provide ongoing documentation (written, electronic or photography) and to document progress of healing and or to assist in the treatment decisions for care.

I also authorize to share such photography and ongoing documentation (written, electronic or through photography) to my care team and or insurance carrier for the purpose of treatment decisions and or authorization of care.

I understand that this photography may be used for medical or scientific purposes such as documentation or planning care, teaching purpose, research or publication.

I further understand that these images may be used any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.

I hereby consent to any or all of the above procedures.

Patient or POA Signature:_____

Date: _____

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New Patient Form: Notice of Privacy Policy

Vanguard Mobile Physicians has always supported and recognized our patients' right to expect that their medical records and other information about their care will be kept confidential.

Vanguard Mobile Physicians policies and procedures comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulations. The HIPAA privacy regulations give patients more control over their health information and also set boundaries on the use and release of patient information.

Please sign below indicating that you have received a notice of our privacy policies. Our notice of Privacy Policy is included in this welcome packet.

Patient or POA Signature:_____

Date: _____

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New Patient Form: Notice of Privacy Policy

Effective Date: 7/11/2010

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

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We May Use and Disclose your PHI in the Following Ways:

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a POA, guardian or caregiver. In this example, a POA, caregiver or guardian may have access to this patient's medical information.

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8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

Use and Disclosure of your PHI in Special Circumstances

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    a. Maintaining vital records, such as births and deaths,
    b. Reporting child abuse or neglect,
    c. Preventing or controlling disease, injury or disability,
    d. Notifying a person regarding potential exposure to a communicable disease,
    e. Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
    f. Reporting reactions to drugs or problems with products or devices,
    g. Notifying individuals if a product or device they may be using has been recalled,
    h. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
    i. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

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4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:
    j. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
    k. Concerning a death we believe has resulted from criminal conduct,
    l. Regarding criminal conduct at our offices,
    m. In response to a warrant, summons, court order, subpoena or similar legal process,
    n. To identify/locate a suspect, material witness, fugitive or missing person,
    o. In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).
5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
    (A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research
2. (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
    (B) The research could not practicably be conducted without the waiver,
    (C) The research could not practicably be conducted without access to and use of the PHI.
8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

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9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

Your Rights Regarding your PHI

1. You have the following rights regarding the PHI that we maintain about you.
2. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Info@azhousecalls.com specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
1. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Info@azhousecalls.com Your request must describe in a clear and concise fashion:
    a. The information you wish restricted,
    b. Whether you are requesting to limit our practice's use, disclosure or both,

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c. To whom you want the limits to apply.

2. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to info@azhousecalls.com in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
3. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to info@azhousecalls.com You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
4. Accounting of disclosures. All of our patients have the right to request an “accounting of disclosures.” An “accounting of disclosures” is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to info@azhousecalls.com All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

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5. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact info@azhousecalls.com.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact healthytomorrowsllc@gmail.com. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

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