# Welcome to Geriatric Solutions

Thank you for choosing Geriatric Solutions to partner in caring for your medical needs. It is our privilege to provide you medical care in the comfort of your own home. Our team will also coordinate in-home lab draws, X-ray services, home healthcare and some specialists, as needed. Our after-hours team of nurses and on-call providers make it possible to contact our care team 24/7 for any urgent needs outside our normal office hours of 8 a.m.–5p.m. Monday–Friday.

This welcome packet includes information about our practice and patient registration forms to help us provide the best care possible. We encourage you to ask any questions or share your concerns with us. We look forward to providing you with exceptional medical care. Please do not hesitate to call our office if you have any questions at (602) 954-0444 or visit our website at geriatricsolutions.org.

Thank you again for choosing Geriatric Solutions and welcome to our practice.

**To make an appointment with Geriatric Solutions**

- Complete Patient Registration so we have the information to best care for you.
- Attach a copy of all of your insurance cards (primary and secondary).
- If applicable, attach a copy of your Medical Power of Attorney (MPOA) documents.
- If applicable, attach a copy of your medication list.
- If available, attach a copy of your most recent medical records.
- Return all of the above via DocuSign email, fax to (602) 952-7146 or mail to Geriatric Solutions at 1510 E. Flower St. Phoenix, AZ 85014.
- Call your insurance plan and notify them that Geriatric Solutions is your primary care provider (many plans require their members to notify a change in providers prior to approving services with a new primary care office).

**Scheduled visits**

- Once we receive your completed Patient Registration, we will schedule your first home visit and assign you a medical assistant who will coordinate any future healthcare needs.
- New patient visits can be scheduled approximately two to four weeks from receipt of your patient registration.
- A window of time for the visit is provided as patient visits vary in length and unexpected traffic conditions may cause delay.
- The office will confirm your home visit 24–72 hours prior.

**Medications and refills**

- You may call the office for medication refills.
- For 90- to 100- day scripts, please call the office when you have a 30-day medication supply remaining.
- Controlled substances/narcotics will only be processed 8 a.m.–4 p.m. Monday–Friday.

**Hospital visits**

- If you have a hospital visit, please notify our office so we can follow your care.
- Upon hospital discharge, please notify our office so we can follow up with a home visit.

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# PATIENT REGISTRATION

Legal name _____ Date of birth _____ ☐ Male ☐ Female

Nickname _____ Patient cell phone _____ Patient landline _____

Patient preferred email _____ Registration completed by _____

Do you have a DNR or Advanced Care Plan? ☐ Yes ☐ No If no, would you like more info on Advance Directives? ☐ Yes ☐ No

Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed Employed? ☐ Yes ☐ No ☐ Retired ☐ U.S. Veteran

Race? ☐ American Indian ☐ Asian ☐ Black/African ☐ American Pacific Islander ☐ White ☐ Decline to specify

Hispanic or Latino? ☐ Yes ☐ No ☐ Decline to specify Peferred language _____ Translator required ☐

**PATIENT RESIDES**

☐ Private home ☐ Group home ☐ Independent living facility ☐ Assisted living facility

Address _____ Unit/Room _____ Gate code _____ City _____ Zip _____

Facility name _____ Phone _____ Fax _____

Facility contact name _____ Phone _____ Email _____

Case manager name _____ Phone _____ Email _____

Primary emergency contact _____ Phone _____ Email _____

Guardian/MPOA contact _____ Phone _____ Email _____

Guardian/MPOA address _____ City _____ State _____ Zip _____

**INSURANCE — PROVIDE COPY OR UPLOAD FRONT AND BACK OF PRIMARY, SECONDARY AND TERTIARY INSURANCE CARDS.**

**PRIMARY INSURANCE/MEDICARE ID (REQUIRED)** _____

Subscriber name _____ ☐ Self ☐ Other _____

Plan name _____ Group # _____

Policy ID # _____ Phone _____

Address _____

**Secondary plan name** _____

Subscriber name _____ ☐ Self ☐ Other Group # _____

Policy ID # _____ Phone _____ Address _____

**GUARANTOR/RESPONSIBLE PARTY INFORMATION (IF NOT PATIENT)**

Bill to _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Mobile _____ Email _____

I hereby authorize Geriatric Solutions – HOV, LLC (GS) to **release information** required in the course of my examination or treatment to any insurance carrier that may be legally responsible or liable to reimburse or indemnify me for my healthcare expenses. I hereby **assign and authorize insurance benefits** made on my behalf be paid directly to GS, for any medical services provided to me by that organization. I understand that I am financially responsible for charges not covered by my insurance or this authorization.

☐ Patient ☐ Guardian signature _____ Date _____

# AUTHORIZATION TO DISCUSS, RELEASE AND/OR OBTAIN MEDICAL INFORMATION

Patient name _____ Date of birth _____ Email _____

Legal representative name _____ Preferred phone _____

- I have an active Medical Power of Attorney (MPOA) making all of my medical decisions on my behalf (attach MPOA document).

MPOA name _____ MPOA preferred phone _____

MPOA address _____ MPOA email _____

- I hereby authorize Geriatric Solutions – HOV, LLC (GS) to call and/or leave messages regarding appointments, referrals and test results on my and/or my MPOA's home phone, cell phone and/or email. I understand that each of these communications is NOT considered completely secure since someone else could access the information.

If **not**, list the exclusion(s): _____

- I hereby authorize GS to discuss my medical care, which may contain confidential HIV/AIDS information, communicable disease-related information, and information relating to mental health and/or alcohol/drug use, with the following individuals or organizations (i.e., relative/caregiver/case manager/group home):

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

Name _____ Relation _____ Phone _____ ☐ Ok to leave message

These authorization/acknowledgments cover all services rendered to me, or the patient I am signing for, today and all future dates of service. This document replaces and nullifies any previous designations made.

I understand that GS will not condition treatment, payment for treatment, enrollment, or eligibility for benefits on my signing this authorization form. I understand that I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the GS Notice of Privacy Practices. To revoke my authorization, I must submit a written request to: Geriatric Solutions at 1510 E. Flower St., Phoenix, AZ 85014. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization recieving the information.

Name of patient/legal representative _____

Signature _____ Date _____

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# AUTHORIZATION TO OBTAIN NEEDED INFORMATION

I grant Geriatric Solutions – HOV, LLC (GS) permission to obtain all medical information (which may contain medication history, confidential HIV/AIDS-related information, communicable disease-related information, information relating to mental health and/or alcohol/drug use) that any healthcare provider or agency may have on record for the purpose of gathering your medical history.

☐ History and physical ☐ Discharge summary ☐ Pathology reports ☐ Physician's progress notes

☐ Radiology reports ☐ Operative reports ☐ Laboratory reports ☐ All of the above

☐ Other (specify) _____

I understand that GS will not condition treatment, payment for treatment, enrollment, or eligibility for benefits on my signing this authorization form. I understand that I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the GS Notice of Privacy Practices. To revoke my authorization, I must submit a written request to: Geriatric Solutions at 1510 E. Flower St., Phoenix, AZ 85014. Unless I revoke this authorization earlier, it will expire 12 months from signing. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization recieving the information.

Signature _____ ☐ Patient ☐ Legal representative Date _____

Legal representative name (print) _____ Relationship to patient _____

Reason patient unable to sign ☐ Lacks decision-making capacity ☐ Unresponsive

☐ Other _____

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# MEDICAL HISTORY

Patient name _____ Date of birth _____ Today's date _____

What is main reason for your visit? _____ Height _____ Weight _____

| PREVIOUS PRIMARY CARE PROVIDER | ADDRESS / PHONE / FAX |
|---|---|
| | |
| **CURRENT CARE TEAM (SPECIALIST/OT/PT/ST/HOSPICE)** | **ADDRESS / PHONE / FAX** |
| | |
| | |
| **PHARMACY** | **ADDRESS / PHONE / FAX** |
| PREFERRED | |
| | |

| ALLERGIES (DRUGS, FOOD AND ENVIRONMENTAL ALLERGIES) | |
|---|---|
| | |
| | |

| Current Medications (prescribed, over the counter, vitamins and supplements) | DOSAGE | FREQUENCY |
|---|---|---|
| IF PREFER, YOU MAY ATTACH A MEDICATION LIST. | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| MEDICAL TESTING | DATE | MEDICAL TESTING | DATE |
|---|---|---|---|
| Mammogram (female only) | | Colonoscopy/colon screening | |
| Pap Smear (female only) | | Echocardiogram | |
| Dexa scan (female only) | | Eye Exam | |
| PSA (male only) | | Skin Cancer Screening | |

| SOCIAL HISTORY | |
|---|---|
| Highest level of education completed | ☐ Grade school ☐ High school ☐ College ☐ Post Graduate |
| Do you have children? | ☐ No ☐ Yes If yes, how many? _____ |
| How many adults live in the household? | ☐ None ☐ Spouse ☐ Other _____ |
| Have you ever used tobacco? | ☐ No ☐ Yes If yes, for _____ years. |
| What nicotine/tobacco product(s) do you use? | ☐ Cigarette ☐ Chew ☐ Vape ☐ Patch ☐ Cigar ☐ Gum ☐ Other |
| Have you quit using nicotine products? | ☐ No ☐ Yes If yes, cease date? _____ |
| Do you use recreational drugs? (i.e., marijuana/THC products) | ☐ Never ☐ Daily ☐ 1–2x/week ☐ 1–2x/month ☐ 1–2x/year |
| Do you drink alcohol? | ☐ Never ☐ Daily ☐ 1–2x/week ☐ 1–2x/month ☐ 1–2x/year |
| Do you exercise? | ☐ Never ☐ Daily ☐ 1–2x/week For how long? _____ |

Patient name _____ Date of birth _____ Today's date _____

| GENERAL | EYES | HEAD, EAR, NOSE, THROAT | HEART |
|---|---|---|---|
| ☐ Fever<br>☐ Chills<br>☐ Fatigue<br>☐ Sweating<br>☐ Weakness<br>☐ Ongoing COVID-19 concerns<br>Date had COVID _____ | ☐ Blurred vision<br>☐ Double vision<br>☐ Light sensitivity<br>☐ Eye pain<br>☐ Eye discharge<br>☐ Eye redness<br>Date of last eye exam<br>_____ | ☐ Headaches<br>☐ Hearing loss<br>☐ Ringing in ears<br>☐ Ear pain<br>☐ Ear discharge<br>☐ Nose bleeds<br>☐ Nose congestion<br>☐ Sore throat<br>Date of last dental exam<br>_____ | ☐ Chest pain<br>☐ Palpitations<br>☐ Leg cramps<br>☐ Leg swelling<br>☐ Trouble breathing while lying flat |
| **LUNGS** | **GASTROINTESTINAL** | **GENITOURINARY** | **MUSCULOSKELETAL** |
| ☐ Cough<br>☐ Sputum production<br>☐ Shortness of breath<br>☐ Wheezing<br>☐ On oxygen | ☐ Heartburn<br>☐ Nausea<br>☐ Vomiting<br>☐ Abdominal pain<br>☐ Diarrhea<br>☐ Constipation<br>☐ Blood in stool | ☐ Urinary burning<br>☐ Urgency to urinate<br>☐ Frequency<br>☐ Blood in urine<br>☐ Incontinence | ☐ Muscle aches<br>☐ Neck pain<br>☐ Mid back pain<br>☐ Low back pain<br>☐ Joint pain<br>☐ Fall within last year<br>☐ Intensity of Pain (10 = severe)<br>_____ |

| SKIN | NEUROLOGICAL | PSYCHIATRIC | ENDOCRINE |
|---|---|---|---|
| ☐ Rash<br>☐ Itching<br>☐ Bed sore<br>Location _____<br>_____<br>_____ | ☐ Dizziness<br>☐ Tingling<br>☐ Tremor<br>☐ Sensory change<br>☐ Speech change<br>☐ Trouble swallowing<br>☐ Seizures<br>☐ Loss of consciousness<br>☐ Weakness on one side of body | ☐ Depression<br>☐ Suicidal thoughts<br>☐ Substance abuse<br>☐ Hallucinations<br>☐ Nervous/Anxious<br>☐ Insomnia<br>☐ Memory loss<br>☐ The past two weeks I have felt depressed or hopeless for _____ days. | ☐ Easy bruising<br>☐ Environmental allergies<br>☐ Extreme thirst<br>☐ Diabetic<br>Morning sugar range _____<br>Evening sugar range _____ |

| ACTIVITIES OF DAILY LIVING | CHECK ALL THAT APPLY |
|---|---|
| Toileting | ☐ Continent of bowels/urine ☐ Incontinent of bowels/urine ☐ Occasional bowel/urine incontinence |
| Caregiver | ☐ I can care for myself ☐ I have caregivers ☐ I cannot care for myself and would like help |
| Ambulatory | ☐ Ambulatory ☐ Non-ambulatory ☐ Bed confined |
| Transfers | ☐ No assistance required ☐ Minimal assistance ☐ 100% Assistance |
| Assisted Device | ☐ Wheelchair ☐ Walker ☐ Cane ☐ Motorized scooter |
| Bath/Grooming | ☐ No assistance required ☐ Minimal assistance ☐ 100% Assistance |
| Feeding | ☐ No assistance required ☐ Minimal assistance ☐ 100% Assistance |
| Diet | ☐ Regular ☐ Pureed ☐ Thickened liquids ☐ Special diet _____ |
| Falls | ☐ None ☐ Rarely ☐ Occasionally ☐ Frequently |

| HOSPITALIZATIONS IN THE PAST 2 YEARS | HOSPITAL AND DATE OF HOSPITALIZATION |
|---|---|
| | |
| | |
| | |

Patient name _____ Date of birth _____ Today's date _____

| SURGICAL HISTORY | DATE |
|---|---|
| | |
| | |
| | |

| IMMUNIZATIONS | DATE(S) |
|---|---|
| Flu (Influenza) | |
| PNA (pneumonia) List date of Pneumovax and Prevnar booster | |
| Tetanus (Tdap) | |
| Shingles/Zostavax | |
| COVID/COVID booster | |

| DO YOU HAVE FAMILY HISTORY OF? | MOM | DAD | SIS | BRO | DO YOU HAVE FAMILY HISTORY OF? | MOM | DAD | SIS | BRO |
|---|---|---|---|---|---|---|---|---|---|
| Alzheimer's disease | ☐ | ☐ | ☐ | ☐ | Blood clot/excessive bleeding | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | Colon cancer | ☐ | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ | ☐ | Breast/Ovarian cancer | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | Mental Health issues | ☐ | ☐ | ☐ | ☐ |

# CONTROLLED SUBSTANCES AGREEMENT

Controlled substances such as opioids, benzodiazepines, muscle relaxers and others are often used as part of a broader plan to help manage painful conditions. Although they can be useful in some circumstances, these medicines carry risks of dangerous physical side effects and possible addiction. These are also medicines that can be misused for illegal purposes. Our providers follow federal and state laws relating to these medications, and practice according to professionally accepted standards for their safe use. This agreement is to help you and your caregivers understand our practice policies for the safe and effective use of controlled substances.

**I UNDERSTAND THAT:**

- The goal of my treatment is to manage pain and help me function at the best level possible. My provider may recommend stopping my medication and trying different therapies (including possibly seeing a pain management specialist), if it is not helping achieve this.
- I may become addicted to my medication, especially if there is a history of addiction in my family.
- My medicine may make me drowsy, and I should not drive after using it.
- My provider will check the state pharmacy monitoring website regularly, as required by law, and may speak to other providers caring for me about my medication use if necessary for my care.
- It is unsafe to use my medication with alcohol or street drugs, and if I do so, my provider may stop the medication.
- My provider may check samples of my blood or urine to make sure I am using my medication properly.
- If I have to stop my medicine, I must do it slowly or I may get very sick.
- Our office will only refill my medicine during regular office hours Monday–Friday, 8 a.m.–4 p.m. Refills will not be given after hours or on weekends. The office should be contacted at least 3 days before a refill is due.

**I AGREE THAT:**

- I am responsible for my medicine. I will not sell, share or trade my medicine and I will not take someone else's medicine.
- I will keep track of my medicine, keep it away from children and secure from individuals who may steal it.
- If my medicine is lost or used up sooner than prescribed, it may not be replaced early.
- I will not change my dose or how I take my medicine without first consulting my provider.
- I will inform my provider if I am having side effects from my medicine.
- I will get my medicine from only one pharmacy.
- I will get my medicine only from my Geriatric Solutions provider. Should I get a prescription from a different source (such as an ER), I will inform my provider immediately.
- I will work with my provider to find non-drug treatments that may help my condition.
- I may ask my provider should I have any questions about these policies or about my specific medicines.
- If I do not follow the policies outlined here, my provider may re-evaluate my treatment plan and recommend treatment for substance abuse/addiction, may refer me to pain management, may stop prescribing my medicine after safely tapering it, or may discharge me from the practice.

Patient name _____ Date of birth _____

Patient signature _____ Date _____

Patient representative signature _____ Date _____

(If patient unable to sign for themselves)


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# ACCEPTANCE & AUTHORIZATION OF GERIATRIC SOLUTIONS' POLICIES

Patient name _____ Date of birth _____ Phone _____

Legal representative name _____ Preferred phone _____

## ACCEPTANCE OF GS POLICIES AND PROCEDURES

My signature indicates that I have received the Geriatric Solutions–HOV, LLC (GS) Patient Registration containing the Notice of Privacy Practices, Patient Family Bill of Rights, and Notice of Health Information Practices. I have had the opportunity to ask questions regarding the information prior to signing this agreement. I understand copies are available on the GS website and I may request additional copies.

Patient/Legal representative _____ Signature _____ Date _____

## AUTHORIZATION TO TREAT AND BILL

I hereby consent to evaluation and treatment as directed by Geriatric Solutions–HOV, LLC (GS) medical provider or his/her designee. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified on this form.

I request payment of authorized Medicare and/or insurance benefits to GS for any services provided for my care by their providers. I authorize any holder of my medical information to release all information necessary for Medicare/Medicaid services and other insurance companies I have listed, and its agents, to determine benefits payable for medical treatment received at GS. I authorize any holder of my medical information, including government, Medicare/Medicaid, primary care physicians and insurance companies, to release all information necessary to determine benefits payable for medical treatment.

Patient/Legal representative _____ Signature _____ Date _____

## NOTICE OF HEALTH INFORMATION PRACTICES

I hereby acknowledge that I received and read the Notice of Health Information Practices. I understand my healthcare provider participates in Health Current, Arizona's Health Information Exchange (HIE). I understand that my health information may be securely shared through HIE, unless I request, complete and return an Opt Out Form to GS. I understand if I opt out, no one will have access to that information through HIE, even in an emergency.

Patient/Legal representative _____ Signature _____ Date _____

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

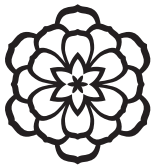
I hereby permit Geriatric Solutions–HOV, LLC (GS) to use and disclose my Protected Health Information (PHI) to any third-party payor, or to any party involved in my healthcare. By signing this Authorization, I understand the following: (1) I have the right to revoke this Authorization by sending written notification to GS. Once GS receives the written revocation, this Authorization will be revoked, except to the extent that GS has already taken action in reliance upon this Authorization; (2) Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law; (3) This Authorization shall be enforced as long as I am a patient of this practice unless, I give written notice to revoke my Authorization; and (4) I have a right to refuse to sign or revoke this Authorization as GS may not condition treatment, payment, enrollment or eligibility for benefits based on whether the individual signs the Authorization.

Patient/Legal representative _____ Signature _____ Date _____

## CONSENT TO RELEASE OF MEDICAL INFORMATION

I hereby authorize Geriatric Solutions–HOV, LLC to convey to any physician and/or medical facility directly involved with my care, my medical history, laboratory reports, X-rays and any other material services, consultations and treatments that I received while under the GS providers' care.

Patient/Legal representative _____ Signature _____ Date _____



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# PATIENT AND FAMILY BILL OF RIGHTS

Patients receiving care from Geriatric Solutions (GS) practice have the following rights and responsibilities:

## Patient rights

- To be fully informed of my rights and receive this notice prior to initiation of care.
- To receive assistance from a family member, representative or other individual in understanding, protecting or exercising my rights.
- To be treated with consideration, respect and full recognition of my dignity and uniqueness regardless of my age, race, national origin, gender, sexual orientation, marital status, diagnosis, disability, religion or source of payment. To be free from any type of discrimination.
- To receive a copy of the agency's privacy practices.
- To have medical records and all information related to my care and treatment—including financial records—kept in confidence, the release of which requires written consent, except as otherwise permitted by law. To have all communications conducted in a confidential, private manner that I understand.
- To be free from mistreatment and/or abuse (verbal, psychological, physical, emotional, sexual or chemical); coercion, sexual assault, manipulation; seclusion; neglect or exploitation, including injuries from an unknown source and/or misappropriation of my property. To file a complaint against the agency without fear of retaliation.
- To inspect or have copies of my medical record, to amend my medical record if it is incomplete or inaccurate, to request restriction on disclosure of my medical record; to request an accounting of disclosures that have been made of my medical record beyond those made for treatment; payment or normal agency operations; and to submit grievances without fear of retaliation.
- To be included in decisions regarding care, including implementation of an individualized plan of care.
- To have my pain and other symptoms taken seriously, assessed and managed to the level that I define.
- To have services provided by skilled, licensed, compassionate professionals.
- To exercise my religious beliefs.
- To have my property respected.
- To make my own healthcare decisions, including the right to refuse treatment; to refuse to participate in experimental research or be photographed; to be informed about healthcare directives and to withdraw from GS services at any time.
- To receive information about the scope of services that GS provides and specific limitations of those services.

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**Patient responsibilities**

- To provide to the best of my knowledge, accurate and complete health information, including past illnesses, hospitalizations, medications or other matters related to my health.
- To report unexpected changes in my condition and to report to my GS team the effectiveness of pain and symptom management.
- To provide the agency with copies of my healthcare directives.
- To assist agency staff in maintaining a safe environment for my care.
- To show respect and consideration for GS staff and property.
- To speak up if I have questions about the healthcare I am receiving.
- To participate in developing my plan of care and treatment, and to comply with that plan.
- To appoint a medical power of attorney.

# NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed, and how you can access this information. Please review it carefully.

## NOTICE OF PRIVACY PRACTICES

Geriatric Solutions is committed to maintaining the privacy and security of your protected health information and is required by law to do so. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. This notice describes the rights you have concerning your own health information. It also describes how we may use information about you within Geriatric Solutions and how we may disclose it to others outside of Geriatric Solutions.

## WHAT ARE YOUR RIGHTS?

**Request information about you:** You or your legally authorized representative are entitled to see or get an electronic or paper copy of your medical and billing information. If you request a copy of your information, we may charge a reasonable, cost-based fee.

**Amend your medical record:** If you see information about you in records created by Geriatric Solutions that you think is incorrect or incomplete, you may ask us to amend the records. You may submit a written request detailing your reason for the amendment. We will do our best to accommodate your request, but reserve the right to decline, if appropriate.

**Confidential communications:** You have the right to request that we communicate with you in a specific way that you feel is confidential. We will accommodate reasonable requests. For example, you may ask that we only call you at a specific phone number or speak with you about your health in private.

**Limit what Geriatric Solutions uses or shares:** You can ask us not to use or share certain health information for treatment, payment or Geriatric Solutions operational purposes. We are not required to agree to your request. If we do agree, we may not comply in certain situations if it would affect your care. If you pay for a service or healthcare item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will comply unless otherwise required by law.

**Right to an accounting of certain disclosures:** You have the right to request an accounting of certain disclosures of your health information made by Geriatric Solutions in the six years prior to your request date. Geriatric Solutions will include all disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures, such as any you asked us to make. Geriatric Solutions will provide the first accounting at no charge, but we may charge you for any accountings you request during a 12-month period.

**Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

**File a complaint.** If you feel your privacy rights have been violated, you may contact Geriatric Solutions' Practice Manager by submitting your concern in writing to: Practice Manager, Geriatric Solutions, 1510 E. Flower St., Phoenix, AZ 85014. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to: 200 Independence Ave., SW, Washington, DC 20201, calling (877) 696-6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints. You will not be retaliated against for filing a complaint.

**Right to a copy of this notice:** You may obtain a copy of the current Notice of Privacy Practices on our website atGeriatric Solutions.org. You can also ask for a paper copy of this notice at any time, even if you have already received a copy. These requests may be made to:

Quality and Compliance Department, Geriatric Solutions
1510 E. Flower St., Phoenix, AZ 85014
(602) 530-6900

## HOW WILL WE USE AND DISCLOSE INFORMATION ABOUT YOU?

**Treatment:** Geriatric Solutions may use your information to provide you medical services and supplies, or share it with other professionals who are treating you.

**Healthcare Operations:** Geriatric Solutions may use and disclose information about you to improve the quality of care we provide to patients or for healthcare operations. For example, we may use information about you to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning.

**Payment:** Your health information may be used and disclosed to bill and get payment for the services and supplies we provide you. For example, we may give information about you to your health insurance plan, so that it will pay for your services.

**Family members and others involved in your care:** Geriatric Solutions may disclose limited information about you to a family member or friend who is involved in your care or payment for your care. You must notify us if you do not want us to disclose information about you to family members or others.

**Public health:** Geriatric Solutions may report certain medical information for public health purposes. For example, we are required by law to report births, deaths and communicable diseases to the state. We may also need to report patient problems with medications or medical products to the manufacturer and the FDA.

**Public safety:** Geriatric Solutions may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials or to the court in response to a search warrant or other court order. We may also disclose medical information to assist law enforcement officials in identifying or locating a person; to prosecute a crime of violence; and to report deaths that may have resulted from criminal conduct. We may also disclose information about you to law enforcement officials and others to prevent a serious threat to health or safety.

**Research:** Geriatric Solutions may use or disclose your de-identified health information. These research projects must go through a special process that protects the confidentiality of your information.

**Required by law:** Geriatric Solutions will share your information where required by any federal, state or local law.

**Relating to decedents:** Health information may be disclosed related to an individual's death to coroners, medical examiners, funeral directors or organ procurement organizations (with regard to anatomical gifts). Unless an individual indicated otherwise before death, Geriatric Solutions may also disclose health information related to the individual's death to family members or others who were involved in the individual's care or payment for care before death.

**Organ and tissue donation requests:** Your information may be shared with organizations that handle organ procurement.

**Medical examiner or funeral director:** Geriatric Solutions may disclose health information with a coroner, medical examiner or funeral director when an individual dies, or if necessary, to carry out their duties prior to and in reasonable anticipation of an individual's death.

**Workers' compensation, law enforcement and other government requests:** Geriatric Solutions can share your health information, (1) for workers' compensation claims; (2) for law enforcement purposes or with a law enforcement official; (3) with health oversight agencies for activities authorized by law; and (4) for special government functions, such as military, national security and presidential protective services.

**Judicial or administrative proceedings:** Geriatric Solutions can share health information about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process

## HEALTH INFORMATION EXCHANGE

Geriatric Solutions participates in health information exchanges (HIEs). Geriatric Solutions uses HIEs as a method to share, request and receive electronic health information with other health care organizations for the purpose of coordinating your care. For questions, or if you want to opt out of sharing your information using HIEs, please contact our Chief Compliance Officer at (602) 636-6301.

## CHANGES TO THIS NOTICE

Geriatric Solutions may amend or revise our practices concerning use and disclosure of patient medical information. These changes will apply to all information, including your health information. If we change our practices, we will publish a revised Notice of Privacy Practices. If you have any questions regarding this notice, please contact:

Quality and Compliance Department, Geriatric Solutions
1510 E. Flower St., Phoenix, AZ 85014
(602) 530-6900

Geriatric Solutions will not use or share your information other than as described here without your written authorization. You may revoke such authorization by sending us a written request.
For more information, see: hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Effective Date: January 2019

healthcurrent

# Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

**How does Health Current help you to get better care?**
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

**What health information is available through Health Current?**
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

**Who can view your health information through Health Current and when can it be shared?**

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

**Does Health Current receive behavioral health information and if so, who can access it?**
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

**How is your health information protected?**
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

## Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

**You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:**

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   **Caution**: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

**IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.**