SPECIALTY ASSOCIATES
HAVASU MEDICAL GROUP
1851 Mesquite Avenue
Suite 210
Lake Havasu City, AZ 86403
P: 928.854.7540
F: 928.854.2405

Khizer Shaikh, MD
Scott Coole, DO
Pulmonology Clinic
Mathew (Josie) Edevattal, MD
Chris Salvino, MD
Trauma/General Surgery Clinic

Welcome to Specialty Associates!

Attached please find your **APPOINTMENT CARD** and our **NEW PATIENT PACKET (*NPP*)**.
This packet consists of:

- Patient Registration
- Medical History (*3 pages*)
- Medicare Questionnaire (***MEDICARE ONLY***)
- Patient Bill of Rights
- HIPAA/Financial Policy (*3pages*)
- Living Will & Power of Attorney (*2 pages* ***OPTIONAL***)
- BLANK Records Request (***SIGN ONLY***)
- Notice of Privacy Practices (***KEEP COPY***)

Please arrive **30 MINUTES PRIOR** to your scheduled appointment and check in with the Front Desk staff.
Please bring your attached ***NPP*** **completed** with you to your appointment.
Please bring your photo **ID/Driver's License** and **Insurance Card(s)**.
Please bring your medication list or medications with you.
Please call our office with any questions you may have.
— If you have had any outside imaging, please bring a disc.—

We look forward to providing your care.

Thank you!
Specialty Associates

Today's Date ____/____/____

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name Last First Middle	▫ Mr ▫ Mrs ▫ Miss ▫ Ms	Marital Status (circle) Single/ Married / Divorced /Sep/ Widow
Is this your legal name? ▫ YES ▫ NO	If not, what is your legal name?	Birthdate / /	Age Sex ▫M ▫F ▫T
Street or Mailing Address (circle one) City State Zip Code		Home Phone Number ( )
Cell Phone Number ( )	E-Mail Address (To be used for appointment reminders)	Social Security - -
Occupation	Employer	Employer Phone Number

Employment Status: ▫1 – Full-Time ▫2 – Part-Time ▫3 – Not Employed ▫4 – Self-Employed ▫5 – Retired ▫6 – Active Military
Student Status: ▫F – Full-Time Student ▫P – Part-Time Student ▫N – Not a Student

Race: ▫American Indian/Alaska Native ▫Asian ▫Native Hawaiian/Pacific Islander ▫Black/African American ▫White ▫Hispanic ▫Other ▫Declined

Ethnicity: ▫Hispanic or Latino ▫Not Hispanic or Latino ▫Declined

Language: ▫English ▫Spanish ▫Indian ▫Japanese ▫Chinese ▫Korean ▫French ▫German ▫Russian ▫Other _____

Pharmacy: | Do you have a living will? ▫ YES ▫ NO

Referred By (Please check one box)
▫ Dr. _____ ▫ Insurance ▫ Hospital ▫ Family ▫ Friend ▫Yellow Pages ▫ Other _____

Other Family Members Seen Here

PCP Name Phone #

RESPONSIBLE PARTY INFORMATION (Information used for patient balance statements)

Responsible Party: ▫Another Patient ▫Guarantor ▫Self ▫Check here if information is same as patient

Name	Address	Home Phone Number ( )
Birth Date / /	E-Mail Address	
Occupation	Employer	Employer Address	Employer Phone Number ( )

INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Is this visit for one of the following? ▫ WORKERS COMPENSATION (WC)
▫ OCCUPATIONAL MEDICINE (OM) ▫ MOTOR VEHICLE ACCIDENT (MVA) ▫ ACCIDENT DATE _____

Does the patient have healthcare coverage? ▫ YES ▫ NO	Insurance Name				
Name of Insured	Social Security Number - -	Birth Date / /	Effective Date / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ▫ Self ▫ Spouse ▫ Child ▫ Other _____					
Name of Secondary Insurance	Name of Insured		Date of Birth / /	Group ID	Subscriber ID (Policy Number)
Patient Relationship to Insured ▫ Self ▫ Spouse ▫ Child ▫ Other _____					

EMERGENCY CONTACT

Name (Last, First)	Relationship to Patient	Home Phone Number ( )	Other Phone Number ( )

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I consent to receive text messages and/or email messages from the practice to any cell number and/or email provided which may include appointment reminders, bills, payment receipts, or marketing materials. I understand that a patient's care is directed by his/her physician(s) and I consent to any services that are appropriate for my care and as ordered by my physician(s).

_____ _____

Patient/ Guardian Signature Date

Specialty Associates

Medical History Intake Form

NAME _____ TODAY'S DATE: _____

BIRTHDATE: _____ PRIMARY CARE PHYSICIAN: _____

WHO REFERRED YOU HERE TODAY? _____

WHY ARE YOU HERE TO SEE THE PHYSICIAN?

1.	
2.	

WRITE A BREIF REVIEW OF THE PRESENT CONDITION THAT PROMPTED THIS VISIT:

LIST ALL YOUR CURRENT MEDICATIONS & DOSAGES (or provide a list if more than 10):

	Name	Strength	How Often	Start Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

LIST PREVIOUS SURGERIES & APPROXIMATE DATES:

	Surgery	Date (Mo/Yr)
1.		
2.		
3.		
4.		

LIST PREVIOUS HOSPITALIZATIONS & APPROXIMATE DATES:

	Hospitalization	Date (Mo/Yr)
1.		
2.		
3.		
4.		

LIST ANY OTHER PREVIOUS or CURRENT MAJOR MEDICAL CONDITIONS & ILLNESS. ***EX - COPD, HEP C, Crohns, Cancer, GERD, Migraines, UTI's, CF, Diabetes, etc.***

	Major Medical Conditions & Illness	Date Diagnosed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

LIST ALL ALLERGIES TO MEDICATIONS, FOOD, CONTRAST DYE, ETC.

	Agent/Substance/Material	Known Reaction
1.		
2.		
3.		
4.		
5.		

SOCIAL HISTORY:

Do you use tobacco products? Yes No Former

If YES, what kind, how much, how often? _____ If FORMER, when did you quit? _____

ALCOHOL USE: Heavily Moderately Socially Occasionally Never

ILLEGAL DRUG USE: Never Used Past Used Current Use

If using currently or in the past, please indicated type used _____

Please indicate your current living situation: Home Owner Renter Homeless Other: _____

Do you exercise? Yes No If YES, what type and how often? _____

FEMALES ONLY - WRITE A BRIEF HISTORY OF OB/GYN:

Are you currently Pregnant? Yes No **Are you currently Breast Feeding? Yes No**

WHAT IS YOUR FAMILY HISTORY? (Please fill out to the best of your ability. Not all apply)

Are you Adopted? Yes No If yes, please fill out the best of your ability of known blood relatives.

Family Members	Status A = Alive D = Deceased U = Unknown	Year of Birth	Age (Yrs)	Known medical conditions or cause of death
Mother	A D U			
Father	A D U			
Brother 1	A D U			
Brother 2	A D U			
Brother 3	A D U			
Sister 1	A D U			
Sister 2	A D U			
Sister 3	A D U			
Daughter 1	A D U			
Daughter 2	A D U			
Daughter 3	A D U			
Son 1	A D U			
Son 2	A D U			
Son 3	A D U			
Maternal Grandmother	A D U			
Maternal Grandfather	A D U			
Paternal Grandmother	A D U			
Paternal Grandfather	A D U			
Other	A D U			

REVIEW OF SYMPTOMS: (Circle Y for Yes or N for No for each item)

CONSTITUTIONAL			Pneumonia	Y	N	INTEGUMENTARY (SKIN)		
Fatigue	Y	N	CARDIOVASCULAR			Dry Skin	Y	N
Ill Feeling	Y	N	Chest Pain	Y	N	Eczema	Y	N
Insomnia	Y	N	Irregular Heartbeat	Y	N	Itchiness	Y	N
Night Sweats	Y	N	Swelling in Leg or Feet	Y	N	NEUROLOGICAL		
EYES			Dizziness	Y	N	Balancing Trouble	Y	N
Blurred Vision	Y	N	GASTROINTESTINAL			Headache	Y	N
Recent Changes in Vision	Y	N	Abdominal Pain	Y	N	Dizziness	Y	N
Dry Eyes	Y	N	Blood in Stool	Y	N	Numbness/Tingling in Legs	Y	N
EAR, NOSE, THROAT			Constipation	Y	N	PSYCHIATRIC		
Ear Pain	Y	N	Diarrhea	Y	N	Anxiety/Worry	Y	N
Nasal Congestion	Y	N	Difficulty Swallowing	Y	N	Depression	Y	N
Hearing Loss	Y	N	GENITOURINARY			ENDOCRINE		
Neck Pain	Y	N	Blood in Urine	Y	N	Chronic Fatigue	Y	N
RESPIRATORY			Painful Urination	Y	N	Heat Intolerance	Y	N
Cough	Y	N	MUSCULOSKELETAL			Sleep Disturbance	Y	N
Coughing Up Blood	Y	N	Back Pain	Y	N	HEMOTOLOGIC/LYMPHATIC		
Wheezing	Y	N	Joint Pain	Y	N	Bruise Easy	Y	N
Asthma	Y	N	Any Other Pain	Y	N	Fatigue	Y	N

PRINT

Medicare Secondary Payer Questionnaire

(Short Form)

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. **Are you receiving benefits from any of the following programs?**

   Black Lung ☐ YES (Long form Part I) ☐ NO
   Research Grant ☐ YES (Long form Part I) ☐ NO
   Veteran Affairs ☐ YES (Long form Part I) ☐ NO

2. **Was illness/injury due to a work related accident/condition?**

   ☐ YES ☐ NO

   If **YES**, answer the following:
   ☐ Work related accident (complete Part I of long form).
   ☐ Non-work related accident (complete Part II of long form).

3. **Is the patient currently employed?**

   ☐ YES (answer next question) ☐ NO

   Do you have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

4. **Is the patient's spouse currently employed?**

   ☐ YES (answer next question) ☐ NO

   Does your spouse have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

5. **Is the patient entitled to Medicare benefits as a result of:**

   Age _____

   End Stage Renal (Kidney) Disease? ☐ YES (Long form part VI) ☐ NO

   Disability? ☐ YES (Long form part V) ☐ NO

6. **Are you currently a patient in a skilled nursing facility such as a nursing home?**
   (Long form not required, ALERT: If yes bill SNF not Medicare)

   ☐ YES ☐ NO

I confirm that the above information if correct.

Patient Name: _____ Date: _____

Patient Signature: _____

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf

Specialty Associates

Patient Bill of Rights

As a patient, I have the following rights:

- Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
- To be treated with dignity, respect, and consideration.
- Not to be subjected to any of the following: Abuse, Neglect, Exploitation, Coercion, Manipulation, Sexual Abuse, Sexual Assault, Restraint or Seclusion except whereas deemed to be medically necessary or required, Retaliation for submitting a complaint to any reporting entity, or Misappropriation of personal and private property.
- To receive treatment that supports and respects my individuality, choices, strengths, and abilities.
- To receive privacy in treatment and care for personal needs.
- To review, upon written request, my medical records.
- To receive a referral to another health care institution if Specialty Associates is not able to provide the services needed by me.
- To participate or have my representative participate in the development of, or decisions concerning, treatment.
- To participate or refuse to participate in research or experimental treatment.
- To receive assistance from a family member, my patient representative, or other individual in understanding, protecting, or exercising my rights.
- To receive, with prior notification so that arrangements may be made, assistance with another language if I do not speak English so I am aware of my patient rights.
- To receive, with prior notification so that arrangements may be made, assistance with a physical or other disability so I am aware of my patient rights.
- To receive, before leaving, a summary of the visit and follow-up instructions that is documented in my medical records, unless I choose to leave against a personnel member's advice.
- To have the ability to refuse or withdraw consent for treatment before treatment is initiated.
- To be informed of risks associated with, or alternatives to, a proposed psychotropic medication or surgical procedures.

As a patient, I have the responsibility to:

- Disclose accurate and complete information regarding physical, hospitalization, medications, allergies, medical history, and related items.
- Participate in developing a Plan of Care, Advanced Directives, assigning a Power of Attorney, and a Living Will.
- Assist in maintaining a safe, peaceful, and efficient healthcare environment.
- Provide new or changed information regarding my health insurance to the receptionist and also to meet my agreed copay during my office visit.
- Contact the office when I am unable to keep my scheduled appointment.
- Cooperate in the planned care and treatment developed for me.
- Request more detailed explanations for any aspect of service I do not understand.
- Inform my physician and staff of any changes in my condition or any new problems or concerns.
- Communicate any temporary or permanent change in my address or telephone number which might hinder contact by Specialty Associates.
- Inform my physician when I am going to need a prescription refill before my supply is gone.

By signing below, I agree that I have read, understand, and agree to the above stated information.

Patient _____ Date _____

Specialty Associates

HIPAA ACKNOWLEDGEMENT, PATIENT CONSENT AND FINANCIAL POLICY

I. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. **NOTICE OF PRIVACY PRACTICES:** Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

_____
Patient Initials

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

NAME	RELATIONSHIP	CONTACT NUMBER

III. **ELECTION TO ELECTRONICALLY TRANSMIT MEDICAL INFORMATION:** I authorize Clinic to provide a copy of the medical record of my treatment, and a summary of care record to my primary care physician(s), specialty care physician(s), and/or any health care provider(s) or facility(ies) to facilitate my treatment and continuity of care. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence,, mental or

behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. The summary of care record consists of information from my medical record, including among other things, information concerning procedures and lab tests performed during this episode of care, my care plan, a list of my current and historical problems, and my current medication list. I understand that I may, by placing my request in writing to the Clinic, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire automatically one year after the date on which my current treatment episode comes to an end.

IV. **PARTICIPATION IN HEALTH INFORMATION EXCHANGE(S):** Federal and state laws may permit this Clinic to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I hereby authorize Clinic to provide a copy of my medical record or portions thereof to any health information exchange or network with which Clinic participates and to any other participant in such health information exchange or network for purposes of treatment, payment, health care operations, and the purposes discussed above, and in accordance with the terms of the participation agreement for that health information exchange or network. A full list of health information exchanges and/or networks with which Clinic participates may be found in the Notice of Privacy Practices, which is available on the Clinic website, and this list may be updated from time to time if and when Clinic participates with new health information exchanges or networks. I understand that information disclosed under this paragraph may include, among other things, confidential HIV-related information and other information relating to sexually transmitted or communicable diseases, information relating to drug or alcohol abuse or drug or alcohol dependence, mental or behavioral health information (excluding psychotherapy notes), genetic testing information, and/or abortion-related information. I understand that I may, by placing my request in writing to the Privacy Officer, revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released under this authorization. This authorization will expire upon revocation.

V. **EMAIL AND TEXT COMMUNICATIONS:** If at any time I provide an email or text address at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the Clinic to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer-assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication from Clinic, its affiliates, contractors, servicers, clinical providers, attorneys, or agents, including collection agencies. Practice may contact me via email and/or text messaging to remind me of an appointment, to obtain feedback on my experience with the Practice's healthcare team, and to provide general health reminders/information.

VI. **FINANCIAL POLICY:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided.

- The Clinic will file your insurance as a courtesy to you; however, you are responsible for the entire bill. **All co-payments, unmet deductibles, and other patient-responsible services must be paid at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**

- In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days), then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we will place your account with an outside collection agency.

- If your insurance plan requires a referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.

- Returned checks will be subject to a returned check fee. A fee may be charged for missed appointments.

VII. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate State agency for payment of a Medicaid claim. I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I request that payment of assignment benefits be made on my behalf.

I acknowledge receipt of the HIPAA Acknowledgement and Consent Form. I further acknowledge that I have been given the opportunity to ask questions.

_____ _____

Printed Name of Patient or Representative Signature of Patient or Representative

_____

Date

Relationship to Patient (if other than patient) _____

CLINIC STAFF USE ONLY

☐ Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known:

_____ _____

Witness (Staff) Signature Witness (Staff) Printed Name

Date: _____

Specialty Associates

Advance Directives – Living Will & Power of Attorney

THIS IS OPTIONAL. Advance Directives are provided as a courtesy to all patients of Specialty Associates. It is encouraged that you complete these forms and turn them in with your new patient packet if you do not already have a Living Will or Power of Attorney. A copy of these forms will be provided to you once you turn them in. If you do already have these items, it is recommended by Arizona State Statute R9-10-1008 that we maintain copies in your patient records to protect your rights. You also have the right to choose not to participate.

LIVING WILL

I, _____ want everyone who cares for me to know what health care I want, when I cannot let others know what I want.

SECTION 1:
I want my doctor to try treatments that may get me back to an acceptable quality of life. However, if my quality of life becomes unacceptable to me and my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

A quality of life that is unacceptable to me means *(check all that apply)*:

- ☐ Unconscious (chronic coma or persistent vegetative state)
- ☐ Unable to communicate my needs
- ☐ Unable to recognize family or friends
- ☐ Total or near total dependence on others for care
- ☐ Other: _____

Check only one:

- ☐ Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).
- ☐ If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

SECTION 2: (You may leave this section blank.)
Some people do not want certain treatments under any circumstance, even if they might recover. Check the treatments below that you do not want under any circumstances:

- ☐ Cardiopulmonary Resuscitation (CPR)
- ☐ Ventilation (breathing machine)
- ☐ Feeding tube
- ☐ Dialysis
- ☐ Other: _____

SECTION 3:
When I am near death, it is important to me that: _____

_____

_____

(Examples of items to discuss here are hospice care, funeral arrangements, end of life wishes.)

BE SURE TO SIGN PAGE TWO OF THIS FORM

- ☐ If you only want a Health Care (Medical) Power of Attorney, draw a large X through this page.
- ☐ Talk about this form with the person you have chosen to make decisions for you, your doctor(s), your family and friends. Give each of them a copy of this form.
- ☐ Take a copy of this with you whenever you go to the hospital or on a trip.
- ☐ You should review this form often.
- ☐ You can cancel or request a new copy to change this form at any time.

HEALTH CARE (MEDICAL) POWER OF ATTORNEY
WITH MENTAL HEALTH AUTHORITY

It is important to choose someone to make healthcare decisions for you when you cannot. **Tell the person (agent) you choose what you would want.** The person you choose has the right to make any decision to ensure that your wishes are honored. If you **DO NOT** choose someone to make decisions for you, write **NONE** in the line for the agent's name.

I, _____, as principal, designate the following person

_____ as my agent for all matters relating to my health (including mental health) and including, without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

_____ By initialing here, I specifically consent to giving my agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician.

_____ By initialing here, this Health Care Directive including Mental Health Care Power of Attorney may not be revoked if I am incapacitated.

Print agent ADDRESS: _____

Print agent PHONE: _____

If my agent is unwilling or unable to serve or continue to serve, I hereby appoint:

_____ as my agent.

Print alternate agent ADDRESS: _____

Print alternate agent PHONE: _____

I intend for my agent to be treated as I would regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D and 45 CFR 160-164.

SIGN HERE for the Health Care (Medical) Power of Attorney and/or the Health Care Directive forms
Please ask one person to witness your signature who is not related to you or financially connected to you or your estate.

Principle Signature _____ Date _____

As the witness, the above named person is personally known to me, and I believe him/her to be of sound mind and to have completed this document voluntarily. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this document. I am not to my knowledge a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness _____ Date _____

This document may be notarized instead of witnessed.

On this _____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above.

Notary Public _____

SIGN ONLY

SPECIALTY ASSOCIATES
HAVASU MEDICAL GROUP

Khizer Shaikh, M.D.

Scott Coole, D.O.

Ph: 928-854-7540

Fx: 928-854-2405

Records Request Authorization

To: _____

I hereby authorize and request you **TO** release the indicated protected health information to Specialty Associates:

☐ All records in your possession to _____ (insert ending date).
☐ All records in your possession corresponding to the following description(s):

_____

_____

This information is disclosed at the patients request for the purpose of continuation of care.

This authorization shall be in force and effect until (choose one):

☐ Revoked in writing by the patient.

☐ The end of business day on or immediately after ___/___/___.

In understand I may revoke this authorization at any time by writing to the Provider. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the provider and may no longer be protected by federal or state law. I understand my authorization may be a condition for medical treatment and if I do not sign this authorization, the Provider is not obligated to provide health care services to me. I understand I have the right, subject to provisions of federal and/ or state law, to inspect or copy my protected health information relating to the care rendered by this Provider. I also understand that I have the right to refuse to sign this authorization.

Name: _____ Date of Birth: _____

Address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE - April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW THIS INFORMATION CAREFULLY. This notice applies to **Specialty Associates** and the doctors and other healthcare providers practicing at this facility.

It is our legal duty and we are required by law to protect the privacy of your information and to notify you of certain breaches of your information. We are providing this notice so that we can explain our privacy practices. We will follow the practices described in this notice or the current notice in effect. We reserve the right to change our policies and notice of privacy practices at any time. If we should make a significant change in our policies, we will change this notice and post the new notice. You can also request a copy of our notice at any time. For more information about our privacy practices or to place a complaint or report a concern or conflict, call the number listed below:

LaSaundra Williams
928-854-7540

Or, if you prefer to remain anonymous, you may call the toll-free number listed next and an attendant will handle your concern anonymously. 1-877-508- LIFE (5433).

You may also send a written complaint to the United States Department of Health and Human Services if you feel we have not properly handled your complaint. You can use the contact listed above to provide you with the appropriate address or visit http://www.hhs.gov/ocr/privacy/. Under no circumstance will you be retaliated against for filing a complaint.

We may use health information about you for your treatment purposes, to obtain payment, or for healthcare operations and other administrative purposes. For example, we may use your information in treatment situations if we need to send your medical record information to a specialist or physician as part of a referral for continuing care. We will send your health information and other identifying information to Medicare, Medicaid or other health insurance plans for our billing purposes. Your information will be used when processing your medical records for completeness and to compare patient data as part of our efforts to continually improve our treatment methods. We may disclose your information to our business associates we contract with to provide service on our behalf that requires the use of our health information. We may contact you or disclose certain parts of your health information to our associate or related foundations, for fundraising purposes. You have the right to opt out of receiving such fundraising communications. We may share certain information with a person(s) you identify as a family member, relative, friend, or other person that is directly involved in your care or payment for your care, or if it becomes necessary to notify these individuals about your location, general condition, or death. In addition we may need to disclose medical information about you to an entity assisting in a disaster relief efforts so that your family can be notified about your condition, status, and location.

Under certain circumstances we may be required to disclose your health information without your specific authorization. Examples of these disclosures are: requirements by state and Federal laws to report cases of abuse, neglect, or other reasons requiring law enforcement; for public health activities; to health oversight agencies; for judicial and administrative proceedings; for death and funeral arrangements; for organ donation; for special government functions including military and veteran requests, and to prevent serious threat to health or public safety. We may also contact you after your current visit for future appointment reminders or to provide you with information regarding treatment alternatives or other health related services that may be of benefit to you. Most uses and disclosures of psychotherapy notes, those for marketing purposes, and those that constitute a sale of medical information will only be made with your written authorization. We will obtain your written authorization for any other disclosures beyond the reasons listed above. Do remember, if you do authorize us to release your information, you always have the right to revoke that authorization later. We will be happy to honor that request except to the extent that we may have already acted.

As a patient, you have rights regarding how your information can be used and disclosed. These rights include access to your health information. In most cases, you have the right to look at or receive

a copy of your health information. This may take up to 30 days to prepare and there may be a preparation fee associated with making any copies. You can ask for an accounting of disclosures. This is a list of instances in which we have disclosed your information for reasons other than treatment, payment and operations that you have not specifically authorized but that we are required to do by law (see section on how your information may be used and disclosed). We can provide you one list per year without charge; all additional requests in the same year will be subject to a nominal charge. If you believe that the information we have about you is incorrect or if important information is missing, you have the right to request that we amend or correct the existing information. There may be some reasons that we cannot honor your request for which you submit a statement of disagreement. You can also request that your health information be communicated to you at an alternate location or address that is different from the one we received when you were registered. If you pay for your service in full up front, you can ask that we not disclose information about your treatment to your health plan. Finally, you can request in writing that we not use or disclose your information for any reasons described in this notice except to persons involved in your care or when required by law, or in emergency circumstances. We are not legally required to accept such a request but we will try to honor any reasonable requests.