Destiny Springs HEALTHCARE

PATIENT LABEL

PATIENT PROFILE & REGISTRATION

LAST NAME:	**FIRST NAME:**	**MI**	**DOB:**	**AGE:**
ADDRESS:				
CITY:	STATE:	ZIP:	COUNTY:	
PHONE:	EMAIL:		SSN:	
EMERGENCY CONTACT:	RELATIONSHIP:		PHONE:	

RELIGION: **RACE:** Caucasian/White ☐ Asian/Pacific Islander ☐ African American/Black ☐ Hispanic ☐ Other ☐

NICKNAME/PREFERRED NAME (*if applicable*) _____

GENDER: Male ☐ Female ☐ ☐ Other: _____

PREFERRED PRONOUNS: (*if applicable*)
He/Him ☐ Her/She ☐ They/Them ☐ Other: _____

SEXUAL ORIENTATION/IDENTITY: ☐ Heterosexual/Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Unsure
☐ Prefer not to answer ☐ Other (*please explain*) _____

(*Both parts if applicable*)
Employer: _____ Address: _____ Phone: _____

School: _____ Grade: _____ Phone: _____

WHO REFERRED YOU TO DESTINY SPRINGS? (*if applicable*)
Internet ☐ Family/Friend ☐ A person who was a patient here ☐ I was a patient here ☐ Other ☐ _____

Name/Business that referred you: _____ Phone Number: _____

Address: _____ City/State/Zip: _____ Email Address: _____

PARENT/LEGAL GUARDIAN INFORMATION | APPLIES TO BOTH ADOLESCENTS & ADULTS (*if applicable*)

Name: _____ Relationship to Patient: _____

Address: _____ City/State/Zip: _____ Phone: _____

IF YOU (LEGAL GUARDIAN) ARE THE GUARANTOR
Employer: _____ DOB: _____ SSN: _____
Cell Phone: _____ Work Phone: _____

******** ARE THE GUARDIAN PAPERS ATTACHED? (Legal decision making, Mental health POA, Fiduciary document) _____ YES _____ NO

INSURANCE INFORMATION

Primary Insurance: _____ Policy Holder Name: _____
Policy Holder DOB: _____ Policy ID: _____ Group # _____
Policy Holder Phone # _____

Insurance Card Attached? Yes ☐ No ☐ Policy Holder ID Attached? Yes ☐ No ☐ If No, Why? _____

(*complete secondary if applicable*)
Secondary Insurance: _____ Policy Holder Name: _____
Policy Holder DOB: _____ Policy ID: _____ Group # _____
Policy Holder Phone # _____
Insurance Card Attached? Yes ☐ No ☐ Policy Holder ID Attached? Yes ☐ No ☐ If No, Why? _____

Destiny Springs HEALTHCARE

PATIENT LABEL

CONSENT FOR ASSESSMENT

Destiny Springs Healthcare provides an assessment service at no cost, by nurses and mental health professionals at our facility to determine the level of care for the patient. The clinician may refer appropriate patients to outpatient services when needed. Before referring or assessing a referred patient the following disclosures must be made to each person seeking treatment or assessment:

- The assessment clinician is an employee of Destiny Springs Healthcare.
- The assessment is confidential unless the client gives permission in writing to release information.
- Financial reimbursements are not given or received by Destiny Springs Healthcare based on referrals.
- Destiny Springs Healthcare is a Physician Owned Hospital.

Please checkmark one of the following below

I consent to the assessment _____ I refuse the assessment _____

I certify that I have read and fully understand the above consent for assessment.

Patient Printed Name	Signature	Date/Time
Parent / Guardian Printed *(if applicable)*	Signature	Date/Time
Printed Staff Name	Signature	Date/Time

FOR OFFICE/HOSPITAL USE ONLY

Verbal Consent given by Patient/Legal Guardian (if applicable) with 2 witness signatures.

Witness 1 – Print and Sign Name	Date/Time
Witness 2 – Print and Sign Name	Date/Time

YOU MAY PRINT THIS FORM FOR YOUR RECORDS OR REQUEST A PRINTED COPY

Destiny Springs HEALTHCARE

PATIENT LABEL

CONSENT FOR TREATMENT AND CONDITIONS OF ADMISSION

The Undersigned Understands, Accepts, Consents, Authorizes, And Agrees to The Following:

Consent To Facility Care and Treatment: I consent to the medical, behavioral, and/or psychiatric treatment or services which may be performed during this Facility stay or while I am an outpatient. These services may include, but are not limited to, emergency treatment or services, laboratory procedures, X-ray examinations, medical or invasive treatments or procedures, telehealth and/or telemedicine services, psychiatric or behavioral diagnosis and treatment, medications, injections, photography, videotaping, general nursing care, or Facility services provided to me under the general and special instructions of my treating practitioner The practice of medicine and delivery of care is not an exact science, and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment at this Facility.

Medical / Psychiatric: The patient will be under the care of an attending practitioner. The Facility and its support staff are responsible for carrying out my treating practitioner's instructions. My treating practitioner is responsible for obtaining my informed consent, when required, to medical, behavioral, or psychiatric treatment, special diagnostic or therapeutic procedures, or Facility services provided to me under my treating practitioner's general and special instructions. I understand that a physician is not staffed on the premises 24-hours a day, however a physician is always available and may be reached 24-hours a day by Facility staff.

Medical Emergencies: I understand that during a stay at Destiny Springs Healthcare medical emergencies may arise, which would be best treated at a general hospital or urgent care facility. For this reason, I am authorizing a general care hospital or urgent care facility to treat the named patient for any medical condition that might occur.

Legal Relationship Between Facility and Practitioners: I understand that the practitioners providing services, including my psychiatrist or Nurse Practitioner and any consulting Physicians are not employees, representatives, or agents of the Facility. They are independent contractors granted the privilege of using this Facility for the care and treatment of their patients. Independent Contractors: The undersigned understands, consents and agrees that certain independent contractors, including canine therapy, may be involved in care during the patient's stay at the Facility. The undersigned further consents to authorize the Facility, its staff, and independent contractors to render to the patient therapy with animals including dogs. Canine assisted therapy incorporates the use of animals within the therapy process. Further consent is also given for any recreational activities and therapy, and other treatment with these animals while receiving care at the Facility. The undersigned indemnifies the Facility and its independent contractors from loss due to injury that may occur because of the patient's voluntary participation in any therapeutic program at the Facility under the care of the independent contractor.

Personal Valuables: The Facility maintains a safe for the safekeeping of money and valuables. The Facility shall not be liable for the loss or damage to money, clothing, jewelry, dentures, or any other articles of value unless placed therein, and shall not be liable for loss or damage to any other individual property, unless deposited with the Facility for safekeeping.

Contraband Items and Searches: The undersigned agrees and understands that drugs, alcohol, weapons, or other articles specified as contraband by the Facility may not be brought onto the premises, and that failure to abide by this rule could result in immediate discharge from the Facility. I understand that this Facility reserves the right to search my personal belongings, my room and my person at any time to determine if I possess contraband or other items that may be dangerous to the health and safety of myself or other patients.

Photographs And Videotaping: The undersigned hereby consents to the taking of photographs for the purpose of identification or for treatment purposes. Photographs may be permanently retained in the patient's medical records. I understand that a patient identification wristband may be used in lieu of a photograph. Further, the undersigned acknowledges and is hereby informed that the Facility uses real-time video surveillance and recording

equipment on its program units solely for monitoring the patient areas for safety. Video surveillance and recording equipment is used in common areas and is never used in a patient's bedroom or bathroom. I understand the photographs or videotapes will be used only for the purpose described above and will not be released or disclosed without my express permission unless authorized by applicable law.

Zero Tolerance Violence Policy: I understand that Destiny Springs enforces a Zero-Tolerance policy regarding violence (verbal or physical), and that Destiny Springs has the right to pursue legal action against any patient who engages in violence, either verbal or physical, against staff members, patients, visitors, or others while on facility premises

Discharging Against Medical Advice: This is to certify that the patient assumes full responsibility for being discharged against the advice of the attending practitioner and the facility administration, and hereby releases the attending physician and Destiny Springs from all responsibility for any ill effects which may result from this action.

Property Damage: Any damage to Facility property caused by the patient will be billed to the patient's account for repair or replacement and must be paid in full on or before discharge.

Destiny Springs Healthcare is committed to preventing, reducing, and striving to eliminate the use of restraint and seclusion. The use of restraint and seclusion is limited to emergencies where there is an imminent risk of self-harm, or harm to others. In the adult program with your consent, your family will be involved in your treatment; this will include notification, with the patient's permission, of a restraint or seclusion episode (parents / guardians will always be notified for children and adolescents or adults under guardianship).

I authorize Destiny Springs staff to notify a representative of any seclusion or restraint: Yes _____ No_____

If yes, representative name/phone number:

_____

Notice Of Privacy Practices and Authorization to Release Information: I acknowledge that this Facility has provided me with a copy of its Notice of Privacy Practices. I authorize the Facility, physicians, and other licensed providers furnishing these services to disclose my Protected Health Information ("PHI") as that term is defined by the federal law referred to as "HIPAA" for purposes of treatment, payment and health care operations to third parties including but not limited to insurance carriers, health plans (including government health programs such as Medicare and Medicaid), or workman's compensation carriers that may be responsible for payment of the services ("Third Party Payers"). The PHI disclosed may include information about my treatment, medical care, medical history, billing information, and other information received or acquired by the Facility and maintained in any form, including written, oral or electronically maintained information.

Notification of Clinical Supervision for Assigned Therapist/Social Worker

I understand that my social worker/therapist, may be working under the supervision of an independently licensed professional whose contact information can be obtained by contacting: **Director of Clinical Services 623-233-3000.** I further understand that the details of my treatment may be discussed during my therapist's clinical supervision sessions with his/her clinical supervisor and that a clinical supervisor may be present during treatment sessions in order to observe my therapist. I am authorizing the release of my clinical information for the purposes of clinical supervision for my assigned therapist.

Confidentiality: *Records of identity, diagnosis, prognosis, or treatment of any* patient *which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall (…) be confidential (42 CFR ch.1 Par. 2.2 (a)).*

Health Information Exchange (HIE): I acknowledge that I received and read the Notice of Health Information Practices. I understand that this facility participates in Health Current, Arizona's Health Information Exchange (HIE).

I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt-Out Form to this facility.

Hospital, Physician, And Practitioner Billing: I understand that each physician, medical group, or other practitioner who provides professional services to me while I am in the Facility, including Facility-Based Physicians and other allied health professionals (collectively "Practitioners"), will bill and collect for their professional services separate and apart from the Facility. This Conditions of Admission document applies to services rendered by the Practitioners as well as the Facility. I also understand I have the right to request an explanation of the Facility and Professional Fee billing processes and a list of the Facility's and Professional Fee charges for any services I might receive.

Assignment Of Benefits and Right of Action: In return for services to be furnished, I make the following irrevocable assignments to the Facility and/or Practitioners:

Assignment Of Health Insurance Benefits: I irrevocably assign to the Facility and other Healthcare Providers / Practitioners who furnish services to me all benefits payable for services rendered to me by each party payable by a Third-Party Payor, including without limitation a health insurance company, health plan, worker's compensation program, ERISA plan, or any other entity responsible for payment of patient's Facility bill. This assignment extends to the total amount of the Facility's bills, with interest as allowed by law.

Assignment Of Personal Injury Proceeds: I assign and transfer my right to receive benefits payable to me under the policies described below to the Facility and Practitioners involved in my care. The policies may include benefits payable under Personal Injury Protection, Medical Pay, Uninsured/Underinsured, and/or liability provisions of any insurance policy under which I am entitled to receive benefits related to the occurrence that caused or contributed to the injuries or condition being treated by the Facility or the Practitioners. I understand and acknowledge that this assignment includes the total amount of my Facility bill(s), including interest as allowed by law.

Assignment Of Claims and Right of Action: I understand that this assignment of benefits gives the Facility and Practitioners the right to be paid directly by my Third-Party Payor for the services provided to me or the individual designated below as the patient for this admission. In return for the services furnished by the Facility and Practitioners, I assign and transfer to these parties all right, title, and interest in all benefits payable for the health care rendered, which are provided in under insurance policies and health benefit plans for which my dependents or I are entitled to recover. This assignment and transfer shall be for the purposes of granting the Facility and Practitioners an independent right of recovery against my Third-Party Payer but shall not be construed as an obligation of these parties to pursue any such right or recovery. In no event will the Facility or Practitioners have any right to retain benefits more than the amount owed to them for the care and treatment rendered during this admission.

Secondary Payers: I understand that any health insurance policies under which I am covered are secondary payers to any existing liability policies or any other sources of payment that may or will cover expenses incurred for services and treatment.

Appointment Of Agent: I appoint the facility, the Practitioners, and any agent acting on their behalf as my authorized representatives to pursue any claims, penalties, and administrative and/or legal remedies on my behalf for collection against any responsible Third-Party Payer or third-party liability carrier of all benefits due me for the payment of charges associated with my treatment. I have read and been given the opportunity to ask questions about this assignment of benefits, and I have signed this document freely and without inducement, other than the rendition of services by the Facility, Facility-Based Physicians, and other affiliated physicians and health care practitioners.

Financial Agreement: I agree, whether signing as a parent, guarantor, agent or the patient, that in consideration of the services provided by the Facility and Practitioners, I will promptly pay all Facility and/ or Practitioner bills in

accordance with that party's standard charges for such services, and, if applicable, the Facility's or Practitioner's charity care and discount payment policies, as well as in accordance with applicable and state and federal law. Should my account be referred to an attorney or collection agency for collection, I will pay actual attorney's fees and collection expenses. I understand that all delinquent accounts may be charged interest at the legal rate. I certify that the information I have provided is true and accurate to the best of my knowledge. I understand that the information I submit is subject to verification, including credit agency scoring, and subject to review by federal and/or state agencies and others as required. I authorize my employer to release proof of my income to the Facility or a Practitioner if requested. I understand that if any information I have given proves to be untrue, the Facility and/or a Practitioner may re-evaluate my financial status and take the appropriate action,

Charity Care and Discounted Payments: If you do not have health insurance, you may qualify for financial assistance. Please contact the Facility Business Office for additional details.

Authorization For Receiving Messages and Automated Calls: I grant the Facility and Practitioners (including their billing agents and third-party collection agents) permission to contact me by telephone at the number(s) I provided during the registration process, or at any time in the future, including wireless telephone number(s) that may result in charges to me. Both the Facility and Practitioners, including their respective agents, may leave messages for me at these numbers and may send text messages or email communications using the email address or address I provide. These voice messages, email and text communications may include information required by law (including debt collection laws) related to amounts I owe the Facility or Practitioners and messages related to my continued care and treatment.
I also understand that the Facility and its agents, including debt collection agencies, may use pre-recorded/artificial voice messages and/or use an automatic dialing devise to deliver messages related to my account and any outstanding balance. I also authorize the Facility and its agents to use the number(s) provided for such pre-recorded or auto dial messages. If I want to limit these communications to a specific telephone number, I understand that I must request that only a designated number be used for these purposes.

Medicare Certification and Authorization to Release Payment Information and Payment Request: I certify that any information given by me in applying for payment under title XVIII of the Social Security Act (Medicare) is correct. If applicable, I authorize the Facility, Facility Based Physicians or any other health care providers who have medical or other information about me to release any information needed for this or a related Medicare claim to the Social Security Administration or its intermediaries or carriers. I request that payment of authorized benefits be made on my behalf.

Consents for Release of Information The undersigned authorizes the Facility to release all patient information, including specific information regarding diagnosis, treatment, and progress with respect to any physical, psychiatric, or drug / alcohol related condition for which the patient is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS) or treatment for drug / alcohol abuse, while at the Facility, to any insurance company, and/or third party payers, or representative providing coverage for this admission, or to and Facility representative including, but not limited to Facility employees, attending physicians, other healthcare professionals or organizations. This information may not be released to any other person or entity unless the undersigned so authorizes.

The undersigned acknowledges that disclosures shall be limited to information necessary for the discharge of the legal or contractual obligations of the person(s) or entities to which the information is released.

The undersigned further authorizes the Facility to release information for the purpose of obtaining pre-authorization for treatment, and concurrent review. This release includes information released to medical review agencies, and/or third-party payers providing coverage or having responsibility for this admission.

The confidentiality of alcohol and drug abuse patient records is protected by federal law and regulations (42 CFR, Part 2). The Facility may not disclose information to anyone outside of the Facility which would identify any patient

as an alcohol or drug abuser unless the patient has consented in writing; the disclosure is allowed by a court order, or the disclosure is made to medical or other qualified personnel in accordance with federal regulations.

Federal law and regulations do not protect information regarding a crime or a threat to commit a crime or any information regarding suspected child abuse or neglect from being reported to appropriate State or local authorities.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient or parent / legal guardian if the patient is a minor, or is duly authorized by the patient as the patient's general agent to execute its terms. By signing below, the individual is filing a request for admission with the administrator of Destiny Springs Healthcare.

Right to Refuse Care, Treatment and Services: The treatment team at Destiny Springs will include you in treatment planning and will make treatment recommendations that are felt to be the most supportive of long-term recovery. These may include recommendations about medications, therapies, or other treatments. Every patient/guardian has the right to refuse and or all elements of care treatment, or services. In the event of adamant and long-term refusal of care, treatment, and services, the treatment team will consider the hospital's ability to best service the needs of the patient and may consider options such as pursuing guardianship or therapeutic discharge.

Smoking/Tobacco Contract (Adults Only): I am requesting smoking/ tobacco products privileges for my inpatient stay at Destiny Springs Healthcare. I understand that this is a privilege, not a right, and I must abide by the guidelines for my safety and the safety of other patients. I also understand that failure to comply with guidelines may result in loss of privileges at any time.

Patient Printed Name	Signature	Date/Time
Parent / Guardian Printed *(if applicable)*	Signature	Date/Time
Printed Staff Name	Signature	Date/Time

FOR OFFICE/HOSPITAL USE ONLY

Verbal Consent given by Patient/Legal Guardian (if applicable) with 2 witness signatures.

Witness 1 – Print and Sign Name	Date/Time
Witness 2 – Print and Sign Name	Date/Time

***Any questions or concerns regarding billing insurance, or payment arrangements should be discussed with our patient account representatives in the business office at (623) 233-3000**

Destiny Springs HEALTHCARE

PATIENT LABEL

ADVANCE DIRECTIVE-HEALTHCARE PROXY ACKNOWLEDGEMENT

Destiny Springs Healthcare will respect the patient's wishes regarding advance directives, the designation of a health care proxy, and any other requests designated on a legal document. Furthermore, if a patient does not have an advance directive but wishes to obtain one, the hospital will provide the information to pursue an advance directive.

YES	NO	
☐	☐	I have an Advance Directive for Medical Care.
☐	☐	I have an Advance Directive for Mental Health Treatment.

I have identified a Health Care Proxy / surrogate decision maker to make decisions on my behalf.

IF YES, name of Healthcare Proxy / surrogate decision maker:

Name: _____ Phone #: _____

Patient has a Legal Guardian:

Name: _____ Phone #: _____

YES	NO	
☐	☐	If you answered yes to any of the above, are you able to provide the facility with a copy of these Advance Directive Documents?

YES	NO	
☐	☐	If you do not have an Advance Directive or Healthcare Proxy, do you wish to execute an Advance Directive or Healthcare Proxy or name a surrogate decision maker?

Patient has provided a copy of their Advance Directive? Yes ☐ No ☐

Patient has provided a copy of their Healthcare Proxy? Yes ☐ No ☐

_____

Patient Printed Name | Signature | Date/Time

_____

Parent / Guardian Printed *(if applicable)* | Signature | Date/Time

_____

Printed Staff Name | Signature | Date/Time

FOR OFFICE/HOSPITAL USE ONLY

Verbal Consent given by Patient/Legal Guardian (if applicable) with 2 witness signatures.

_____ _____

Witness 1 – Print and Sign Name | Date/Time

_____ _____

Witness 2 – Print and Sign Name | Date/Time

Destiny Springs HEALTHCARE

PATIENT LABEL

CURRENT MEDICATIONS TAKEN AT HOME

Patient Name: _____ DOB: _____

MEDICATION NAME		DIRECTIONS FOR USE & TIME TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

I give permission to Destiny Springs Healthcare to continue administering the above-listed medications.

_____

Patient Printed Name | Signature | Date/Time

_____

Parent / Guardian Printed *(if applicable)* | Signature | Date/Time

_____

Printed Staff Name | Signature | Date/Time

FOR OFFICE/HOSPITAL USE ONLY

Verbal Consent given by Patient/Legal Guardian (if applicable) with 2 witness signatures.

_____ _____

Witness 1 – Print and Sign Name | Date/Time

_____ _____

Witness 2 – Print and Sign Name | Date/Time

Destiny Springs HEALTHCARE

PATIENT LABEL

TELEPHONE/VISITOR AUTHORIZATION FORM

Patient Name:	Patient ID #:	Unit:

I hereby allow the individuals identified below to participate in phone calls and visitation. I understand that it is my responsibility to provide these individuals with the patient's identification number. I also understand that without the patient identification number and if not listed on this form phone calls and visitation will not be approved. This list can be updated at any time during the patient's stay. Visitor Identification (Government Issued Photo /P) will be checked prior to visitation for visitors over the age of 18.

This form does not grant permission for the release of information. Information about the patient's treatment will only be shared pursuant to a signed authorization to release medical, mental health and addiction records.

I hereby allow the following individuals to participate in phone calls and/or visitation.

NAME		PHONE NUMBER
Parent/Legal Guardian #1 (*if applicable*)		
Parent/Legal Guardian #2 (*if applicable*)		
Primary Contact (*if applicable*)		
Secondary Contact (*if applicable*)		

INDIVIDUALS NAME	RELATIONSHIP	PHONE NUMBER	PHONE CALLS?	VISITATION?

Flowers and/or other deliverable arrangements are not accepted to protect the patient's confidentiality.

_____

Patient Printed Name | Signature | Date/Time

_____

Parent / Guardian Printed *(if applicable)* | Signature | Date/Time

_____

Printed Staff Name | Signature | Date/Time

FOR OFFICE/HOSPITAL USE ONLY

Verbal Consent given by Patient/Legal Guardian (if applicable) with 2 witness signatures.

_____ _____

Witness 1 – Print and Sign Name | Date/Time

_____ _____

Witness 2 – Print and Sign Name | Date/Time

Destiny Springs HEALTHCARE

PATIENT LABEL

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____ Phone #: _____

Dates of Service Requested: _____

I AM REQUESTING DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE FOLLOWING PURPOSES (*Checkmark Below*)

Legal ☐	Personal Use ☐	Armed Forces/Military ☐	Disability Determination ☐
Employment ☐	Coordination of Care ☐	Academic ☐	Other: _____

I AUTHORIZE THE INFORMATION TO BE DISCLOSED BY:	**I AUTHORIZE THE INFORMATION TO BE DISCLOSED TO:**
Destiny Springs Healthcare 17300 N. Dysart Rd. Surprise, AZ 85378 P: (623) 233-3000 F: (623) 399-1239 medicalrecords@destinysprings.com	_____ Name/Agency/Credentials _____ Address City State Zip _____ Phone Number Fax Number Email

PLEASE RELEASE MY INFORMATION VIA: (*Checkmark Below*)

VERBAL ONLY ☐ SECURE EMAIL ☐ _____ MAIL ☐ PICK-UP ☐ FAX (#) ☐ _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING TYPE OF RECORD (*Initials Required Below*)

_____ Alcohol / Substance Abuse or Treatment / Referral
_____ Sexually Transmitted Diseases
_____ HIV/AIDS-related treatment.

I AUTHORIZE/REQUEST THE RELEASE OF THE FOLLOWING INFORMATION: (*Checkmark Below*)

- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Billing Statement(s)
- ☐ Psychiatric Evaluation
- ☐ Other: _____
- ☐ Initial Assessments
- ☐ Lab/Diagnostic Reports
- ☐ Transition of Care
- ☐ History & Physical

YOUR RIGHTS REGARDING THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

My signature below acknowledges my understanding of the following:

- I understand that signing this authorization is voluntary and is not a condition of receiving services here.
- I understand the matters discussed on this form and that I can receive a copy of it. I release the provider and its employees of liability for the disclosure of my information pursuant to this request.
- Your records are protected under the federal regulations governing Confidentiality of Alcohol & Drug Abuse Records **(42 CFR, Part 2 & HIPPA 45 CFR Parts 160 & 164),** which prohibits further disclosure without written consent unless provided by law or regulation.
- If not subject to federal, state, or HIPAA confidentiality regulations, I am aware that the recipient may re-disclose my PHI without my permission.

_____

Patient Printed Name Signature Date/Time

_____

Parent / Guardian Printed *(if applicable)* Signature Date/Time

_____

Printed Staff Name Signature Date/Time

You have the right to revoke this authorization, by written request, at any time. This authorization will expire on _____/_____/_____ and/or one year from the date signed. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Revocation signature: _____ Date/Time Signed _____

Destiny Springs HEALTHCARE

PATIENT LABEL

PATIENT ACKNOWLEDGEMENTS AND CONSENTS

ACKNOWLEDEGEMENT OF YOUR PRESENCE

All patients have a right to receive approved visitors and phone calls while you are a patient with Destiny Springs Healthcare. For example, the staff may receive phone calls inquiring about the patient from those who know and are concerned about the patient. Without patient acknowledgement, we will neither confirm nor deny patient presence in our facility.

To protect patient privacy and confidentiality, the facility will assign a confidentiality code number for each admission. Upon admission, the patient will be informed of his or her confidential code number and his or her responsibility to give it to individuals he or she deems appropriate.

No acknowledgement of the Patient's current or former presence at the facility will be given to anyone without the correct code number. (This includes speaking to patients or visiting, by phone or in person, accepting personal items at the reception desk, telephone inquiries, etc.). Even when the correct number is given, specific information regarding the patient's care and treatment cannot be communicated to anyone without written consent of the patient or individual authorized to give consent, as noted above.

☐ I consent to allowing Destiny Springs Healthcare to inform the patient's attending physician and/or referral sources of the patient's admission and any progress at the facility. I also desire to receive visitors and phone calls while at Destiny Springs Healthcare.

☐ I voluntarily request that Destiny Springs Healthcare keep acknowledgement of the patient indicated below strictly confidential and not give out information about the patient to anyone. Therefore, I waive the right for the patient to receive phone calls and visitors as acceptance of these would acknowledge patient's presence.

ACKNOWLEDGEMENT OF RECEIPT OF THE PATIENT HANDBOOK TO INCLUDE: PATIENT RIGHTS, GRIEVENCE POLICY, IMPORTANT NUMBERS AND THE NOTICE OF HEALTH INFORMATION PRACTICES, IMPORTANT MESSAGE FOR MEDICARE (IF APPLICABLE), SMI RULES, NOTICE OF PATIENT ON PHYSICIAN OWNERSHIP

The undersigned acknowledges they have received Destiny Springs Healthcare receipt of a copy of the patient handbook which includes HIPAA Notice of Privacy Practices, Patient Rights (R9-10-212), the Grievance policy, Important phone numbers and the Notice of Health Information Practices, Important message Medicare, SMI Rules, and Notice of Patient on Physician Ownership. I / We have been given an opportunity to ask questions for further explanation.

Patient Printed Name	Signature	Date/Time
Parent / Guardian Printed *(if applicable)*	Signature	Date/Time
Printed Staff Name	Signature	Date/Time

FOR OFFICE/HOSPITAL USE ONLY

Verbal Consent given by Patient/Legal Guardian (if applicable) with 2 witness signatures.

Witness 1 – Print and Sign Name	Date/Time
Witness 2 – Print and Sign Name	Date/Time

Destiny Springs HEALTHCARE

PATIENT LABEL

THIS FORM ONLY APPLIES TO GUARDIANS THAT CANNOT PROVIDE LEGAL DOCUMENTATION SUPPORTING GUARDIANSHIP, LEGAL DECISION-MAKING, AND/OR MENTAL HEALTH POWER OF ATTORNEY.

*****THIS DOES NOT INCLUDE NATURAL/BIOLOGICAL PARENTS WHO DO NOT HAVE LEGAL GUARDIANSHIP/DECISION MAKING IN PLACE OR THE DEPARTMENT OF CHILD SAFETY (DCS)*****

Patient Name: _____ **DOB:** _____

Per Destiny Springs Healthcare policy, adoptive parents, and/or legal guardians are required to provide proof of documentation establishing their guardianship and/or legal decision-making rights. This includes natural/biological parents who have legal decision making in place with the other parent. This documentation must be provided in full, upon admission. If the legal guardian/parent cannot provide this supporting documentation, they are required to complete this form, in full, prior to and at admission.

LEGAL GUARDIANSHIP STATEMENT

Guardian Name: _____ **Phone Number:** _____

(*if a second guardian is applicable, please complete below*)

Guardian Name: _____ **Phone Number:** _____

I/We are the legal guardian of the adolescent child named above and have maintained sole custody and/or psychological decision-making rights since (***insert date***) _____

I am aware that I must provide custody, legal decision-making, or guardianship documentation once it has been received. In addition, if there is a change in custody, legal decision-making, or guardianship, I must provide written notice and updated documentation to Destiny Springs Healthcare.

Documentation can be provided at the following addresses below.

Mail: 17300 N. Dysart Road Surprise, AZ 85378
Fax: (623) 399-1239
Email: intake2@destinysprings.com

_____

Parent / Guardian Printed *(if applicable)* | Signature | Date/Time

_____

Printed Staff Name | Signature | Date/Time

FOR OFFICE/HOSPITAL USE ONLY

Verbal Consent given by Patient/Legal Guardian (if applicable) with 2 witness signatures.

_____ _____

Witness 1 – Print and Sign Name | Date/Time

_____ _____

Witness 2 – Print and Sign Name | Date/Time

PATIENT LABEL

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, a Contexture company. 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 twocases. 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 theinformation.

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 nothave.

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.

Destiny Springs HEALTHCARE

healthcurrent

CONSENT TO RELEASE BEHAVIORAL HEALTH & SUBSTANCE ABUSE INFORMATION
(FOR TREATING PROVIDERS)

Patient Name: _____ Date of Birth: _____

By signing this form, I permit all of my past, present and future healthcare providers where I have received behavioral health treatment, including any treatment for substance use disorders, to release my information to Health Current, the statewide health information exchange (HIE), and to the organization listed here:

Destiny Springs Healthcare, LLC			623-233-3000
Name of Healthcare Organization with a Treatment Relationship			Phone Number
17300 N Dysart Rd.	Surprise	AZ	85378
Address	City	State	Zip

I am receiving (or will receive) treatment from this organization. The purpose of this disclosure is for:

- My treatment;
- Payment for my treatment (for example, billing insurance companies); and
- Healthcare operations activities (for example, improving the quality of care for patients, managing the care of patients, patient safety activities, and other activities necessary to run a health care organization).

I authorize the disclosure of all my medical information for these purposes, including behavioral health information and substance use disorder information (*e.g.*, drugs and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health, communicable disease-related information, and HIV/AIDS-related information.

I understand that the organization listed above will obtain this information about me through Health Current, the statewide HIE. I understand that if I previously opted out of having my health information shared through the HIE, this form will change that decision. I understand that if I sign this form, I agree to have my health information shared through the HIE. I understand that I can change this decision at any time.

I understand that I may take back or cancel this consent to share my information at any time, except where someone already relied on my consent to release the information. If I want to cancel my consent or if I have questions, I will contact the organization at the contact information listed above. **Unless I cancel this consent earlier, it will automatically terminate <u>one year</u> from the date of my signature**. I understand that my substance use disorder treatment information will continue to be protected by federal law after it is released.

_____ _____
Signature of Patient* Date

_____ _____
Signature of Parent/Guardian *(If Patient is a child under the age of 18)** Date
*Both the child and parent/guardian must consent to disclosure of the child's substance use disorder information, unless the child is married, homeless, or emancipated.

_____ _____
Signature of Patient's Health Care Decision Maker Date
(If Patient has been declared incompetent by a court or is deceased)

Notice to Recipient of Substance Use Disorder Information: 42 CFR part 2 prohibits unauthorized disclosure of these records.