LIGHTHOUSE MEDICAL CENTER

New Patient Form

In order to provide you with the best wellness care, please complete this form in its entirety. All information is strictly confidential. Our staff will need to photocopy your driver's license, insurance card, and a debit/credit card to keep on file for payments. Please print.

Patient Information

Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email: _____

Is it ok to text you regarding appointments? ☐ Yes ☐ No Is it ok to email you regarding appointments? ☐ Yes ☐ No

Your email will NOT be shared with any third parties, and is used for general office announcements and promotions. We won't spam you, promise!

Gender: ☐ Male ☐ Female Age: ___ Birth Date: _____ /_____ /_____ Number of Children: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Race: ☐ Caucasian ☐ Black ☐ Hispanic ☐ Asian ☐ Other: _____

Driver's License #: _____ Social Security #: _____

Employer: _____ Occupation: _____ Years at Current Employer: _____

How did you find out about us? ☐ Facebook ☐ Instagram ☐ Twitter ☐ Website ☐ Google/Web Search

❑ Referral (Name): _____ ☐ Other: _____

Account Information **PERSON RESPONSIBLE FOR THIS ACCOUNT.**

Name: _____ Relationship to Patient: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Driver's License #: _____ Social Security #: _____

Is your health insurance provided through your employer? ☐ Yes ☐ No

Insurance Company: _____ ID #: _____ Group #: _____

Name of Insured on Policy: _____ DOB of Insured: _____ /_____ /_____

Insured's Employer: _____ Occupation: _____ Years at Current Employer: _____
If on spouse or parent's policy

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **LIGHTHOUSE MEDICAL CENTER** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been or will be rendered or provided***; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually) We file your primary insurance at no charge to you. Filings for policies in addition to your primary coverage are completed for a fee and as time permits.

I understand that outstanding balances of more than 30 days will be charged to this account. _____
Initials

Patient Signature: _____ Date: _____ /_____ /_____

Parent or Guardian Signature: _____ Date: _____ /_____ /_____

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SOCIAL HISTORY:

Marital Status (*select one*): Single☐ Married☐ Divorced☐ Widowed☐

Number of children: _____ **Race or Ethnicity**: _____

Females (*select*): Are you Pregnant?☐ Nursing?☐ Planning pregnancy?☐

Date of Last Menstrual Period: _____

Occupation (if retired, previous occupation): _____

Smoking

Have you ever smoked? (*select*): Yes☐ No☐

If yes, what age did you start? _____ How many cigarettes per day? _____

Have you tried to quit? _____ If successful, at what age did you quit? _____

Alcohol

Do you drink any alcohol? (*select*): Yes☐ No☐

If yes, how much (# of drinks per day, month, or year)? _____

If so, what type of alcohol? (*Select all that apply*): Wine☐ Beer☐ Liquor☐

Recreational Drugs

Have you ever used recreational drugs? (*select*): Yes☐ No☐

If yes, which ones & when was the last date of use? _____

MEDICAL HISTORY:

Allergies (list any allergy to drug, latex and/or food): _____

Medications (list all medications- with dosages- you regularly take including over the counter, herbal & natural remedies. If you are on **insulin**, please clarify administration method- vials, pens, or pump):

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Medical Conditions:
Please ***select*** diagnosed medical conditions.

Diagnosis

Diabetes
Select one: Type 1 ☐ Type 2 ☐ Gestational ☐ Unknown ☐ Pre- Diabetes ☐
High Blood Pressure ☐ **High Cholesterol** ☐ **Heart Murmur** ☐
Heart Attack(s) ☐ **Stroke(s)** ☐
Thyroid Disorder *Select*: Hyperthyroidism ☐ Hypothyroidism ☐ Thyroid nodule(s) ☐ Other ☐

Liver Disease
Select: Hepatitis ☐ Fatty Liver ☐ Other ☐

Kidney Issues
Select: Kidney Stones ☐ Chronic Kidney Disease ☐ On Dialysis ☐ Other ☐

Gastrointestinal Problems
Select: Gastroparesis ☐ Acid Reflux ☐ Diverticulitis ☐ Other ☐

Eye Disease
Select: Cataracts ☐ Glaucoma ☐ Retinopathy ☐ Other ☐

Reproductive Issues
Select: Erectile Dysfunction ☐ Prostate Enlargement ☐ Infertility ☐ Other ☐

Vitamin Deficiencies
Select: Low Vitamin D ☐ Low Vitamin B12 ☐ Low Magnesium ☐ Other ☐

Psychological Diagnosis
Select: Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Other ☐

Anemia
Specify type if known:

Cancer
Specify type if known:

Other Conditions:

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Surgical History:
Please list prior surgeries and an accompanying date or year, if known.

_____ _____

_____ _____

_____ _____

Family History (check all that apply):

☐ Respiratory Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Hypertension	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ GI/GU Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Diabetes Mellitus	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Skin Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Neurologic Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Arthritic Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Stroke	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Cancer	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Heart Disease	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Deaths in Family	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Spine Surgery	☐ Mother	☐ Father	☐ Brother	☐ Sister
☐ Disc Problems	☐ Mother	☐ Father	☐ Brother	☐ Sister

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Diabetes-specific Health Information:
Select your answers as designated. For some, note that **Y** indicates "Yes" & **N** indicates "No".

1. What was your most recent HgbA1c? _____% Date: _____

2. Have you been hospitalized in the last 12 months due to diabetes? **Y** ☐ **N** ☐

3. Do you have neuropathy (nerve damage) in your hands or feet? Y ☐ N ☐
    a. Numbness/tingling in your hands? Y ☐ N ☐
    b. Pain in your hands? Y ☐ N ☐
    c. Do you have pain in your feet? Y ☐ N ☐
    d. Numbness/tingling in your feet? Y ☐ N ☐

4. Do you have retinopathy (bleeding behind your eyes)? Y ☐ N ☐
    a. Date of your last diabetic eye exam? _____
    b. Have you ever received injections in your eyes for retinopathy? Y ☐ N ☐
    Date:

5. Do you wear glasses or contacts? Y ☐ N ☐ Glasses ☐ Contacts ☐

6. Do you have kidney disease (nephropathy)? Y ☐ N ☐
    a. Have you seen a kidney doctor (nephrologist)? Y ☐ N ☐
    b. Are you on dialysis? Y ☐ N ☐ hemodialysis ☐ peritoneal dialysis ☐

7. Do you check your blood sugars? Y ☐ N ☐
    a. How many times per day? _____
    b. What are your average blood sugars? _____
    c. What is your blood sugar when you wake up? _____
    d. What is your blood sugar at bedtime? _____
    e. What is your highest blood sugar? _____
    f. What is your lowest blood sugar? _____ Do you go below 80? Y ☐ N ☐
        i. If so how often do you go below 80? _____
    g. What is the lowest blood sugar you can have before you start having symptoms? _____

8. How many meals do you eat per day? _____ Snacks? _____

9. Have you seen a dietician? Y ☐ N ☐

10. Do you count carbohydrates? Y ☐ N ☐ Grams per meal? _____ Total daily grams? _____

11. Do you exercise? Y ☐ N ☐
    a. Days per week? _____
    b. What kind of exercise? _____

Review of Systems: (Please check current and/or chronic issues or a recent significant change)

- General:
    - ❑ Fever
    - ❑ Chills
    - ❑ Sleep disturbances
    - ❑ Fatigue
    - ❑ Loss of appetite

- ❑ Weight loss or gain
- ❑ Night sweats

- Head, Ears, Eyes, Nose, & Throat:
  - ❑ Headaches
  - ❑ Vertigo
  - ❑ Vision changes
  - ❑ Eye pain
  - ❑ Eye drainage
  - ❑ Sensitivity to light
  - ❑ Eye pain
  - ❑ Sinus problems/allergies
  - ❑ Nasal congestion
  - ❑ Runny nose
  - ❑ Bloody noses
  - ❑ Ringing in your ears
  - ❑ Hearing loss
  - ❑ Dental problems/disease
  - ❑ Hoarseness
  - ❑ Neck pain
- Lungs:
  - ❑ Shortness of breath
  - ❑ Cough
  - ❑ Sputum
  - ❑ Wheezing
- Heart:
  - ❑ Chest pain
  - ❑ Difficulty breathing when lying flat
  - ❑ Shortness of breath with exertion/activity
  - ❑ Passing out
  - ❑ Leg swelling
  - ❑ Leg pain
- Gastrointestinal:
  - ❑ Difficulty swallowing
  - ❑ Abdominal pain
  - ❑ Heartburn
  - ❑ Nausea
  - ❑ Vomiting
  - ❑ Diarrhea
  - ❑ Constipation
  - ❑ Blood in your vomit
  - ❑ Black or bloody stools
  - ❑ Incontinence
- Genitourinary:
  - ❑ Pain with urination
  - ❑ Straining with urination
  - ❑ Urinary frequency
  - ❑ Nighttime urination
  - ❑ Blood in your urine
  - ❑ Weak stream
  - ❑ Hesitance
  - ❑ Dribbling
  - ❑ Urgency
  - ❑ Vaginal/penile discharge

- Endocrine
    - ❑ Excessive thirst
    - ❑ Excessive urination
    - ❑ Heat or cold intolerance
    - ❑ Skin, hair, or nail changes
- Hematologic/lymphatic
    - ❑ Easy/excessive bleeding
    - ❑ Easy/excessive bruising
    - ❑ Swelling of your lymph nodes
- Skin:
    - ❑ Delayed wound healing
    - ❑ Rashes
    - ❑ Discoloration
    - ❑ Lesions
- Musculoskeletal:
    - ❑ Neck pain
    - ❑ Back pain
    - ❑ Joint pain
    - ❑ Extremity pain
    - ❑ Foot pain
    - ❑ Joint stiffness
    - ❑ Muscle weakness
    - ❑ Muscle cramps or spasms
    - ❑ Difficulty walking
- Neuropsychiatric:
    - ❑ Loss of sensation
    - ❑ Tremors
    - ❑ Dizziness
    - ❑ Weakness
    - ❑ Loss of balance
    - ❑ Seizures
    - ❑ Memory changes
    - ❑ Confusion
    - ❑ Depression
    - ❑ Anxiety
    - ❑ Depression
    - ❑ Suicidal thoughts

LIGHTHOUSE MEDICAL CENTER

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the provider(s) has/have the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient: ..... Date: ..... /..... /.....

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name: _____ Date: _____ /_____ /_____

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this _____ day of _____, 20 _____

By_____

If patient is a minor or under a guardianship order as defined by State law:

By_____

Signature of Parent / Guardian (circle one)

LIGHTHOUSE
MEDICAL CENTER

Authorization for the Release of Protected Health Information (PHI)

Name of Patient: _____ Date of Birth: _____ /_____ /_____

I hereby request and authorize Lighthouse Medical Center, 1765 South 20th Avenue Safford, AZ 85546

☐ To disclose medical information to the following individual(s):
☐ To receive medical information from the following individual(s):

Name: _____ Relationship to Patient: _____ Phone: _____
Name: _____ Relationship to Patient: _____ Phone: _____
Name: _____ Relationship to Patient: _____ Phone: _____

☐ To disclose medical information to the following physician(s) or entity(ies):
☐ To receive medical information from the following physician(s) or entity(ies):

Physican Name: _____ Practice Name: _____
Type of Doctor: _____ Phone: _____
Physican Name: _____ Practice Name: _____
Type of Doctor: _____ Phone: _____

Physican Name: _____ Practice Name: _____
Type of Doctor: _____ Phone: _____

Information to be disclosed includes (check all that apply):

☐ Entire Patient Record
☐ Financial Information
☐ Treatment Plan Information
☐ Email Imaging to: _____
☐ Initial Exam Notes
☐ X-ray Reports/Film
☐ Daily Treatment Notes
☐ MRI Reports/Film

By signing this form, I authorize Compass Medical Center to release confidential health information about me, by releasing a copy of my patient records, or a summary or narrative of my protected health information, to the person(s) or entity(ies) listed above. I understand that I have a right to revoke this authorization at any point in time by stating so in writing.

Signature of Patient: _____ Date: _____ /_____ /_____

If patient is a minor or under a guardianship order as defined by State law:

By_____ Date: _____ /_____ /_____
Signature of Parent / Guardian (circle one)

Staff Signature: _____ Date: _____ /_____ /_____

LIGHTHOUSE
MEDICAL CENTER

CONSENT TO TREAT INCLUDING GROUP PROVISIONS

This document sets forth a brief description of the Infusion therapy that you will be receiving, and your consent to the procedures, which include being treated in a group setting unless you make other written arrangements. You may refuse treatment now, or at any time.

Metabolism Restoration:

Treatment:
The patient must follow the pre-treatment therapy guidelines. The patient's blood glucose levels are maintained slightly high during the treatment so that the liver gets the two signals needed to generate proper metabolism.

1. Patient vital signs are recorded: weight, blood pressure, heart rate, respiratory rate, temperature, and capillary blood glucose. Oral glucose is given at the start of treatment. Normal saline and insulin are placed in the syringe attached to the pump.
2. An intravenous catheter is inserted in the right/left arm or hand.
3. The patient's O2/CO2 level is measured and documented on a breathing machine, which measures the amount of cellular energy and type of metabolism (fat, protein, or carbohydrates). We do these two (2) times during the treatment.
4. The patient's capillary blood glucose is monitored frequently throughout the entire treatment. This measurement may be monitored more frequently if the blood sugars are lower or higher than what is optimal for the treatment.

For the initial treatment, the patient is scheduled for 2 days, back-to-back or with one day between treatment days, for one-three consecutive weeks. Thereafter, the treatment is usually once a week for 90 days or 3 months until further treatment decisions are made, based on the patient's individualized care plan.

After Treatment:

1. After the infusion is complete, the IV site is disconnected.
2. Patients must continue to monitor his or her blood sugar carefully, particularly if they engage in any exercise or physical activity.
3. It is normal to have somewhat elevated blood glucose after the treatment. Patients are advised to engage in some form of light physical activity during the post-activation period to decrease the amount of glucose stored in the muscles. This will help in keeping blood glucose levels in a more normal range. **Patients should review any physical plans with the practitioner.**

The Patient must report any changes in his or her health or any medically related complications since the last treatment.

Exclusions:

1. Medical disorders (HTN, Dialysis, ESRD), unstable psychiatric disorders
2. Pregnant
3. Patients who do not comply with the treatment recommendations will be counseled and/or dropped from the treatment program. This includes missed appointments.

Risks, Discomforts, and Complications: Local complications of intravenous (IV) therapy rarely occur but may present as adverse reactions or mild trauma to the surrounding venipuncture site. These complications can be recognized early by objective assessment. Proper venipuncture technique is the main factor related to the prevention of most local complications associated with IV therapy. Local complications can include bleeding, hematoma, thrombosis, phlebitis, post-infusion phlebitis, thrombophlebitis, infiltration, extravasation, local infection, venous spasm, and hypersensitivity reactions. Systemic complications may include hypoglycemia, hyperglycemia, nausea/vomiting, mild diarrhea, bloating, and muscle cramping, sometimes due to the ingestion of glucose. There is no known unusual or additional risk from IV access other than any other IV therapy.

Benefits: The overall effect of metabolic reconditioning and recovery therapy is to treat the root cause of the metabolic disease or disorder and restore the patient's ability to lead a normal, or near normal, lifestyle by mitigating or eliminating the chronic effects of the disease. The benefits demonstrated in the ongoing research program include:

1. More controlled and stable blood glucose levels.
2. Increased energy levels and a feeling of wellbeing.
3. The reduction of complications related to diabetes and other metabolic failures.

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4. There is no absolute certainty you will react like other patients, or that you will receive the benefits suggested by clinic studies or prior patient outcomes. However, these outcomes are anticipated and normal with the great majority of other patients.

Right to refuse or withdraw: Your treatment is voluntary, and you may refuse any or all treatment, and you may discontinue treatment at any time.

Anonymous and Confidential Data Collection: Any information that specifically identifies you will be kept in a secure location and only the healthcare professionals and their authorized staff will have access to the data, or as otherwise agreed by you.

Group Setting and Group Interface, including Visitors: The treatment is usually provided in the presence of other patients, and perhaps their families, friends, and visitors. This implies that you will learn about other people in this setting, and they may hear or see something about you. The fact that you are being treated suggests that you have diabetes or a related disease, and other facts of your medical, mental, and emotional condition may be disclosed, and those are confidential facts disclosed in a group setting. By group treatment, there are many other things that occur that normally would be private, such as psychological help, prayer, or other non-physical aspects of life. You hereby agree that privacy of treatment cannot be maintained in this setting. You may ask to talk in a private room at any time about these issues. However, Compass Medical Center personnel are not able to control what is said or seen by others, and it is not unusual for information of the most personal type to come out. Information about religious, political, sexual, or socioeconomic views will routinely be discussed in an open forum and if you are not able to be treated in this open forum manner, then private treatment arrangements must be made at a cost that is usually not paid for by insurance. Compass Medical Center personnel will attempt to keep loud obtrusive and offensive conduct to a minimum. If you want special private treatment settings, you must inform the Compass Medical representative at the first possible time.

Group Instruction: Some of the instructions to you will include information that is usually confidential, and you agree to be instructed in public, with the further agreement that your personal interviews, as well as any of your requests, will be conducted in a private room.

Photographs, images of injured tissue, and graphic depictions: To follow the treatment outcomes, photographs, images, and other recorded means may be used to exhibit progress. This information is used for both your treatment and to substantiate the results and outcomes and can be shared with others not using your name.

Whom to contact with questions: If you have any questions about your treatment, please contact the Clinic Manager.

Acceptance & signature: I have read the information provided above, have been asked any questions, and all my questions have been answered to my satisfaction. I can continue to ask questions at any time I request treatment and will reserve a copy of this consent form for my information.

_____ _____

Patient's or Patient's Representative's Signature Date

_____

Print Name of Patient and Representative

LIGHTHOUSE
MEDICAL CENTER

Consent to X-Ray

I hereby acknowledge that a healthcare provider and/or a staff member at Lighthouse Medical Center has informed me of the advisability of, risk inherent in, and the probable consequences of not receiving X-rays. He/She has also explained to me the reasons and need for such X-rays. I do hereby authorize any of the licensed healthcare providers to perform all such X-rays as are deemed pertinent to the diagnosis and management of my case.

Signature of Patient: _____ Date: _____ /_____ /_____

Staff Signature: _____ Date: _____ /_____ /_____

Pregnancy Waiver

TO BE COMPLETED BY ALL FEMALES OF CHILDBEARING AGE

I hereby acknowledge that a healthcare provider and/or a staff member at Lighthouse Medical Center has informed me prior to being X-rayed of the advisability of risk and the probable consequences of receiving X-rays during pregnancy. I have

stated on my own volition that I am not pregnant nor am I attempting to get pregnant as of this date and do hereby release and hold harmless from any legal action or responsibility caused by the use of this procedure.

Date: _____ /_____ /_____

_____
Patient Printed Name

_____
Patient Signature

Witness:

_____
Printed Name

_____
Signature

LIGHTHOUSE
MEDICAL CENTER

NOTICE OF PRIVACY PRACTICES

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

This serves as our Health Information Portability and Accountability Act (HIPAA) notice. It took effect on January 20, 2015 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION
The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY | Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION
The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information*. We will not disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.*

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.
FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.
FOR DATA BREACH NOTIFICATION PURPOSES: We may use your medical information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information due to a breach.
FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to service you.
ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, or medical information to you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use your medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information or where we are improving our services.

Funeral Director Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for the purpose of sending you appointment emails, phone calls, texts, postcards, or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

LIGHTHOUSE
MEDICAL CENTER

4.YOUR INDIVIDUAL RIGHTS | You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you $5 plus postage if you want the copies mailed to you. Additionally, if we maintain an electronic health record contacting your health information, you have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency)
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we do not create the information, you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.
7. You have the right to restrict information given to your third-party payer (e.g. health insurance plan) if you fully paid for your health care services out of your own pocket. If you paid in full for services out of your own pocket, you could request that the information regarding the services not be disclosed to your third party payer since no claim is being made against the first party payer.
8. You have the right to be notified if we (or one of our Business Associates) discover a breach of your unsecured protected health in formation. Notice of any such breach will be made in accordance with federal regulations.

QUESTIONS AND COMPLAINTS:
If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Sections 4 of this notice by writing to the following address:

1765 South 20th Avenue Safford, AZ 85546

LIGHTHOUSE
MEDICAL CENTER

Financial Policy

Thank you for choosing Lighthouse Medical Center, PLLC as your healthcare provider. This office is committed to providing exceptional patient care and service. We politely request that you read and understand our policy regarding your responsibility for payment of professional services rendered to you by licensed providers of this office.

Patients Without Insurance
Payment for all services is due at the time the services are rendered, unless arrangements are made with our billing staff as part of a payment plan. We accept cash, Visa, Discover, MasterCard, American Express and Care Credit. We also accept HRA and/or FSA payments.

Patients With Health Insurance
We are an in-network provider for most major insurance plans. While not all insurance plans provide coverage for all medical, chiropractic and/or rehabilitation treatment, most do. We do accept assignment on MOST insurance plans. We do accept assignment on MVA (automobile accident claims). We do accept Letters of Protection from attorneys. We must have your insurance information verified prior to your first visit to do any insurance billing. In the event that your insurance company does not pay within 45 days, we reserve the right to transfer balances to your responsibility. We will be happy to assist you by providing you with claim forms and an explanation of benefits from your primary insurance after your balance with us has been satisfied. Please be aware that some of the services provided may not be considered reasonable and necessary under your health plan. All copays and deductibles are due at the time of treatment unless a payment plan is authorized.

Credit Card Guarantee / Electronic Debit Authorization
Our office utilizes a credit card guarantee to provide simplicity for both the patient and our billing staff in securing payment of outstanding balances. **ALL patients with ALL types of cases accepted by this office are required to have a valid credit card on file.** This card will only be billed for the following reasons:

1. Patient gives specific authorization to use this card in accordance with pre-arranged payment for professional services as part of ongoing treatment plan.
2. Upon notification of an outstanding balance, including missed appointment fees, if a patient refuses to make other arrangements with our billing staff, the card on file will be charged for all balances owed.

***If a patient does not wish to provide a credit card guarantee, this office will require payment up front for all services prescribed as part of the treatment plan, and it will be your responsibility to recoup payment from any third party payer (insurance).** **Patient Initials:** _____

Treatment Financing Options
Our office works hard to make sure the care you need is affordable for you. We do provide the following financing options: Care Credit and weekly payments. This will be explained in detail to you after your treatment plan has been prescribed and explained by the doctor.

Missed Appointment Policy
Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. While emergencies happen periodically, we ask that you contact us by phone at 928-424-1600 in the event you won't be able to make your appointment. This will enable us to offer your appointment time to other patients that desire to get their treatment performed that day/time. Our policy is to charge $50.00 for missed (no-show chiropractic appointments and $65.00 for massage appointments. **Patient Initials:** _____

Practice Fee Schedule
Our practice is committed to providing the highest quality treatment available to our patients. We charge a fee for all services provided that is "usual and customary" for our geographic area. While we are a participating provider for various insurance networks, and we do take contractual write-offs where appropriate, please remember that you remain responsible for payment regardless of any insurance company's arbitrary determination for usual and customary rates.

Minor Patients
Parents or legal guardians are required to accompany minor patients to the initial exam and explanation of treatment appointments. They are also required to give informed consent prior to any treatment being performed. Once treatment commences, parents/legal guardians retain full financial responsibility for all services performed.

Assignment of Benefits
I do hereby assign all medical and/or chiropractic benefits to Lighthouse Medical Center, PLLC. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I authorize Lighthouse Medical Center, PLLC to release all information necessary to secure payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. By my signature below, I acknowledge that I have read and agree to the aforementioned financial policy for Lighthouse Medical Center, PLLC.

Signature of Patient / Parent / Legal Guardian: _____ Date: _____ /_____ /_____

Staff Signature / Witness: _____ Date: _____ /_____ /_____