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Valor Health Services

New Patient Registration Information

Phase 2 Paperwork; After choosing a VHS PCP

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Last Name: _____ First Name: _____ M.I. _____

Mailing Address:

_____

City/State/Zip:

_____

Home Phone: _____ Cell Phone: _____

I authorize the use/disclosure of information about me as described below:

History & Physical, Emergency Dept. Physician Notes, Discharge Summary, Consultation Reports, Operative & Procedure Reports, Laboratory Reports, Pathology Reports, Diagnostic Studies, Psychiatric and Psychological Evaluations, Mental Health Progress Notes, Imaging Reports, All Other Diagnostic Studies, etc.

My signature acknowledges that my representative or I received a copy of this document that I have read and understand the content of this authorization, and voluntarily consent to the release of the information.

Name (Printed): _____ DOB: _____

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

THIS PORTION TO BE COMPLETED WHEN A PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE:

We the undersigned, do verify that the above authorization has been read to the patient and that he/she understands the nature of the release and freely gives his/her verbal consent for the release of the above information.

Verbal consent requires the signatures of two witnesses:

Witnessed by: _____ Date: _____

Witnessed by: _____ Date: _____

PERMISSION TO RELEASE MEDICAL/DIAGNOSTIC INFORMATION TO ANOTHER INDIVIDUAL

Effective Date: _____

Patient‘s Full Name (Print): _____

DOB: _____

I give Valor Health Services permission to release diagnostic test results to and discuss protected health information with the following person(s):

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

I give Valor Health Services entities permission to leave any protected health information on an answering machine or voicemail.

☐ YES ☐ NO

By signing this form, I give Valor Health Services entities permission to send office correspondence to the address provided.

Signature _____ Date _____

Witnessed by _____ Date _____

Notice of Health Information Practices

I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider 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 my healthcare provider.

Signature Date

PATIENT BILL OF RIGHTS

VALOR HEALTH SERVICES strives to provide comprehensive, quality healthcare in a spirit of personal caring, safety and concern. In the effort to accomplish this goal, we believe that you, as our patient, and/or your significant other have the responsibility to make decisions regarding your healthcare and have the right to:

- Receive impartial access to treatment. Treatment will be provided to our patients without regard to sex; cultural, economic, educational, religious backgrounds; or source of payment.
- Have cultural and personal values, beliefs and preferences respected.
- Be treated by medical and non-medical staff with consideration, dignity and respect, in a safe environment that is free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on your behalf.
- Examine and receive an explanation of your bill regardless of source of payment.
- Receive appropriate assessment and management of pain.
- Receive treatment which is appropriate and complies with the standard of care in the community.
- Receive reasonable continuity of care.
- Be informed of continuing healthcare treatments and requirements.
- Select your primary care clinician.
- Have knowledge of the name of the provider who has the primary responsibility for coordinating your care and the names of other physicians and non-physician staff who are involved in your treatment.
- Seek a second opinion and to seek specialty care.
- Have your personal provider notified promptly of your admission to the hospital.
- Have a family member or representative of your choice notified promptly of your admission to the hospital.
- Leave the hospital even against the advice of your provider.
- Receive information from your provider about your illness, course of treatment, outcomes of care (including unanticipated outcomes), and your prospects for recovery in terms that you can understand to allow for effective communication.
- Participate in the development and implementation of your care and actively participate in decisions regarding your medical care. To the extent permitted by law, this includes your right to request or refuse treatment.
- Obtain from your provider information concerning current diagnosis, treatment plan (including risks and benefits), alternate plans and prognoses in order to give informed consent or refuse treatment. In the event that you choose to refuse treatment, you have the right to be informed of the medical consequences of that decision.
- Be advised if the medical practice or your provider(s) propose to engage in or perform human experimentation affecting your care. You have the right to refuse to participate in such research projects. Your refusal to participate or your choice to discontinue participation in research, investigation and/or clinical trial will not compromise your access to care, treatment and services. Should you choose to participate in research, investigation and/or clinical trials, you have the right to full support and respect of all of your patient rights, including the right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information that is given to you as a participating subject will be contained in the medical record or research file, along with all consent forms.
- Formulate advance directives regarding your healthcare, and to have staff and practitioners who provide care comply with these directives (to the extent allowed by state laws and regulations).
- Be informed that all information concerning your medical care and records will be treated in a confidential manner. Written permission will be obtained from you, or the person who has legal responsibility to make decisions for you, before medical records are released to anyone not directly related and/or involved in your care.
- Access information contained in your medical record within a reasonable time frame, including access to disclosures of protected health information in accordance with laws and regulations.
- Receive a response to any reasonable request for service.
- Be informed that a multidisciplinary group of healthcare professionals provide patient and family education programs.
- Have all of your patient’s rights apply to the person who may have legal responsibility to make decisions regarding medical care on your behalf.
- Be aware that Valor Health Services is committed to high standards of care, safety and hospitality for patients and their families.

PATIENT BILL OF RIGHTS

Signature of Receipt

I have received a copy of my Patient Rights and have had an opportunity to have my questions answered to my satisfaction.

Name (Printed): _____ DOB: _____

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

PATIENT RESPONSIBILITIES

The care a patient receives depends partially on the patient himself; therefore, in addition to these rights, a patient has certain responsibilities as well.

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications and other matters relating to his/her health.
- The patient is responsible for asking questions about his/her condition, treatments, procedures and diagnostic test results.
- The patient is responsible for reporting perceived risks in his/her care and unexpected changes in his/her condition to his/her responsible practitioner.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient’s care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her provider, including the instructions of nurses and other health professionals as they carry out the provider's orders.
- The patient is responsible for acknowledging when he/she does not understand the treatment course or care decision.
- The patient and family are responsible for immediately reporting any concerns or errors they may observe.
- The patient is responsible for keeping appointments and for notifying the office or provider when he/she is unable to do so.
- The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her provider's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled as promptly as possible.
- The patient is responsible for following Valor Health Services policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and staff.