



# NORTHWEST

## PRIMARY & SPECIALTY CARE

NORTHWEST HEALTHCARE

### Patient Registration - MINOR

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE PRINT

Patient First Name		Patient Middle Name		Patient Last Name	
<b>Sex:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> MtF Female <input type="checkbox"/> FtM Male	<b>Social Security #:</b>			
<b>Street Address (Arizona)</b>		<b>Apt/Space</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Street Address (Out of State)</b>		<b>Apt/Space</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Primary Phone</b>			<b>Secondary Phone</b>		
<b>Marital Status:</b>		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other			

Insurance Information			
<b>Is patient the insurance policy holder?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If NO, indicate patient's relationship to policyholder:</b>	<input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other
<b>Policyholder's Name (if different from patient)</b>		<b>Policyholder's Date of Birth</b>	
<b>Guarantor - Person Legally Responsible for Payment (if not the patient)</b>		<input type="checkbox"/> Parent <input type="checkbox"/> Other _____	
<b>Name of Responsible Party</b>		<b>Social Security #</b>	<b>Date Of Birth</b>
<b>Address</b>		<b>City-State-Zip</b>	<b>Phone</b>

Emergency Contact Information		
<b>Contact is:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Friend <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other		
<b>First Name</b>	<b>Middle Name</b>	<b>Last Name</b>
<b>Home Phone</b>	<b>Cell Phone</b>	<b>Other Phone</b>

Continued on Back

Patient's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Please print)

Who referred you to Northwest Allied Physicians?	
<input type="checkbox"/> Primary Care Provider	<input type="checkbox"/> Advertising <input type="checkbox"/> Internet <input type="checkbox"/> Family or Friend <input type="checkbox"/> Health Fair
<input type="checkbox"/> Other Provider(Name): _____	<input type="checkbox"/> Hospital or Urgent Care <input type="checkbox"/> Insurance
Name of Patient's Primary Care Provider	Phone Number

Are there any other family members in this household with a Northwest Allied Physician primary care provider?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	*If yes, would you like information on Combined Family Billing? <input type="checkbox"/> Yes <input type="checkbox"/> No

Language, Race and Ethnicity		
<p>If your preferred language is other than English, we can arrange for an interpreter when you visit our doctors. Please inform clinic staff if you will be requiring an interpreter at your appointment.</p> <p>Studies show that our racial and ethnic backgrounds may place us at different risks for certain diseases. By knowing more about your background, we can get a better idea of health risks you may have and better meet your medical needs.</p>		
<u>Preferred Language:</u> (check one)	<u>Race:</u> (check one)	<u>Ethnicity:</u> (check one)
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Arabic <input type="checkbox"/> Chinese (all types) <input type="checkbox"/> French <input type="checkbox"/> German <input type="checkbox"/> Greek <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Navajo <input type="checkbox"/> Polish <input type="checkbox"/> Russian <input type="checkbox"/> Tagalog <input type="checkbox"/> Ukrainian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	<input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Black or African American <input type="checkbox"/> Chinese <input type="checkbox"/> European <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race	<input type="checkbox"/> Central American <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Hispanic or Latino/Spanish <input type="checkbox"/> Latin American/Latin, Latino <input type="checkbox"/> Mexican <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Puerto Rican <input type="checkbox"/> South American <input type="checkbox"/> Spaniard

I certify the information provided in this form is true and accurate.

\_\_\_\_\_  
 Patient's Signature or Legal Representative

\_\_\_\_\_  
 Date



Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Service: \_\_\_\_\_

## Financial Responsibility

Each time you come to see your doctor, we will ask to see your personal identification and proof of insurance so that we can properly bill your insurance company(ies) and charge you the correct amount.

**Payment:** Any amount you owe is due when you arrive to see your provider. Cash, personal checks and credit cards are accepted as payment. If your bank returns your check to our office as unpayable, there will be a **\$35 return check fee charged to you**. A collection agency will be used to collect on delinquent accounts.

**Insurance:** If your visit with our provider is not covered for any reason by your insurance company, you are responsible for paying for the entire visit based on our fee schedule.

**No Insurance:** If you do not have insurance, you will need to pay the full cost of your visit at the time of service. A discount of 30% is given for payment in full at the time of the visit.

**Appointment Cancellation:** We want to make sure our patients have access to their providers when they need them, so we pay close attention to how we schedule appointments. If you arrive late for your appointment, you may be asked to reschedule for another time. Please give our office at least 24 hours advance notice (not including weekends) when you need to change or cancel an appointment, **otherwise a \$27 cancellation fee may be charged**. Repeatedly not showing for your appointment may lead to termination of the relationship between you and your medical care provider.

## Preferred Method of Communication

HIPAA privacy rules give you the right to request a restriction on uses and disclosures of your protected health information (PHI). By signing this document, you agree, restrict or object to providing PHI to family members, friends or caregivers. Your preferences indicated on this document will remain effective until you further notify us of any changes. If your communication preferences vary for different Allied providers, please indicate for which provider(s) this specific form is being submitted.

**Northwest Allied Physicians usually sends lab, radiology, test or procedure results to your home address by mail. Sometimes we will call you about your results or to set an appointment to discuss them with your provider. If we call, we will make an attempt to get in touch with you according to your request as indicated on the second page of this document.**

## Contact Preferences

Please indicate below the contact phone numbers that you authorize Northwest Allied Physicians to leave a phone message at, **or** indicate that you do not want phone messages left at any contact phone number.

- Ok to leave a phone message with detailed health information at following phone number:  
 (        )  
 \_\_\_\_\_
- Ok to leave a phone message with callback phone number only at the following phone number:  
 (        )  
 \_\_\_\_\_
- Do NOT leave a phone message at any number.

**If we have permission to share your information with anyone else, in case we cannot reach you by phone, please fill in their name and phone number below:**

- OK to disclose lab, radiology, test, or procedure results info **ONLY**
- OK to discuss & disclose any/all clinical information

Name	Relationship to Patient	Contact Phone Number
Contact #1		
Contact #2		

**I have read this document, indicated my preferred method of communication and agree to the terms for financial responsibility.**

- **I understand it is my responsibility to notify Northwest Allied Physicians of any changes to the communication permissions I have given in this document.**
- **I understand my responsibility for payment to Northwest Allied Physicians and have been given the opportunity to ask questions about it. If additional information is needed to ensure insurance coverage, I will provide it in an accurate and timely basis.**

\_\_\_\_\_  
 Patient or Legal Representative - *Printed Name*

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Patient or Legal Representative-*Signature*

\_\_\_\_\_  
 Date



## Patient Portal Access Form

**The Patient Portal** is an easy way to go online to request prescription refills; ask your doctor questions; and see your medications, laboratory and radiology reports, vitals, allergies, diagnoses and procedures.

### Sign me up!

Patient's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
*(Please Print)*

E-mail Address \_\_\_\_\_ Last Four #s SSN \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Patient's Signature** (Patients 16 yrs old and above): \_\_\_\_\_ Date: \_\_\_\_\_

*(If patient is under 16 yrs. only parent has to sign this form; if patient is 16-17 yrs. both child and parent must sign)*

**Signature of Parent/Guardian** (for patients under 18 yrs old): \_\_\_\_\_

You can designate a relative, friend or caregiver to see your info or use the portal on your behalf.

### I also authorize the following person/people to access my patient portal:

Full Name: \_\_\_\_\_ | Full Name: \_\_\_\_\_  
*(Print Please)* | *(Print Please)*

Relationship to Patient: \_\_\_\_\_ | Relationship to Patient: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ | E-mail Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ | Mailing Address: \_\_\_\_\_

City, State: \_\_\_\_\_ | City, State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ | Zip code: \_\_\_\_\_

Telephone: \_\_\_\_\_ | Telephone: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Select **one** category below:

**Billing ONLY**

**Full Access:** allows person to see patient's information, plus request prescription refills and ask questions of the patient's provider.

## Minor Acknowledgement of Parental Access

Our patients may have a “patient portal” to see some health information online. If you are a minor and your parent or guardian created a patient portal account for you, they may be able to see your information.

By law in some states, you can choose to keep your data private from your parent or guardian. If you have certain health care conditions under state law, or are emancipated or independent under state law, you must turn off your patient portal account to keep the data private in the portal.

By signing this, I have received the information on how to turn off my patient portal. I know I am responsible for following the directions to turn off my portal account right away to prevent my data from being seen by my parents or guardian.

I know if I do not turn off my portal account right away my information in the patient portal could be seen by my parents or guardian.

Minor Patient Signature	Date/Time
Interpreter, if Utilized	Date/Time
Registrar	Date/Time

## Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to the check-in desk.

All of the communication accessibility aids and/or services that you need are **free of charge to you** by staff or contracted vendors.

Do you think you need any of the following aids and/or services?*	YES	NO
American Sign Language interpreter (must be requested at least 5 business days in advance of appointment)		
Foreign language		
Reading aloud of written materials		

\*Please note that these services may only be necessary in certain situations.

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own*. I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

X Primary Spoken Language: \_\_\_\_\_

Patient's preferred language for discussing healthcare: \_\_\_\_\_

Interpreter services are available during regular business hours.

Some Limited English Proficiency (LEP) persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services using the applicable CyraCom services will be provided to the LEP person.

Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.

Contact your Northwest Primary & Specialty Care clinic or Central Scheduling directly. The staff will coordinate language services.

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Contact your Northwest Primary & Specialty Care clinic or Central Scheduling directly. The staff will coordinate language services.

Kwe'é ats' íis baa áháyánígi éi Wááshindoon bibeehaz'áanii bíla'ashdla'ii nináhoniljiddji ha'át'íida doo baq̄h doot'jįda bíla'ashdla'ii lahgo át'éhígíí biniinaa, bikágí ánoolninínígíí biniinaa, náánálahdée' kéyahdée' yigáálgíí biniinaa, binááhahígíí, baq̄h dahaz'ánígíí, éi doodago asdzáni éi doodago hastjį nílínígíí biniinaa t'áa sahdii at'égo bina'anishígíí doo beehaz'ánígíí yik'eh hó'j dóo yidísín.

DÍI BAAKÓNÍNÍZIN: Diné Bizaad bee yánilti'go, t'áa jíik'e saad bee áká aná'álwo'jį ata hane', bee níká i'doolwoł.

Contact your Northwest Primary & Specialty Care clinic or Central Scheduling directly. The staff will coordinate language services.

X Patient/Family Member/Companion Signature	Date/Time
Signature of person, <i>if any</i> , who filled out this form on behalf of the patient, family member, or companion:	Date/Time
Witness	Date/Time

Notice of Communication Accessibility Services – AZ

1730-ADM-7610-AZ

03/15 (Rev. 08/16, 09/16, 11/16, 03/17, 04/17)

Northwest Primary & Specialty Care and Urgent Care

Page 1 of 1

Patient Label

**1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:**

I hereby assign and authorize payment directly to the Physician Clinic all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Physician Clinic, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand I am responsible to pay any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with the regular rates and terms of the Facility.

I understand that I am obligated to pay the account of the Physician Clinic in accordance with the regular rates and terms of the Physician Clinic. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Physician Clinic visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the Physician Clinic to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

**2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):**

I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

**3. CONSENT TO RELEASE HEALTH INFORMATION:**

I understand this Physician Clinic uses an electronic medical record. I understand that the electronic medical record contains information about my health from my past, current and future health care providers. I agree that this health information may be released through the Physician Clinic's electronic medical record or by other means (for example, fax, telephone, email, or hand delivery): (1) to the Physician Clinic; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities (for example, managing my care, providing quality care, patient safety activities, and other activities necessary to run the Physician Clinic). I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug 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 information, communicable disease-related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

**4. NOTICE OF PRIVACY PRACTICES:**

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Physician Clinic's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.



**5. HEALTH INFORMATION EXCHANGE:**

I understand that this Physician Practice participates in one or more health information exchanges (HIEs). I acknowledge that I received and read the HIE Notice of Health Information Practices. I understand that this Physician Practice may send and receive my health information through a HIE, unless I complete and return a HIE Opt-Out Request form to the Physician Practice. I understand that I can change my mind regarding my HIE participation status at this Physician Practice at any time by requesting the appropriate form from the Physician Practice.

**6. GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES:**

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

**7. CONSENT FOR VIRTUAL HEALTH/TELEMEDICINE SERVICES:**

I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that “virtual health” or “telemedicine services” includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

**8. ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**

Federal law requires that patients be provided information about their rights to make advanced health care decisions, including Living Will, Durable Medical Power of Attorney or designation of surrogate decision maker for health care decisions. By signing, you acknowledge awareness of these rights and understand the Physician Clinic can provide you with additional information and appropriate forms should you desire them.

**9. RESEARCH STUDIES:**

If you are currently participating in any research studies or clinical trials, we ask you please notify Registration and your Provider. You will be asked to provide a description of what is being studied (drug, medical device or other) and the Research Coordinator’s contact information should your Provider have questions about the Study.

**10. CONSENT TO PHOTO/VIDEO:**

I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

**11. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:**

I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice’s ambulatory medical record electronically as my photo identification.

**12. COMMUNICATIONS:**

I consent to this Facility, its successors or assignees contacting me via the methods I provide to the Facility. I understand the communications may occur in any manner, including phone calls to my cell phone or landline, voicemails on my cell phone or landline, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, text messages to my cell phone, or email messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. I understand that these

communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. If I incur any cost from being contacted at the telephone number(s) or email address(es) provided to the Facility, including but not limited to data, roaming, text messages, additional minutes or other fees, I understand that the Facility is not responsible for paying these charges. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

**13. VIDEOTAPING/RECORDING:**

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

The undersigned certifies that s/he has read (or have had read to me) the foregoing, understands it, accepts its terms, and has received a copy of. I hereby agree to all terms and conditions set forth above and understand that any sections of this consent that I do not consent to, I have struck through and initialed the section that does not have my consent or permission.

Patient's Signature or Legal Representative			Date	Time	
Relationship to Patient		Interpreter, if Utilized	Date	Time	
Witness Signature	Date	Time	If Telephone Consent, Second Witness Signature	Date	Time

Patient Label



## Pre-Authorization for Minors

**I (we) request the Practice and its personnel to deliver medical care to my (our) child listed below:**

Child's Name (*Print*) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian's Name (*Print*): \_\_\_\_\_  Mother  Father  Legal Guardian

Parent/Guardian's Name (*Print*): \_\_\_\_\_  Mother  Father  Legal Guardian

**In my (our) absence, my (our) child may be brought for treatment by the following person(s) who is 18 or older:**

Name (*Print*): \_\_\_\_\_ Relationship: \_\_\_\_\_

Name (*Print*): \_\_\_\_\_ Relationship: \_\_\_\_\_

I give permission for this person(s) to seek treatment (including any type of procedure) and provide consent for such treatment if attempts to contact me are unsuccessful.

I give permission for this person(s) to seek treatment (including any type of procedure) and provide consent for such treatment without having to contact me.

If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardians with no-parent, etc.) please explain in the space below:

*Legal documentation **must** be submitted to Northwest Allied Physicians in order to aid enforcement.*

\_\_\_\_\_  
\_\_\_\_\_

### Signature is REQUIRED for Treatment

I (we) hereby state that I (we) are the parent(s) or I (we) have legal custody of aforementioned minor. I (we) acknowledge that I (we) give permission to Northwest Allied Physicians to provide healthcare services to my (our) child. **I (we) understand that it is my (our) responsibility to notify Northwest Allied Physicians of any changes to the permissions given in this document.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Patient Acknowledgement

- I acknowledge as the patient or patient's representative that I have already signed the Consent to Medical Treatment form for Northwest Allied Physicians, and that my signed Consent applies to my treatment today at this clinic.
- I acknowledge as the patient or patient's representative that I have received a copy of the Patient Rights and Responsibilities for Northwest Allied Physicians.

\_\_\_\_\_  
**Patient's Signature** (or Legal Representative's signature)

If you are the patient's Legal Representative, please indicate your relationship to the patient below:

Parent    Guardian    Spouse    Domestic Partner    Other

\_\_\_\_\_  
Name of Interpreter, if utilized

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

### FOR STAFF USE ONLY

**Patient's Name:** \_\_\_\_\_  
(Please Print)

**Patient's Date of Birth:** \_\_\_\_\_

**Date of Service:** \_\_\_\_\_

**Clinic Name:** \_\_\_\_\_

*If patient received copy of Rights and Responsibilities but is declining acknowledgement, a staff member must sign below:*

\_\_\_\_\_  
Staff Signature

#### Patient Rights and Responsibilities

In caring for our patients, Northwest Allied Physicians strives at all times to respect the patient's individuality, privacy and other rights.  
**Patients may request a copy of these Patient Rights and Responsibilities at any time.**

#### A PATIENT HAS THE FOLLOWING RIGHTS:

1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnosis.
2. To receive treatment that supports and respects the patient's individuality, choices, strengths and ability.
3. To receive privacy in treatment and care for personal needs.
4. To review, upon written request, the patient's own medical record.

5. To receive a referral to another provider or healthcare facility, if the physician is unable to provide physical health services or behavioral health services for the patient.
6. To participate or have the patient's representative participate in the development of, or decisions concerning treatment.
7. To participate or refuse to participate in research or experimental treatment.
8. To receive assistance from a family member, representative, or other individual in understanding, protecting or exercising the patient's rights.
9. To be treated with dignity, respect and consideration.
10. Is not subject to: abuse, sexual abuse, sexual assault, neglect, exploitation, coercion, manipulation, restraint or seclusion, retaliation for submitting a complaint to the Health Department or another entity, misappropriation of personal and private property by an employee, volunteer or student.
11. A patient or patient's representative:
  - a. Except in an emergency either consents to or refuses treatment
  - b. May refuse or withdraw consent for treatment before treatment is initiated
  - c. Except in an emergency is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure
  - d. Is informed of the following;
    - i. Health care directives
    - ii. Patient complaint process
  - e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to a clinic for identification and administrative purposes
  - f. Except as otherwise permitted by law, provides written consent to the Release of Information in the patient's Medical Record or Financial Records.

**PATIENT RESPONSIBILITIES:**

1. **Provision of Information:** A patient has the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, existing advanced directives, and other matters relating to their health. The patient has the responsibility to report changes in their condition and whether they clearly understand instructions.
2. **Refusal of Treatment:** The patient is responsible for the outcome of their actions if they refuse treatment or do not follow medical instructions.
3. **Physician Practice Charges:** The patient is responsible for assuring that the financial obligations of their health care are fulfilled promptly.
4. **Physician Practice Rules and Regulations:** The patient is responsible for following clinic rules concerning patient care and conduct.
5. **Respect and Consideration:** The patient is responsible for being considerate of the rights of other patients and providers and other clinic staff.

**RATE SCHEDULE:**

A copy of the fee schedule is available upon request from the front desk.

**COMPLAINTS AND GRIEVANCES:**

We strive to provide the best possible care during your visit. If you have any concerns, questions or complaints about your care or treatment, please let your Provider or the Practice Director know. If you have a complaint we want to resolve it as soon as possible. If you believe your concern has not been addressed you may also lodge a complaint directly with the Department of Health Services without first filing an internal complaint by contacting:

**Arizona Department of Health Services**  
**150 N. 18<sup>th</sup> Avenue, Suite 450, Phoenix AZ 85007**  
**Phone: (602) 364-3030, Fax (602) 792-0466**

**STATE INSPECTIONS:**

As part of our ongoing commitment to providing Quality Care, our office has been surveyed by the Arizona Department of Health. A state inspection report is available upon request from our front desk.