PINNACLE HEALTH CARE

Taking Health Care to a Higher Level

6890 East Sunrise Drive
Suite 120, #223
Tucson, Arizona 85750
Phone (520) 441-3282
Fax (520) 204-1940

Welcome,

Thank you for choosing Pinnacle Health Care as your primary source of of medical services. Our team works to deliver the highest quality, compassionate care to the patients we serve.

We accept most insurance plans. If you have any questions about insurance acceptance, please contact our office at the number above.

Included in this new patient packet, you will find helpful information regarding our policies and procedures. Please review the included information to best understand the services that we deliver. Prior to our first visit with you, we would ask that you complete all of the forms in this packet. We will collect these from you at the first visit.

When you have made the decision to come under our care, you may work with the staff in your living community to assist in scheduling your first appointment. Generally, we can schedule your flrst visit within one week. Follow-up visits will be scheduled on a periodic basis. The frequency of these visits will vary depending on your specific needs and medical conditions.

If you would like us to provide medical information or speak to family members on your behalf, please complete a medical Power of Attorney form (not included in this packet) and fax or mail to our office.

We look forward to partnering with you to achieve optimal health and wellness.

Let Pinnacle Health Care help you to achieve your highest health care goals, right where you live.

Sincerely,

Harbir Singh, M.D
CEO, Pinnacle HealthCare

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Notice of Privacy Practices

PURPOSE:

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Our intent as an organization is to be fully compliant with the Health Insurance and Portability and Accountability Act (HIPPA) of 1996.

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. This notice will tell you about the ways we may use and share the 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

The law requires us to keep your medical information private. The law also requires that we give you this notice describing our legal duties, privacy practices and your rights regarding your medical information. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make the changes to our privacy practices and the new terms of our notice effective for all medical information including information previously created or received prior to the changes. Before we make a change to our practices we will amend this notice and make the changes 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 of the different ways we are permitted to use and disclose medical information. **We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific medical information use or disclosure may be revoked at any time upon providing us with a receipt of your written intent not to disclose any further medical information.**

TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about your to doctors, nurses, technicians, medical students, or other people who are taking care of you.

HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care 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 serve you.

PAYMENT: We may use and disclose your medical information for payment purposes.

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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 of family member or personal representative
- Disaster Relief Law Enforcement
- Research in limited circumstances
- Funeral Director, Coroner or Medical Examiner
- Specialized Government Functions
- Court Orders or Judicial and Administrative Proceedings
- Public Health Activities/Health Oversight Activities
- Victims of Abuse, Neglect or Domestic Violence

4. YOUR INDIVIDUAL RIGHTS

- You have the right to copies of your medical information
- You must make a request in writing with a medical record release of information
- If you request copies of your medical record for your personal files, a nominal charge will apply to cover our costs.
- You have the right to 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.
- You have the right to request that additional restrictions be placed on our use or disclosure of your medical information. (We will attempt to abide, though we are not required, to the restrictions except in the case of an emergency.)
- You have the right to request that we communicate with you about your medical information by different means (written) or to different locations (workplace). This request must be made in writing.
- You have the right to request that we change your medical information. We may deny your request if we did not create the information you wanted changed or for certain other reasons.
- You may respond with a statement of disagreement that will be added to the medical record.

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RIGHT TO REVISE PRIVACY PRACTICES:

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

COMPLAINTS:

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

If you have reason to believe that your privacy rights have been violated, you may bring the matter to our attention by sending a letter describing the nature of your concern. You will not be penalized or retaliated against for filing a complaint.

ACKNOWLEDGEMENT:

I have received the Notice of Privacy Practices form and have had an opportunity to review.

Signature of Patient Date

Power of Attorney or Authorized Signature Date

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Financial Policy

The following is a statement of our financial policy which we ask you to read and sign prior to your first appointment. Additionally, we may require you to present your insurance card/s at your first appointment.

MEDICARE

We are Medicare providers and we do accept assignment.

HMO and PPO

It is your responsibility to know your beneflts regarding covered services, deductibles, copays, coinsurance and referrals. You may call the Member Services phone number on your insurance card for assistance.

CONTRACTED INSURANCE CARRIERS

We will submit a claim to your insurance company for medical visits. If payment is not received within 60 days, the balance will become your responsibility. It will be your responsibility to recover the reimbursement from your insurance carrier.

PRIVATE INSURANCE CARRIERS

We will supply you with the necessary paperwork for you to submit the claims to your insurance company for reimbursement. Full payment is required at the time services are rendered.

I have read this policy and I understand the regardless of insurance, I am financially responsible for payment of services.

Signature: _____ Date: _____

Printed Name: _____ Date: _____

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Authorization for Release of Information

Patient Name _____ Date of Birth _____

Phone Number _____

I _____ consent to the release of my medical information to:

Pinnacle Health Care
6890 East Sunrise Drive,
Suite 120, #223
Tucson, Arizona 85750

The information that I wish to release is (circle all that apply):

Pertinent Information Laboratory/Pathology Entire Chart

Potential for Re-Disclosure:
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Pinnacle Health Care discloses it to another party.

Rights of the Individual:

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Signature

_____

Name of Patient

_____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

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Registration form

Patient Name: _____ SS#: _____

Address: _____ DOB: _____

City/State: _____ Zip Code: _____

Marital Status: _____ DNR: Y N Sex: M F

Preferred Pharmacy: _____Pharmacy Phone: _____

Responsible Party Name: _____

Responsible Party Address: _____

Responsible Party Phone #: _____

Relationship to Patient _____

Name of Medical Power of Attorney: _____Phone: _____

Billing Information

Primary: _____ I.D.# _____

Group#: _____

Secondary: _____ I.D.# _____

Group#: _____

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize:

- ☐ that payment for services rendered should be made payable to Pinnacle Health Care, LLC
- ☐ the release of medical information necessary to process any claims
- ☐ Use of my photo in the EMR

I have read all the terms and conditions contained in this agreement and agree to be bound to these terms and conditions.

Signature: _____ Date: _____