Date: ____/_____/_____ Time: _____

Admitting Physician: _____

Admit type: Adult Adult w/Guardian T36 Room Number:_____

Provisional Diagnosis: _____ Referral Source: _____

Patient Name:_____

Sex: M or F Ethnicity: _____ Religious Preference: _____

DOB: ____/_____/_____Age:_____ SSN: _____-_____-_____Marital Status: S M D W

Mailing Address: _____

_____

Physical Address: _____

Mother's Maiden Name: _____ Advanced Directives: Y N

Home #:_____ Work #: _____ Cell #:_____

Patient Employer: _____ Occupation: _____

Employer's Address: _____

Spouse's Name (If applicable):_____DOB: _____

Mailing Address: _____

Physical Address: _____

_____

Home #: _____ Work #: _____ Cell #: _____

Spouse's Employer: _____Occupation:_____

Employer's Address: _____

Is there a Guardian? Y or N

If yes, which type? ف POA ف MH POA ف T-14 ف T-14 Plus

Guardian's Name: _____

Guardian's Home #: _____ Work #: _____ Cell #: _____

Guardian's Address: _____

Guardian's Employer: _____ Occupation: _____

Employer's Address: _____

Parent's Name: _____ Relationship to PT:_____

DOB: _____

Parent's Mailing Address: _____

Parent's Physical Address: _____

Home #: _____ Work #: _____ Cell #: _____

Parent's Employer: _____ Occupation: _____

Employer's Address: _____

Emergency Contact #1: _____Relationship to PT:_____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Emergency Contact # 2: _____Relationship to PT:_____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Primary care Physician: _____

PCP Address: _____ Phone Number: _____

Guarantor's Name: _____ Phone #: _____

Mailing address: _____

Primary Insurance: _____ ID # : _____

Subscriber's Name: _____ DOB: _____

Group #: _____ Phone #: _____

Mental Health Carve Out: _____ Phone #: _____

Date: _____ Talked To: _____

_____

_____

_____

Billing Address: _____

_____

Case Manager/UR: _____ Phone #: _____

Authorization #: _____ # of Days Authorized: _____

Date of Concurrent Review: _____

Secondary Insurance: _____ ID # : _____

Subscriber's Name: _____ DOB: _____

Group #: _____ Phone #: _____

Mental Health Carve Out : _____ Phone #: _____

Date: _____ Talked To: _____

_____

_____

_____

Billing Address: _____

Case Manager/UR: _____ Phone #: _____

Authorization #: _____ # of Days Authorized: _____

Date of Concurrent Review: _____

CONDITIONS OF ADMISSION/TREATMENT AGREEMENT

I, the Patient or the person authorized to act for the Patient, agrees to the following terms of admission and/or treatment at the healthcare facility. The term "healthcare facility" means the location of care where I'm currently registering to receive healthcare services

1. **GENERAL INFORMED CONSENT:** I consent to Patient receiving routine healthcare services/treatment ordered by the provider responsible for the Patient's care. I understand treatment may be provided by physicians, medical students, licensed independent practitioners, nurses, students or other individuals functioning within their approved scope of practice. I agree that this consent to treatment will be valid until Patient is discharged from the healthcare facility. _____ ***(Please initial).***
2. **PHYSICIANS:** I understand that physicians responsible for the Patient's care may not be employees or agents of the healthcare facility, and may be independent contractors. I understand that Patient's physicians are responsible for their own treatment activities, and that the healthcare facility is not liable for the actions or omissions of physicians that are not employees of the healthcare facility. I accept responsibility to ask any physician whether the physician is an independent contractor or healthcare facility employee.
3. **EMERGENCY SERVICES NOTICE:** I understand that if Patient comes to the healthcare facility or healthcare facility emergency department, requesting treatment for an emergency medical condition, the healthcare facility is obligated to provide a medical screening examination and any stabilizing treatment or transfer, whether or not Patient has the ability to pay for these services.
4. **RELEASE OF INFORMATION:** Northern Arizona Healthcare's Notice of Privacy Practices has information about how the organization may release Patient's health information. I acknowledge that I have received a copy of the Northern Arizona Healthcare's Notice of Privacy Practices. I understand I may be contacted by an outside patient satisfaction agency, on behalf of Northern Arizona Healthcare, concerning my patient experience. _____ ***(Please initial).***
5. **CONSENT TO RECORD, PHOTOGRAPH, OR FILM:** I give consent to the healthcare facility for recording, photographing, or filming the Patient for purposes of treating patient, or for the healthcare facility's internal operations, such as improvement of quality of care, and educating students and professionals.
6. **PERSONAL ITEMS AND BELONGINGS:** The healthcare facility does not accept any responsibility for personal belongings. If admitted to the hospital, the hospital has a safe in which Patient may store money and other valuables. The maximum liability in case of loss or damage for items deposited in the safe is $500. Northern Arizona Healthcare is not responsible for loss or damage to any items that are not deposited in the safe by Patient, such as money, jewelry, eye glasses, dentures, hearing aids, contact lenses, or documents. The healthcare facility will dispose of any property that remains in the safe for five (5) years or more under the Uniform Unclaimed Property Act (A.R.S. 44-301, et. seq.). _____ ***(Please initial).***
7. **FINANCIAL AGREEMENT:** I agree that in return for services provided to Patient, the Patient is responsible for any health insurance deductibles and co-payments. The payment of deductibles and co-payments may be requested at the time of service. The Patient agrees to pay Patient's account in full. When practical the healthcare facility healthcare will bill the Patient's insurance for services provided. **Assignment of benefits:** If Patient is entitled to any benefits from an insurance policy that insures Patient or any other party liable to Patient, Patient assigns the benefits to the healthcare facility. The Patient also assigns to the healthcare facility the rights to payment for the charges of the physician(s) for whom the healthcare facility is authorized to bill in connection with its services. I understand that I remain responsible for payment of the bill regardless of this assignment of insurance coverage. **Price quotes:** I understand that any price quotations given are estimates of expected services. The price quotes may not include physician fees for services. Price quotes may vary significantly from actual charges, which are based on the treatment ordered by Patient's physician(s), the provider responsible for the Patient's care, and Patient's actual medical conditions. **Physicians: I also understand that most physicians will bill separately from the healthcare facility.** Patient's physicians may or may not participate with the same insurance plans as the healthcare facility which could affect the reimbursement made by Patient's insurance carrier for these physicians' services. **Lien rights:** I understand that if the healthcare facility is providing services to Patient as a result of an accident or the negligent or wrongful acts of another, the healthcare facility may have a lien on any judgment, damages, or settlement recovered by Patient for the healthcare facility full billed charges. I agree to provide the healthcare facility with any information necessary for the healthcare facility to pursue its' statutory lien or secure payment for Patient's insurer and understand that if I fail to provide necessary information, I may be personally responsible for the healthcare facility full bill. I also understand that CMS may initiate a lien and that the healthcare facility must comply with any lien rights or reporting requirements of CMS. **Collections:** I agree to pay reasonable attorney's fees and collection expenses if the account is sent to an attorney or collection agency. I understand that the healthcare facility may charge a delinquent account interest at the legal rate.
8. **ADVANCE DIRECTIVE ACKNOWLEDGMENT:** I also understand that adult patients have the right to make advance directives that will direct care in the event they are unable to make their own health care decisions. *Please read and check the appropriate statements below.*

   Patient has the following advance directive(s): **(Initial or check those that pertain)**

   _____ Living Will _____ Health Care Power of Attorney _____ Mental Health Care Power of Attorney

   _____ Pre-healthcare Facility Medical Care Directive _____ Written Consent - Patient Representative

   _____ Patient has provided the healthcare facility with a copy of the above advance directive(s).

   _____ Patient has not executed an advance directive. Patient has been offered written material on advance directives.

   _____ Patient or Authorized Party does not know if Patient has an advance directive.
9. **CHANGES TO THIS FORM:** Personnel handling Patient's admission to the healthcare facility do not have authority to agree to any changes to this Condition of Admission form. To discuss changes to this form, contact the Central Business Office Director or designee.

THE UNDERSIGNED CERTIFIES:

(1) I HAVE READ AND UNDERSTAND THESE CONDITIONS OF ADMISSION, INCLUDING PATIENT'S/PATIENT REPRESENTATIVE'S BILL OF RIGHTS ON THE BACK OF THIS PAGE;
(2) I HAVE RECEIVED OR BEEN OFFERED A COPY OF THESE CONDITIONS OF ADMISSION;
(3) I AM THE PATIENT OR I AM THE LEGAL REPRESENTATIVE OF THE PATIENT AND AM AUTHORIZED TO SIGN THIS AGREEMENT ON BEHALF OF THE PATIENT; AND
(4) I AGREE TO ALL TERMS IN THESE CONDITIONS OF ADMISSION.

_____ _____

Patient or Patient Representative Printed Name and Signature* **Date and Time of Signing**

* If you are the Patient's Representative, please check the box indicating your authority to act on behalf of Patient and provide copy of applicable documents:

☐ Parent ☐ Legal Guardian ☐ Health Care Power of Attorney ☐ Mental Health Care Power of Attorney ☐ Written Consent of the Patient
☐ Patient does not have the capacity to make health care decisions or is being admitted in an emergency, and I have the following surrogate relationship with Patient: _____

☐ Other (explain): _____

Northern Arizona Healthcare
Check box when completing manually
☐ **Flagstaff Medical Center** ☐ **Verde Valley Medical Center**

CONDITIONS OF ADMISSION/ TREATMENT AGREEMENT

Place Patient Label Here

CONDITIONS OF ADMISSION/TREATMENT AGREEMENT

PATIENT'S/PATIENT REPRESENTATIVE'S BILL OF RIGHTS

Patient/Patient Representative:

1. **HAS THE RIGHT** to be informed of the patient's rights at the time of admission and in advance of furnishing or discontinuing care.
2. **HAS THE RIGHT** to receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.
3. **HAS THE RIGHT** to care in a comfortable environment with respect to privacy, dignity, and his/her personal values, beliefs, choices, strengths, and abilities under the supervision of competent, qualified, and experienced clinical staff;
4. **HAS THE RIGHT** to make informed decisions regarding all aspects of his/her medical care, including the decision to accept, refuse or limit treatment, to the extent permitted by law, to be informed of the medical consequences of his/her action, and to delegate his/her right to make informed decisions to another person.
5. **HAS THE RIGHT** to participate in the development, periodic review, and implementation of his/her individualized plan of care/program plan and to be informed of his/her health status, including diagnosis, treatment and prognosis, in terms that he/she can understand.
6. **HAS THE RIGHT** to receive from his/her physician information necessary to give specific informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for specific informed consent should include, but not be limited to, the specific procedure(s) and/or treatment, alternatives to the medical procedure(s) and/or treatment, associated risks, and possible complications.
7. **HAS THE RIGHT** to be informed about outcomes of care whenever those outcomes differ significantly from the anticipated outcomes.
8. **HAS THE RIGHT** to have pain assessed and managed when admitted and throughout patient's healthcare hospitalization.
9. **HAS THE RIGHT** to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be the least restrictive method and discontinued at the earliest possible time.
10. **HAS THE RIGHT** to expect that the healthcare facility will provide a mechanism whereby the patient is informed by the physician or an agent of the physician of a referral or transfer to another facility when medically appropriate, or of discharge plans, including any continuing health care requirements following the patient's discharge.
11. **HAS THE RIGHT** to make an informed decision on whether to participate in an investigative study, research project, experimental treatment, clinical trial, or educational activity related to his/her care or treatment. A refusal to participate will not compromise access to service.
12. **HAS THE RIGHT** to have a family member or representative of his/her choice and his/her physician notified as soon as can be reasonably expected of the patient's admission to the healthcare facility. The patient has the right to have access to a phone, and involve or exclude family members from care decisions.
13. **HAS THE RIGHT** to formulate advance directives and to have healthcare facility staff and physicians comply with these directives.
14. **HAS THE RIGHT** to participate and to assist in resolving ethical issues or dilemmas that arise in his/her care (i.e., issues of conflict resolution, provision of futile care, withdrawing of life-sustaining treatment, etc.).
15. **HAS THE RIGHT** to prompt resolution of a grievance. The healthcare facility will not retaliate against a patient or representative for filing a grievance with either the healthcare facility or Arizona Department of Health Services. Please notify your care providers of unmet care needs or care concerns. If your needs or concerns are not met, you may request to speak with a Patient Relations Representative (FMC dial (928) 779-3366 ext: 13528; VVMC or SMC dial (928) 639-6000 ext: 36263) and/or file a grievance with the Arizona Department of Health Services, Division of Licensing, Medical Facilities Licensing, 150 N. 18th Ave., 4th Floor, Suite 450, Phoenix, AZ, 85007. Phone: (602) 364-3030
16. **HAS THE RIGHT** to receive care in a safe and secure healthcare facility environment and to be free from all forms of discrimination, abuse or harassment from staff, other patients or visitors.
17. **HAS THE RIGHT** to review the patient's own medical record, as permitted by law. To confidentiality with respect to communications and records regarding his/her health care and to access the information, as permitted by law, in the medical record. The healthcare facility's Notice of Privacy Practices describes how the healthcare facility can use and disclose protected health information, the patient's rights under the HIPAA Privacy Standards, and the healthcare facility's legal duties regarding protected health information.
18. **HAS THE RIGHT** to obtain a schedule of healthcare facility healthcare facility rates and charges, examine and receive an explanation of his/her bill regardless of source of payment.
19. **HAS THE RIGHT** to obtain information regarding the relationship of the healthcare facility to other health care providers, education institutions, and payers, as far as his/her care is concerned.
20. **HAS THE RIGHT** to know what healthcare facility rules and regulations apply to patient's conduct.
21. **HAS THE RIGHT** to a full explanation of any restrictions, including clinical restrictions, placed by the healthcare facility on a patient's visitors, mail, telephone calls, or other forms of communication.
22. **HAS THE RIGHT** to access protective services. Local community protective service agencies may assist patient in determining whether protective services are needed and how to correct hazardous living conditions or situations.
23. **HAS THE RIGHT** subject to his or her consent (which may be withdrawn at any time), to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend.

PATIENT'S/PATIENT REPRESENTATIVE'S RESPONSIBILITIES

Patient/Patient Representative:

1. **IS RESPONSIBLE** for providing, to the best of his/her knowledge, accurate and complete information about the patient's health care status including current copies of Advanced Directives that include: Living Will, Health Care Power of Attorney, Mental Health Care Power of Attorney, Pre-healthcare facility Medical Care Directive, and Consent for Patient Representative.
2. **IS RESPONSIBLE** for reporting perceived risks in the patient's care and unexpected changes in the patient's condition.
3. **IS RESPONSIBLE** for following the care, service, or treatment plan developed. The patient/representative should express any concerns or questions about his/her ability to follow and comply with the proposed care plan.
4. **IS RESPONSIBLE** for following the healthcare facility's rules and regulations concerning patient care and conduct and for being considerate of the healthcare facility's personnel and property.
5. **IS RESPONSIBLE** for providing, to the best of his/her knowledge, accurate and complete information to allow payment of healthcare facility's charges and, as applicable, for promptly meeting any financial obligation agreed to with the healthcare facility.
6. **IS RESPONSIBLE** to notify his/her care providers of unmet care needs or care concerns.

Rights of Persons with Serious Mental Illness

Civil and Other Legal Rights

I have the right to acquire and dispose of property, execute instruments, enter into contractual relationships, hold professional, occupational or vehicle operator licenses, unless adjudicated otherwise. I have the right to be free from unlawful discrimination on the basis of race, creed, religion, sex, and sexual preference, and age, physical or mental handicap. I have the right to equal access to all existing behavioral health services, community services, and generic services. I have the right to religious freedom and practice. I have the right to vote. I have the right to reasonable access to a telephone and opportunities to make and receive confidential calls and assistance when desired and necessary. I have the right to unrestrictedly send and receive uncensored and unopened mail, to be provided stationery and postage to the extent reasonable, and help in exercising this right. I have the right to be visited and visit with others within reasonable restrictions to protect the privacy of others and avoid serious agency disruptions. I have the right to associate with anyone of my choice, to form associations, and to discuss, along with the group with management, matters of general interest. I have the right to privacy, including not be fingerprinting or photographing without authorization. I have the right to be informed, in appropriate language and terms, of my rights. I have the right to state my grievances when I feel my rights have been violated, including when such grievances have not been considered in a fair, timely, and impartial procedure. I have the right to not be retaliated against for filing a grievance. I have the right of access to a human rights advocate. I have the right to be assisted by and attorney or designated representative of my choice, including the right to meet in a private area with the same. I have the right to exercise all other rights, entitlements, privileges and immunities provided by law. I have the same civil rights as all other citizens of Arizona, including the right to marry and to obtain a divorce, to have a family, and to live in the community of my choice without constraints upon independence, except those to which all citizens are subject.

Support and Treatment

I have the right to behavioral health services or community services under conditions that support my personal liberty and restrict same only as provided by law. I have the right to receive support and treatment from a flexible service system provided in a way that preserves my dignity, respects my individuality, abilities, needs, and aspirations, and encourages my self-determination, freedom of choice, and participation in treatment to my fullest capacity. I have the right to assurance of freedom from the discomfort, distress an deprivation that arise from an unresponsive and inhumane environment. I have the right to have my privacy protected and promoted, including-whenever possible-private living, sleeping and personal care spaces. I have the right to treatment which maximizes integration into my community and offers humane and adequate support and treatment which is least restrictive, culturally sensitive, voluntary, and home-based to the extent possible with opportunities for normalized experience.

I have the right to ongoing participation in the planning of services and revision of my individual service plan. I have the right to a reasonable explanation of all aspects of my condition and treatment. I have the right to give informed consent and to refuse services. I have the right not to participate in experimental treatments. I have the right to a humane treatment environment that protects me from harm, provides privacy and freedom from verbal or physical abuse. I have the right to enjoy basic good and services without threat of denial or delay. I have the right to be informed, in advance, of charges for services. I have the right to a continuum of care in a unified and cohesive system of services that is well integrated, and not limited…which includes clinical case management, outreach, training and opportunities, day treatment, rehabilitation services, peer support, social support, recreation services, advocacy, family support services, outpatient counseling and treatment, transportation, and medication evaluation and maintenance. I have the right to other programs that offer different levels of intensity of services, to treatment, based on my individual and unique needs, to services provided in the most normal and least restrictive setting, and to clinical case management services and a case manager. I have the right to participate in treatment decisions and in the development and implementation of my ISP as well as the type and location of services. I have the right to prompt consideration of discharge from an inpatient facility and the identification of steps necessary to secure same. I have the right to be represented by a qualified advocate or other designated representative of my choice in the development of the ISP and the inpatient treatment and discharge plan and in the grievance process.

Protection from Abuse, Neglect, Exploitation, and Mistreatment

I have the right to be free from abuse, neglect, exploitation, and mistreatment. Mistreatment includes but is not limited to: abuse, neglect, or exploitation; corporal punishment; any other unreasonable use or degree of force or threat of force not necessary to protect me or another; infliction of mental or verbal abuse, such as screaming, ridicule, or name calling; incitement or encouragement of others to mistreat me; transfer or the threat of transfer for punitive reasons; restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; any act in retaliation for reporting a violation, or commercial exploitation.

Restraint and Seclusion

I have the right to be free from restraint or seclusion other than that permitted by and incompliance with Chapter 9, A.A.C. 20 and other applicable federal or state law.

Labor

I have the right to be free from performing labor which involves the essential operation and maintenance of the service provider.

Competency and Consent

I shall not be deemed incompetent solely by reason of admission to a mental health agency.

Informed Consent

I have the right to provide voluntary, informed consent for psychotropic medication, E.C.T, telemedicine, participation in research, admission for detoxification, and inpatient/residential admission.

Medication

I have the right to be free from unnecessary or excessive medication, medication used as punishment, for the convenience of staff, or as a substitute for other behavioral services. I have the right to the least amount medically necessary, prescribed by a physician/psychiatrist, to be seen monthly (or as otherwise designated in my ISP) and written evaluation relative to dosage, medication mixture, signs of tardive dyskinesia or other effects, the reason, and the effectiveness. I have the right to self-administer my medications unless otherwise restricted. I have the right to be free from PRN orders for medication used as a restraint.

Property and Possessions

I have the right to acquire, retain and dispose of personal property, including the right to maintain a bank account unless under guardianship, conservatorship, representative payee or a court order.

Records

I have the right to privacy of my records and disclosure only with appropriate authorization under the law.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS

AS A HOSPITAL INPATIENT, YOU HAVE THE RIGHT TO:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here: **Health Services Advisory Group (HSAG) 1-800-359-9909**

YOUR MEDICARE DISCHARGE RIGHTS

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
    - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
    - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- **Step by step instructions for calling the QIO and filing an appeal are on page 2.**

To speak with someone at the hospital about this notice, call **FMC Utilization Management Phone # 928-773-2220, ext. 12220 from hospital bedside phone**

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative _____ Date/Time _____

Place Patient Label Here

STEPS TO APPEAL YOUR DISCHARGE

- **STEP 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
    - Here is the contact information for the QIO:
      Health Services Advisory Group (HSAG)
      1-800-359-9909
    - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
    - Ask the hospital if you need help contacting the QIO.
    - The name of this hospital is: **Flagstaff Medical Center, Provider ID Number: 030023**
- **STEP 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **STEP 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **STEP 4:** The QIO will review your medical records and other important information about your case.
- **STEP 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
    - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
    - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

IF YOU MISS THE DEADLINE TO APPEAL, YOU HAVE OTHER APPEAL RIGHTS:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
    - If you have Original Medicare: Call the QIO listed above.
    - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

#1 Copy of signed Medicare Hospital Discharge Appeal Rights given to pt on: Date _____ Patient's Initials _____

#2 Copy of signed Medicare Hospital Discharge Appeal Rights given to pt on: Date _____ Patient's Initials _____

Northern Arizona Healthcare

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to disclose the following information from the health record of:
(Enter Hospital name or Clinic name)

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ MRN # (for internal use only) _____

Address _____ Area Code and Phone Number _____

City _____ State _____ Zip Code _____

INFORMATION REQUESTED

Service Dates From: _____ **To:** _____

- ☐ All Pertinent Records
- ☐ Allergies
- ☐ Consultation
- ☐ Discharge Summary
- ☐ ER Report
- ☐ EKG Report
- ☐ History & Physical
- ☐ Laboratory
- ☐ Medication List
- ☐ Other _____
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Radiology Reports
- ☐ Discharge Instructions
- ☐ X-ray Images
- ☐ Billing Record
- ☐ Entire Medical Record

I authorize the provider to disclose information related to: (check all that apply)

- ☐ Behavioral Health/Psychiatric/Mental Health Information
- ☐ AIDS/HIV and Other Communicable Disease
- ☐ Alcohol and/or Substance Abuse Screening and/or Treatment
- ☐ Genetic Testing

Method of Delivery ☐ _____

☐ Call When Ready ☐ Paper Request ☐ CD

CLINIC RECORDS

☐ Clinic Notes ☐ H & P ☐ Lab Tests ☐ X-Ray Reports
☐ Discharge Summary ☐ OP Report ☐ Progress Notes ☐ Others

PURPOSE

- ☐ Self
- ☐ Continuing Medical Care
- ☐ Workmen's Compensation
- ☐ Insurance Coverage
- ☐ Other: _____

INFORMATION to be VIEWED BY OR GIVEN TO

Company, Person, Facility _____ Area Code and Phone Number _____

Street Address _____ Area Code and Fax Number _____

City _____ State _____ Zip Code _____

I may refuse to sign this authorization form. I understand that the Facility will not condition or deny treatment on my signing this authorization.

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Healthcare/Psychiatric Care, Treatment of Alcohol and/or Drug Abuse, and Genetic Testing; My signature authorizes release of any such information.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Unless I revoke this authorization earlier, it will expire in one year. To revoke my authorization, I must submit a written request to the Medical Records Custodian at the applicable facility: Flagstaff Medical Center, 1200 N. Beaver St., Flagstaff, AZ 86001; Verde Valley Medical Center, 269 S. Candy Lane, Cottonwood, AZ 86326 or Northern Arizona Home care, 107 E. Oak Avenue, Flagstaff, AZ 86001.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature _____ Date _____ Patient Authorized Representative Signature _____ Date _____

☐ Legal Guardian ☐ Power of Attorney ☐ Surrogate Decision Maker ☐ Patient Representative ☐ Minor ☐ Patient Deceased

For Healthcare Use Only

Employee completed/reviewed form with patient: _____ **ID verified** _____

Date Received: _____ **Date Sent:** _____ **Date Faxed** _____ **# of pages** _____

Copy Service: _____ **Date Copied:** _____ **Completed By:** _____ Emailed to Copy Service on: _____

ROI

Northern Arizona Healthcare

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize _____ to disclose the following information from the health record of:
(Enter Hospital name or Clinic name)

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ MRN # (for internal use only) _____

Address _____ Area Code and Phone Number _____

City _____ State _____ Zip Code _____

INFORMATION REQUESTED

Service Dates From: _____ **To:** _____

- ☐ All Pertinent Records
- ☐ Allergies
- ☐ Consultation
- ☐ Discharge Summary
- ☐ ER Report
- ☐ EKG Report
- ☐ History & Physical
- ☐ Laboratory
- ☐ Medication List
- ☐ Other _____
- ☐ Operative Report
- ☐ Pathology Report
- ☐ Radiology Reports
- ☐ Discharge Instructions
- ☐ X-ray Images
- ☐ Billing Record
- ☐ Entire Medical Record

I authorize the provider to disclose information related to: (check all that apply)

- ☐ Behavioral Health/Psychiatric/Mental Health Information
- ☐ AIDS/HIV and Other Communicable Disease
- ☐ Alcohol and/or Substance Abuse Screening and/or Treatment
- ☐ Genetic Testing

Method of Delivery ☐ _____

☐ Call When Ready ☐ Paper Request ☐ CD

CLINIC RECORDS

☐ Clinic Notes ☐ H & P ☐ Lab Tests ☐ X-Ray Reports
☐ Discharge Summary ☐ OP Report ☐ Progress Notes ☐ Others

PURPOSE

- ☐ Self
- ☐ Continuing Medical Care
- ☐ Workmen's Compensation
- ☐ Insurance Coverage
- ☐ Other: _____

INFORMATION to be VIEWED BY OR GIVEN TO

Flagstaff Medical Center - Behavioral Health Unit
Company, Person, Facility

(928) 213-6300
Area Code and Phone Number

1200 N. Beaver St.
Street Address

(928) 214-6301
Area Code and Fax Number

Flagstaff
City

AZ
State

86001
Zip Code

I may refuse to sign this authorization form. I understand that the Facility will not condition or deny treatment on my signing this authorization.

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Healthcare/Psychiatric Care, Treatment of Alcohol and/or Drug Abuse, and Genetic Testing; My signature authorizes release of any such information.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Unless I revoke this authorization earlier, it will expire in one year. To revoke my authorization, I must submit a written request to the Medical Records Custodian at the applicable facility: Flagstaff Medical Center, 1200 N. Beaver St., Flagstaff, AZ 86001; Verde Valley Medical Center, 269 S. Candy Lane, Cottonwood, AZ 86326 or Northern Arizona Home care, 107 E. Oak Avenue, Flagstaff, AZ 86001.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient Signature _____ Date _____ Patient Authorized Representative Signature _____ Date _____

☐ Legal Guardian ☐ Power of Attorney ☐ Surrogate Decision Maker ☐ Patient Representative ☐ Minor ☐ Patient Deceased

For Healthcare Use Only

Employee completed/reviewed form with patient: _____ **ID verified** _____

Date Received: _____ **Date Sent:** _____ **Date Faxed** _____ **# of pages** _____

Copy Service: _____ **Date Copied:** _____ **Completed By:** _____ Emailed to Copy Service on: _____

ROI

Flagstaff Medical Center
Northern Arizona Healthcare

CONSENT FOR ADULT PROGRAM

I have received information regarding the following:

_____ Recreational Outings	_____ Phone Times	_____ Quiet Time
_____ Contraband Items	_____ Time-Out System	_____ Searches
_____ Restraint / Seclusion	_____ Visiting Hours	_____ Medication Policy

_____ I understand that Flagstaff Medical Center Behavioral Health Services maintains a tobacco free environment. Nicotine supplements are available upon request pending Physician approval. I also understand that if I abuse the nicotine replacement product(s), this privilege will be revoked.

_____ I have been informed of the Patient Bill of Rights and have received a copy of this document.

_____ I have been informed of the right to file a grievance and have received a copy of this document.

_____ I give my permission to be photographed for patient identification purposes.

_____ I have received a copy of the pertinent telephone contact numbers.

_____ I have been informed that my treatment will occur on a locked psychiatric unit.

_____ I have received a copy of the Inpatient Adult Unit Handbook.

_____ If I am enrolled in a Regional Behavioral Health Authority and Seriously Mentally Ill, I have received a copy of the Right For Persons With a Serious Mental Illness (initial if applicable)

_____ _____
Patient Signature Date/Time

_____ _____
Witness Signature Date/Time

Flagstaff Medical Center
1200 North Beaver Street • Flagstaff, Arizona 86001

CONSENT FOR ADULT PROGRAM

Place Patient Label Here

CNS

FLAGSTAFF MEDICAL CENTER
BEHAVIORAL HEALTH SERVICES
CONSENT FOR CONTACT WITH SUPPORT PERSONS

I, _____ , give permission for
Patient Name

Flagstaff Medical Center Behavioral Health Services staff to contact the person(s) on the following list to receive and to disclose information that will be helpful in planning my treatment and/or to schedule a therapy session in which this person(s) would be included. I understand that the goal of this contact is to help me receive the best possible treatment and support during my hospitalization:

Name of Contact(s):

_____

_____

_____

_____

_____ _____
Patient Signature Date

Adult Contact List

☐Accept ALL Visitors _____ Initials*

☐NO Visitors _____Initials*

☐Accept ALL Calls _____ Initials*

☐NO Calls _____Initials*

☐Exception:_____ _____ Intake Initials*

*Please choose one of the above options OR fill in the information below for specific individuals you wish to have visits/contact with.

NAME	RELATIONSHIP	ADDRESS	PHONE #	PHONE CALLS	VISITS

Patient or Legal Guardian Signature Date

Flagstaff Medical Center
Behavioral Health Services
1200 N. Beaver Street * Flagstaff, AZ 86001
Contact List
BH - 04

Place Patient Label Here

Flagstaff Medical Center
Northern Arizona Healthcare

INFORMED CONSENT FOR PSYCHOTHERAPY/COUNSELING

I hereby voluntarily consent to utilize the services provided by my therapist/counselor. Possible services include: Individual counseling/psychotherapy, marital therapy, family therapy, group therapy, psychological consultation and psychological testing. I understand my therapist is not warranting a cure or offering any guarantee of results or improvement of my condition.

ASSUMPTION OF RISKS:
As a patient utilizing the services of a mental health professional, I understand that I have a right to ask any questions I may have about my plan of care. In addition, I understand I have the right to terminate therapy at any time. I understand that potential benefits of undergoing psychological services include obtaining a professional opinion, increased understanding of myself, and relief of symptoms. I understand potential risks include discussion of material that may be "difficult and painful", and that positive results are not guaranteed. I understand and agree that my continued participation in therapy implies voluntary informed consent. I understand that alternative procedures include services provided by another mental health professional.

LIMITS OF CONFIDENTIALITY:
All communication and records which involve mental health treatment are confidential. No one from this hospital or clinic may release any information except under the following special circumstances:

(1) upon express written consent of the patient or legal guardian of a minor patient;
(2) if release is ordered by a court, or if the patient introduces their mental status into issue in a lawsuit;
(3) if there is sufficient reason to suspect that abuse or neglect of a child, or elderly, disabled or incompetent individual is occurring;
(4) upon the need to disclose information to protect the rights and safety of self or others if a patient indicates he/she may present a danger to self or others. In such circumstances, possible actions could include notification of a family member, notification of law enforcement authorities, notification of individual(s) at risk of harm, or arrangement for voluntary or involuntary hospitalization of the patient;
(5) if necessary to collect fees owed for professional services rendered, provided that only information relevant to the financial resolution may be disclosed; and in accordance with HIPPA regulations;
(6) if legal proceedings or complaints with a licensing board or regulatory body are initiated against the mental health professional. In that unlikely event, information necessary for response to such a claim or action may be disclosed.

PRIVACY OF OTHERS:
I understand that if I am a participant in a therapy group that I will be encouraged to share information about myself related to the problem which brings me here for treatment. I will also hear information shared by other group members. It is expected that I will keep entirely private/confidential any such information that I hear about or from other patients.

RELEASE OF INFORMATION: PATIENT/PARENT/GUARDIAN:
While the patient has the legal right to the information contained in the medical record, this information will be given to the patient only after a clinician has reviewed the information. A written patient authorization must be secured.

MANAGED CARE CONTRACTS:
I understand that this hospital or clinic may have contracts with several managed care companies and preferred provider organizations and that FMC may exchange any and all information pertaining to this case with a managed care company representative(s) when disclosure is necessary for case management, claims processing, coordination of treatment, quality assurance or utilization review purposes and only in accordance with HIPPA Regulations.

STATEMENT OF UNDERSTANDING:
My signature below indicates I have read this form or it has been read and explained to me and that I fully understand the above information and that I consent for either myself or for a minor child for whom I am legally responsible to receive services.

Patient or Legal Guardian _____ Date _____

Flagstaff Medical Center
Northern Arizona Healthcare

INPATIENT ADULT UNIT HANDBOOK

Welcome to the Behavioral Health Services unit at Flagstaff Medical Center. In order to make your stay here safe, comfortable, safe and helpful, the following guidelines are provided. Thank you for your assistance with our efforts to foster a healthy environment.

* Because we want to provide you and all other patients as well with the most helpful experience possible, please remember that whatever you talk about in the hospital is confidential information. It is important that you do not talk with family members, friends, or others about what patients say or do while here, or provide them with any other information such as names, locations, or occupations of other patients.

* We have both adults and adolescents in our locked inpatient unit. Opportunities for contact between the adult and adolescent patients are extremely rate, but if present, please do not engage in any interaction with the adolescents, and be aware of this boundary during transition times from one part of the hospital to another.

* For safety reasons and to respect personal boundaries, patients are not to be in other patient bedrooms. If you would like to have a private conversation with another patient, please inform staff of this request and we will attempt to accommodate you if this request would be helpful for all concerned.

* Your assigned mental health technician is available to assist with any requests through the day, including snacks, personal hygiene items, and other daily living items.

* Because phones are limited, please be sensitive to the needs of all patients and keep your phone calls reasonably short. We also ask that you plan to make phone calls during specified phone hours, so that your treatment here is not interrupted. If you would like to make a phone call outside these hours, exceptions may be made by your treatment team. We are not able to permit cell phone use in the hospital. Staff may assist you in making an initial long distance call to notify family members and friends about where you are and our phone number here so that they may contact you.

* It is important that you fill out a phone and visitor list when you arrive and include anyone that you wish to talk with, so that we can protect your privacy. Please remind friends and family members to call during phone hours so as not to interrupt your treatment.

* When your friends or family members bring additional personal possessions for you, it is important that they be brought to the nurses' station so that we can add them to your inventory. If this is not done, we have no way of insuring that you have all your

belongings when you leave. Please discuss with the nurse any plans your family may have to bring snacks or a meal while you are here in advance. The Charge Nurse will determine with you what will be acceptable.

* For the safety of all patients we are not able to permit metal objects, glass or mirrors, razors, CD's, or any other objects deemed unsafe. If you are on suicide precautions, we are unable to permit you to have drawstrings, shoelaces, belts, robe ties, etc. for that period of time.

* You will be held financially and possibly legally responsible for any damage or destruction of property that you may cause.

* We request that no provocative or inappropriate clothing be worn on the unit. That includes low-cut tops, short-shorts or very short skirts, t-shirts with violent, drug or alcohol related themes, or sexual content. We will assist you in covering tattoos if necessary.

* Due to limited storage, we ask that you limit clothing to three changes of clothes, and that you send extra belongings and valuables home with family or friends if possible. Laundry facilities are available to assist you in having clean clothing on a daily basis. Please do not share any clothing or personal items, including toiletries with other patients.

* Because we are committed to your safety and unit safety, room searches occur on a regular basis. Patients have the right to be present during the searches, so please notify a staff member if you would like to observe.

* Because the effectiveness of your treatment here is dependent on your participation in programming and interaction with peers and staff, patients are strongly encouraged to attend all groups and watch TV during non-group times only. We strongly encourage you to attend all groups because this allows you to get the most from this experience.

* We strongly discourage you from exchanging phone numbers or addresses with other patients. We also discourage you from accepting phone calls from other patients that have been discharged or from making phone calls to patients still here after you leave. This will help insure that while you are in the hospital you have the privacy and safety needed to stay focused on your own treatment. Please discuss any concerns about this guideline with staff.

* This hospital is tobacco-free, in all forms. Please discuss nicotine substitutes with your physician if you smoke.

* In order to provide additional safety on the unit, please return your silverware, both metal and plastic, to the assigned staff for proper handling after all mealtimes and snacks.

Flagstaff Medical Center
Northern Arizona Healthcare

Personal belongings such as cell phones, purses, and jackets will not be permitted on the unit at any time for the safety of all persons.

FMC Behavioral Health Services

1200 N Beaver St. (2nd Floor West Campus)
Flagstaff, AZ 86001
(928) 213 – 6300

ADULTS AND ADOLESCENTS
Daily Schedule

9:00 – 10:00 am	Phone and Visitation
2:00 – 3:00 pm	Phone hours
6:30 – 8:00 pm	Phone and Visitation
8:30 – 9:30 pm	Phone hours

At staff discretion

Appointment Date: _____ Counselor: _____ Time: _____

Please note that a Voluntary Admission to Flagstaff Medical Center Behavioral Health Services means that you understand the following:

- **You are being admitted to a locked inpatient psychiatric behavioral health facility.**
- **You agree to remain in the hospital unit until you and your psychiatrist mutually agree you are ready to leave. The average length of stay last 7 – 10 days.**
- **Your psychiatrist may recommend medications as part of your treatment.**
- **You agree to participate in our treatment program.**

Packing List for Behavioral Health Services

ITEMS TO BRING TO THE HOSPITAL:

No more than three changes of clothes (we have laundry facilities and provide all linens). All clothing must be in good repair. This should include:

Comfortable pants, such as jeans or sweats without drawstrings
Socks
Sleepwear
Underwear – Bras without underwires
Slip-on shoes
Basic toiletries such as shampoo, conditioner, lotion, comb or toothbrush & deodorant

PROHIBITED ITEMS

For health and safety reasons, all patients and patient belongings must be searched carefully.

Weapons or tools
Items with removable metal parts such as spiral notebooks, paper clips, thumbtacks, staples, pens with metal clips
Items containing glass such as compacts, cosmetic bottles, vases
Provocative sleepwear or clothing
Clothing with lettering that refers to drugs, alcohol or has inappropriate messages
Blade style razors
Adolescent patients may not wear jewelry
Nutritional supplements and vitamins, unless approved by doctor or pharmacist
Products containing alcohol, such as mouthwash, skin care products or perfumes
Brushes, combs or picks with metal parts
Plastic bags and plastic wrap
Large scrunchies (hair ties)
Cords, ropes
Shoes with pointed toes, heavy boots, steel-toed boots
Money greater than $25.00
Food from outside places other than the hospital
Compact discs, headphones, disc / tape players, cell phones & computers
Baseball caps, beanies, bandanas
Sunglasses

Any prohibited items or extra items will be inventoried and sent home with your family or will be stored.

Any exceptions to the items listed above will be at the discretion of the Treatment Team.

Visitors: Please leave all valuables, purses, backpacks and coats locked in your car.

PHONE CONTACTS

ARIZONA DEPT OF HEALTH SERVICES (ADHS) (602) 364-4558
150 N. 18th Avenue 2nd Floor
Phoenix, AZ 85007

NORTHERN ARIZONA REGIONAL BEHAVIORAL HEALTH AUTHORITY
(NARBHA) (928) 774-7128
1300 S. Yale St.
Flagstaff, AZ 86001

NAVAJO REGIONAL BEHAVIORAL HEALTH AUTHORITY (928) 871-6235
PO Box 2505
Window Rock, AZ 86515

CHILD PROTECTIVE SERVICES (CPS) (928) 779-3681
397 Malpais Lane, Suite 8
Flagstaff, AZ 86001

ADULT PROTECTIVE SERVICES (APS) (928) 779-2731
397 Malpais Lane
Flagstaff, AZ 86001

ARIZONA CENTER FOR DISABILITY LAW (800) 927-2260
3829 n. Third Street Suite 209
Phoenix, AZ 85012

OFFICE OF HUMAN RIGHT ADVOCATES (602) 364-4585
150 N. 18TH Ave. 2nd Floor
Phoenix, AZ 85007

FLAGSTAFF MEDICAL CENTER: BEHAVIORAL HEALTH SERVICES
Inpatient (928) 213-6300
1200 N Beaver St.
Flagstaff, AZ 86001

FMC: BHS INTAKE (928) 214-3937

FMC: BHS OUTPATIENT (928) 213-6400

FMC: BHS PATIENT GRIEVANCE (928) 213-6300