Welcome to Geriatric Solutions

Thank you for choosing Geriatric Solutions to partner in caring for your medical needs. It is our privilege to provide you medical care in the comfort of your own home. Our team will also coordinate in-home lab draws, X-ray services, home healthcare and some specialists, as needed. Our after-hours team of nurses and on-call providers make it possible to contact our care team 24/7 for any urgent needs outside our normal office hours of 8 a.m.–5p.m. Monday–Friday.

This welcome packet includes information about our practice and patient registration forms to help us provide the best care possible. We encourage you to ask any questions or share your concerns with us. We look forward to providing you with exceptional medical care. Please do not hesitate to call our office if you have any questions at (602) 954-0444 or visit our website at geriatricsolutions.org.

Thank you again for choosing Geriatric Solutions and welcome to our practice.

To make an appointment with Geriatric Solutions

- Complete Patient Registration so we have the information to best care for you.
- Attach a copy of all of your insurance cards (primary and secondary).
- If applicable, attach a copy of your Medical Power of Attorney (MPOA) documents.
- If applicable, attach a copy of your medication list.
- If available, attach a copy of your most recent medical records.
- Return all of the above via DocuSign email, fax to (602) 952-7146 or mail to Geriatric Solutions at 1510 E. Flower St. Phoenix, AZ 85014.
- Call your insurance plan and notify them that Geriatric Solutions is your primary care provider (many plans require their members to notify a change in providers prior to approving services with a new primary care office).

Scheduled visits

- Once we receive your completed Patient Registration, we will schedule your first home visit and assign you a medical assistant who will coordinate any future healthcare needs.
- New patient visits can be scheduled approximately two to four weeks from receipt of your patient registration.
- A window of time for the visit is provided as patient visits vary in length and unexpected traffic conditions may cause delay.
- The office will confirm your home visit 24–72 hours prior.

Medications and refills

- You may call the office for medication refills.
- For 90- to 100- day scripts, please call the office when you have a 30-day medication supply remaining.
- Controlled substances/narcotics will only be processed 8 a.m.–4 p.m. Monday–Friday.

Hospital visits

- If you have a hospital visit, please notify our office so we can follow your care.
- Upon hospital discharge, please notify our office so we can follow up with a home visit.

PATIENT REGISTRATION

Patient name _____ SSN _____ ☐ Male ☐ Female

DOB (MM/DD/YYYY) _____ Patient phone number _____

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race? ☐ American Indian ☐ Asian ☐ Black/African ☐ American Pacific Islander ☐ White ☐ Decline to specify

Hispanic or Latino? ☐ Yes ☐ No ☐ Decline to specify

Preferred language _____ ☐ Translator required

Who will provide consent to treat? ☐ Patient ☐ MPOA* ☐ Guardian*

Who is the guarantor or responsible party? Name _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

PATIENT RESIDES

☐ Private home ☐ Group home ☐ Independent living facility ☐ Assisted Living Facility

Address _____ Unit/Room _____ Gate code _____ City _____ Zip _____

Facility name _____ Phone _____ Fax _____

Facility contact name _____ Phone _____ Email _____

MEDICAL POA/GUARDIAN INFORMATION

Name _____ Relationship _____

Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

**Note: POA/Guardian must provide legal documentation establishing the authority to act on the patient's behalf prior to signing consent and authorizations.*

INSURANCE INFORMATION

Primary insurance carrier _____ Policy ID _____

Group # _____ Subscriber name _____

Secondary insurance carrier _____ Policy ID _____

Group # _____ Subscriber name _____

Please include a copy of all Insurance Cards

ENROLLMENT CHECKLIST

☐ Completed Enrollment Form ☐ Medication List

☐ Insurance Cards ☐ POA/Guardianship Documents

GERIATRIC SOLUTIONS

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ACCEPTANCE & AUTHORIZATION OF GERIATRIC SOLUTIONS' POLICIES

Patient name _____ Date of birth _____

Legal representative name _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby permit Geriatric Solutions–HOV, LLC (GS) to use and disclose my Protected Health Information (PHI) to any third-party payor, or to any party involved in my healthcare. By signing this Authorization, I understand the following: (1) I have the right to revoke this Authorization by sending written notification to GS. Once GS receives the written revocation, this Authorization will be revoked, except to the extent that GS has already taken action in reliance upon this Authorization; (2) Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by

Federal or State Law; (3) This Authorization shall be enforced as long as I am a patient of this practice unless, I give written notice to revoke my Authorization; and (4) I have a right to refuse to sign or revoke this Authorization as GS may not condition treatment, payment, enrollment or eligibility for benefits based on whether the individual signs the Authorization.

I grant Geriatric Solutions – HOV, LLC (GS) permission to obtain all medical information (which may contain medication history, confidential HIV/AIDS-related information, communicable disease-related information, information relating to mental health and/or alcohol/drug use) that any healthcare provider or agency may have on record for the purpose of gathering your

medical history.

ACCEPTANCE OF GS POLICIES AND PROCEDURES

My signature indicates that I have received the Geriatric Solutions–HOV, LLC (GS) Patient Registration containing the Notice of Privacy Practices, Patient Family Bill of Rights, and Notice of Health Information Practices. I have had the opportunity to ask questions regarding the information prior to signing this agreement. I understand copies are available on the GS website and I may request additional copies.

AUTHORIZATION TO TREAT AND BILL

I hereby consent to evaluation and treatment as directed by Geriatric Solutions–HOV, LLC (GS) medical provider or his/her designee. If I am not the patient being treated, I am authorized to consent to treatment and billing for the patient identified on this form.

I request payment of authorized Medicare and/or insurance benefits to GS for any services provided for my care by their providers. I authorize any holder of my medical information to release all information necessary for Medicare/Medicaid services and other insurance companies I have listed, and its agents, to determine benefits payable for medical treatment received at GS. I authorize any holder of my medical information, including government, Medicare/Medicaid, primary care physicians and insurance companies, to release all information necessary to determine benefits payable for medical treatment.

NOTICE OF HEALTH INFORMATION PRACTICES

I hereby acknowledge that I received and read the Notice of Health Information Practices. I understand my healthcare provider participates in Health Current, Arizona's Health Information Exchange (HIE). I understand that my health information may be securely shared through HIE, unless I request, complete and return an Opt Out Form to GS. I understand if I opt out, no one will have access to that information through HIE, even in an emergency.

CONSENT TO RELEASE OF MEDICAL INFORMATION

I hereby authorize Geriatric Solutions–HOV, LLC to convey to any physician and/or medical facility directly involved with my care, my medical history, laboratory reports, X-rays and any other material services, consultations and treatments that I received while under the GS providers' care.

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CONSENT AGREEMENT FOR TELEHEALTH SERVICES

By signing this Agreement, you consent to Geriatric Solutions (referred to as "Provider", providing Telehealth services to you as described. You certify that you understand the potential benefits and risks to you of receiving such services, and possible alternatives. You certify that you are competent to consent to treatment, have had the opportunity to ask questions and have them answered, and that you consent to receive telehealth services from Geriatric Solutions and its providers.

AUTHORIZATION TO DISCUSS, RELEASE AND/OR OBTAIN MEDICAL INFORMATION

I hereby authorize GS to discuss my medical care, which may contain confidential HIV/AIDS information, communicable disease-related information, and information relating to mental health and/or alcohol/drug use, with the following individuals or organizations (i.e., relative/caregiver/case manager/group home):

Patient Name _____ Date of Birth _____

Legal representative Name _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

These authorization/acknowledgments cover all services rendered to me, or the patient I am signing for, today and all future dates of service. This document replaces and nullifies any previous designations made.

CONSENT TO TELEPHONE CALLS (INCLUDING CALLS TO MOBILE PHONE), EMAILS, AND TEXT MESSAGES

Geriatric Solutions – HOV, LLC (GS) and its affiliates use electronic communications methods to enhance communication and coordination efforts with our patients. By signing this consent, you are confirming your agreement to the following:

- I understand that by providing a telephone number or email address, I am giving GS the permission to contact me at that email or number (including via live, artificial, and automated calls, computer aided technology, prerecorded messages, and text messages, unless prohibited by applicable law).
- I understand that I may receive calls, emails and text messages regarding services, or other communications such as appointment reminders and confirmations, follow-up care reminders, and important health information provided by or on behalf of GS. I also acknowledge this means of communication is not considered secure for the transmission of private information.
- I understand that participation in the text (SMS) messaging service may involve standard messaging charges applied by my mobile service provider. (Please consult your mobile service provider regarding applicable fees and charges.)
- Please indicate who we should contact regarding scheduling appointments, scheduling changes, or appointment confirmations.
- Only once cell phone number can be selected for automated text appointment notifications.
- Only one email can be selected for automated appointment notifications.

YOU MAY SELECT MORE THAN ONE TYPE OF NOTIFICATION BELOW:

☐ Text (cell phone) _____ Name _____

☐ Call _____ Name _____

☐ Email _____ Name _____

Patient Sign Here (if no POA/Guardian)

Signature _____

Print Name _____

Date _____

POA/Guardian Sign Here**

Signature _____

Print Name _____

Date _____

*** Signee must submit Power of Attorney (POA) or Legal Guardianship documents with the enrollment packet.*

MEDICAL HISTORY

Patient name _____ Date of birth _____

Emergency contact name _____ Relationship _____

Emergency contact phone _____ Emergency Contact Email _____

Preferred Pharmacy (Name, Address/Phone/Fax)

_____

_____

ALLERGIES ☐ NO ALLERGIES

Drug/Food/Envronmental Allergies	**Allergic Reaction**

MEDICATIONS

Medications (please list all)	**Dose** (Mg., pill, etc)	**Times per day**

If you need more room to list medications, please write them on a blank sheet of paper with the required information

VACCINATION HISTORY

Last Tetanus Booster or TdaP	Last Pneumonia Vaccine
Last Flu Vaccine	Last COVID/COVID Booster
Last Zoster Vaccine (Shingles)	

HEALTH MAINTENANCE SCREENING TEST HISTORY

Echocardiogram	Date	Facility/Provider
Colonoscopy/Sigmoid	Date	Facility/Provider
Mammogram	Date	Facility/Provider
Eye Exam	Date	Facility/Provider
Bone Density/Dexa	Date	Facility/Provider

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SURGICAL HISTORY

Type (specify left/right)	Date	Location/Facility

SOCIAL HISTORY

Highest level of education completed	☐ Grade School ☐ High School ☐ College ☐ Post Graduate
How many adults live in the household?	☐ None ☐ Spouse ☐ Other _____
Do you have children? ☐ Yes ☐ No	If yes, how many? _____
Have you ever used tobacco?	☐ Yes ☐ No ☐ If yes, for _____ years.
What nicotine/tobacco product(s) do you use?	☐ Cigarette ☐ Chew ☐ Vape ☐ Patch ☐ Cigar ☐ Gum ☐ Other
Have you quit using nicotine products?	☐ Yes ☐ No ☐ If yes, cease date? _____
Do you use recreational drugs? (Marijuana,THC Products)	☐ Never ☐ Daily ☐ 1-2x/week ☐ 1-2x/month ☐ 1-2x/year
Do you drink alcohol?	☐ Never ☐ Daily ☐ 1-2x/week ☐ 1-2x/month ☐ 1-2x/year
What type of alcohol?	☐ Beer ☐ Wine ☐ Liquor # of Drinks/week _____
Do you exercise?	☐ Never ☐ Daily ☐ 1-2x/week For how long? _____

HOSPITALIZATIONS

Reason (last 2 years)	Date	Location/Facility

FAMILY MEDICAL HISTORY

☐ **No significant family history is known** ☐ **Adopted**

Check all that Apply

	Mother	Father	Brother	Sister		Mother	Father	Brother	Sister
Alcohol/Drug Abuse	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐
Emphysema (COPD)	☐	☐	☐	☐	Kidney Disease	☐	☐	☐	☐
Depression/Anxiety	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Bipolar/Suicidal	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Cancer Type _____	☐	☐	☐	☐
Early Death	☐	☐	☐	☐	Other	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

GASTROINTESTINAL TRACK	HEART	LUNGS	NERVOUS SYSTEM
☐ None ☐ Heartburn/Reflux/GERD ☐ Ulcers ☐ Irritable Bowel Syndrome ☐ Liver Disease/Cirrhosis ☐ Diverticulitis ☐ Constipation ☐ Hemorrhoids ☐ Other (Specify) _____	☐ Heart Attack ☐ Heart Failure ☐ High Blood Pressure ☐ Aortic Stenosis ☐ Angina ☐ High Cholesterol ☐ Heart Murmur	☐ None ☐ Asthma ☐ COPD/Emphysema ☐ Respiratory Disease ☐ Bronchitis ☐ Tuberculosis ☐ Pneumonia ☐ Aspiration Pneumonia	☐ None ☐ Dementia or Alzheimer's Disease ☐ Parkinson's Disease ☐ Stroke ☐ Epilepsy or seizures ☐ Neuropathy/nerve damage ☐ Depression ☐ Anxiety ☐ Other (Specify) _____

ENDOCRINE	EYE & EAR	PODIATRY	KIDNEY & URINARY TRACK
☐ None ☐ Thyroid overactive (high) ☐ Thyroid underactive (low) ☐ Diabetes ☐ Other (Specify) _____	☐ None ☐ Macular degeneration ☐ Cataracts ☐ Glaucoma ☐ Hearing loss ☐ Hearing aid ☐ Other (Specify) _____	☐ None ☐ Bunions ☐ Corns ☐ Hammertoes ☐ Plantar Fasciitis ☐ Warts ☐ Other (Specify) _____	☐ None ☐ Frequent Bladder Infections ☐ Kidney Disease ☐ Enlarged Prostate ☐ Urinary Incontinence ☐ Kidney Stones ☐ Other (Specify) _____

TUBES/LINES	BONES & JOINTS
☐ None ☐ Foley ☐ IVs ☐ Feeding Tube ☐ Other (Specify) _____	☐ None ☐ Gout ☐ Lower Back Pain ☐ Osteoporosis ☐ Arthritis (indicate location)) _____ ☐ Joint Pain (indicate location)) _____

OTHER PROVIDERS/SPECIALIST

Specialist	Name	Phone Number
Previous Primary Care Doctor		
Stomach Doctor/GI Doctor		
Heart Doctor/Cardiologist		
Brain Doctor/Neurologist		
Lung Doctor/Pulmonologist		
Kidney Doctor/Nephrologist		
Eye Doctor/Ophthalmologist/Optometrist		
Pain Doctor		
Cancer Doctor/Oncologist		

CONTROLLED SUBSTANCES AGREEMENT

Controlled substances such as opioids, benzodiazepines, muscle relaxers and others are often used as part of a broader plan to help manage painful conditions. Although they can be useful in some circumstances, these medicines carry risks of dangerous physical side effects and possible addiction. These are also medicines that can be misused for illegal purposes. Our providers follow federal and state laws relating to these medications, and practice according to professionally accepted standards for their safe use. This agreement is to help you and your caregivers understand our practice policies for the safe and effective use of controlled substances.

I UNDERSTAND THAT:

- The goal of my treatment is to manage pain and help me function at the best level possible. My provider may recommend stopping my medication and trying different therapies (including possibly seeing a pain management specialist), if it is not helping achieve this.
- I may become addicted to my medication, especially if there is a history of addiction in my family.
- My medicine may make me drowsy, and I should not drive after using it.
- My provider will check the state pharmacy monitoring website regularly, as required by law, and may speak to other providers caring for me about my medication use if necessary for my care.
- It is unsafe to use my medication with alcohol or street drugs, and if I do so, my provider may stop the medication.
- My provider may check samples of my blood or urine to make sure I am using my medication properly.
- If I have to stop my medicine, I must do it slowly or I may get very sick.
- Our office will only refill my medicine during regular office hours Monday–Friday, 8 a.m.–4 p.m. Refills will not be given after hours or on weekends. The office should be contacted at least 3 days before a refill is due.

I AGREE THAT:

- I am responsible for my medicine. I will not sell, share or trade my medicine and I will not take someone else's medicine.
- I will keep track of my medicine, keep it away from children and secure from individuals who may steal it.
- If my medicine is lost or used up sooner than prescribed, it may not be replaced early.
- I will not change my dose or how I take my medicine without first consulting my provider.
- I will inform my provider if I am having side effects from my medicine.
- I will get my medicine from only one pharmacy.
- I will get my medicine only from my Geriatric Solutions provider. Should I get a prescription from a different source (such as an ER), I will inform my provider immediately.
- I will work with my provider to find non-drug treatments that may help my condition.
- I may ask my provider should I have any questions about these policies or about my specific medicines.
- If I do not follow the policies outlined here, my provider may re-evaluate my treatment plan and recommend treatment for substance abuse/addiction, may refer me to pain management, may stop prescribing my medicine after safely tapering it, or may discharge me from the practice.

Patient name _____ Date of birth _____

Patient signature _____ Date _____

Patient representative signature _____ Date _____

(If patient unable to sign for themselves)

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

NOTICE OF PRIVACY PRACTICES

Geriatric Solutions (GS) is committed to maintaining the privacy and security of your protected health information and is required by law to do so. This notice describes the rights you have concerning your own health information. It also describes how we may use information about you and how we may disclose it to others outside of GS. We must follow the duties and privacy practices described in this notice and provide you a copy. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We will not use or share your information other than described without your written authorization. You may change your mind at any time by notifying us in writing.

WHAT ARE YOUR RIGHTS?

Limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or operational purposes. We are not required to agree to your request, and we may say "no" if it would affect your care. For example, if you pay for a service or healthcare item out of pocket in full, you can ask us not to share that information for the purpose of payment, or our operations with your health insurer. We will comply unless otherwise required by law.

Confidential communications: You have the right to request that we communicate with you in a specific way that you feel is more confidential. We will accommodate reasonable requests. For example, you may ask that we only call you at a specific phone number, send mail to a different address, or speak with you about your health in private.

Request information about you: You or your legally authorized representative are entitled to see or obtain an electronic or paper copy of your medical and billing information. We will provide a copy of your health information, usually within 30 days of your written request. We may charge a reasonable, cost-based fee. If a particular request has been denied, we will provide an explanation in writing.

Amend your medical record: If you see information about you in records created by us that you think is incorrect or incomplete, you may ask us to amend the records. You may submit a written request detailing your reason for the amendment. We will do our best to accommodate your request, but reserve the right to decline, if appropriate, but will tell you why in writing within 60 days.

Right to an accounting of certain disclosures: You have the right to request a written list of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with and why. We will include all disclosures except for those to carry out treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make) usually within 60 days. We will provide the first accounting at no charge, but we may charge a reasonable, cost-based fee for any additional requests within a 12-month period.

Right to a copy of this notice: You may obtain a copy of the current Notice of Privacy Practices on our website at geriatricsolutions.org. You can ask for an electronic or paper copy of this notice at any time.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: If you feel your privacy rights have been violated, you may contact our Civil Rights Coordinator in person or by mail, phone, fax, or email. You will not be retaliated against for filing a complaint.

Civil Rights Coordinator c/o Quality & Compliance Department
1510 E. Flower St., Admin Bldg. 1, Phoenix, AZ 85014
(602) 287-7077 (phone), (602) 636-5326 (fax), EMAILQualityandCompliance@hov.org

You can also file a complaint by sending a letter to:

U.S. Department of Health and Human Services, Office for Civil Rights
200 Independence Ave, SW, Washington, DC 20201
1 (877) 696-6775 (phone), hhs.gov/ocr/privacy/hipaa/complaints/

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HOW WILL WE USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU?

Your choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, tell us what you want us to do, and we will follow your instructions.

- **Family members and others involved in your care:** We may disclose limited information about you to a family member, caretaker, or friend who is involved in your care or payment for your care. You can tell us your choices about what we share.
- **Fundraising:** Many of our patients and families like to make contributions to support the care we provide. We may contact you to raise funds for this purpose. You have the right to opt out from receiving these communications.
- **Marketing or sale of your information:** We never share your information unless you give us written permission. We do not sell your information.

Our uses and disclosures: We typically use or share your health information in the following ways:

- **Treatment:** We may use your information to provide you medical services and supplies or share it with other professionals who are treating you. We use a Health Information Exchange (HIE) as a method to share, request, and receive electronic health information with other healthcare organizations for the purpose of coordinating your care. If you want to opt out of sharing your information, please contact us.
- **Payment:** Your health information may be used and disclosed to bill and get payment for the services and supplies we provide you. For example, we may give information about you to your health insurance plan, so that it will pay for your services.
- **Healthcare operations:** We use health information about you to manage your treatment and services, and to contact you directly. We may use and disclose information about you to improve the quality of care we provide to patients or for healthcare operations. For example, we may use your information to conduct quality-improvement activities; to obtain audit, accounting or legal services; or to conduct business management and planning.

How else can we share your information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information: hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Public health:** We may report certain medical information for public health purposes. For example, we are required by law to report births, deaths, and communicable diseases to the state. We may also need to report patient problems with medications or medical products to the manufacturer and to the FDA.
- **Public safety:** We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials or to the court in response to a search warrant or other court order. We may also disclose medical information to assist law enforcement officials in identifying or locating a person; to prosecute a crime of violence; and to report deaths that may have resulted from criminal conduct. We may report suspected abuse, neglect, or domestic violence. We may also disclose information about you to law enforcement officials and others to prevent a serious threat to health or safety.
- **Required by law:** We will share your information where required by any federal, state, or local law.
- **Organ and tissue donation requests:** Your information may be shared with organizations that handle organ procurement.
- **Medical examiner or funeral director:** We may disclose health information with a coroner, medical examiner, or funeral director when an individual dies, or if necessary, to carry out their duties prior to and in reasonable anticipation of an individual's death.
- **Workers' compensation, law enforcement, and other government requests:** We can share your health information (1) for workers' compensation claims; (2) for law enforcement purposes or with a law enforcement official; (3) with health oversight agencies for activities authorized by law; and (4) for special government functions such as military, national security, and presidential protective services.
- **Judicial or administrative proceedings:** We can share health information about you in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process.
- **Research:** We may use or disclose your information for research purposes. These research projects must go through a special process that protects the confidentiality of your information.

Uses and disclosures not described in this notice will be made only with your written authorization. You may revoke your authorization at any time by sending us a written request.

CHANGES TO THIS NOTICE

We may revise our practices concerning use and disclosure of all information, including your health information. The new notice will be available upon request in our office and on our website. Please contact us with any questions regarding this notice.

For more information: hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Effective Date: January 2019

PATIENT AND FAMILY BILL OF RIGHTS

Patients receiving care from Geriatric Solutions (GS) practice have the following rights and responsibilities:

Patient rights

- To be fully informed of my rights and receive this notice prior to initiation of care.
- To receive assistance from a family member, representative or other individual in understanding, protecting or exercising my rights.
- To be treated with consideration, respect and full recognition of my dignity and uniqueness regardless of my age, race, national origin, gender, sexual orientation, marital status, diagnosis, disability, religion or source of payment. To be free from any type of discrimination.
- To receive a copy of the agency's privacy practices.
- To have medical records and all information related to my care and treatment—including financial records—kept in confidence, the release of which requires written consent, except as otherwise permitted by law. To have all communications conducted in a confidential, private manner that I understand.
- To be free from mistreatment and/or abuse (verbal, psychological, physical, emotional, sexual or chemical); coercion, sexual assault, manipulation; seclusion; neglect or exploitation, including injuries from an unknown source and/or misappropriation of my property. To file a complaint against the agency without fear of retaliation.
- To inspect or have copies of my medical record, to amend my medical record if it is incomplete or inaccurate, to request restriction on disclosure of my medical record; to request an accounting of disclosures that have been made of my medical record beyond those made for treatment; payment or normal agency operations; and to submit grievances without fear of retaliation.
- To be included in decisions regarding care, including implementation of an individualized plan of care.
- To have my pain and other symptoms taken seriously, assessed and managed to the level that I define.
- To have services provided by skilled, licensed, compassionate professionals.
- To exercise my religious beliefs.
- To have my property respected.
- To make my own healthcare decisions, including the right to refuse treatment; to refuse to participate in experimental research or be photographed; to be informed about healthcare directives and to withdraw from GS services at any time.
- To receive information about the scope of services that GS provides and specific limitations of those services.

GERIATRIC SOLUTIONS

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Patient responsibilities

- To provide to the best of my knowledge, accurate and complete health information, including past illnesses, hospitalizations, medications or other matters related to my health.
- To report unexpected changes in my condition and to report to my GS team the effectiveness of pain and symptom management.
- To provide the agency with copies of my healthcare directives.
- To assist agency staff in maintaining a safe environment for my care.
- To show respect and consideration for GS staff and property.
- To speak up if I have questions about the healthcare I am receiving.
- To participate in developing my plan of care and treatment, and to comply with that plan.
- To appoint a medical power of attorney.

NOTICE OF NON-DISCRIMINATION

Geriatric Solutions complies with applicable Federal civil rights laws and State of Arizona compliance regulations and does not discriminate on the basis of race, color, national origin, religion, age, sex, gender, sexual orientation, marital status, disability or diagnosis. All individuals have the right to access health programs without facing discrimination.

AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

Geriatric Solutions

Provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator at EMAILQualityandCompliance@hov.org or (602) 287-7077.

Grievance Process

If you believe that Geriatric Solutions has failed to provide these services or discriminated in another way, you may file a grievance with our Civil Rights Coordinator in person or by mail, phone, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

Civil Rights Coordinator c/o Quality & Compliance Department
1510 E. Flower Street, Admin Bldg. 1
Phoenix, AZ 85014
(602) 287-7077 (phone), (602) 636-5326 (fax), EMAILQualityandCompliance@hov.org

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave, SW, Room 509F, HHH Building
Washington D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at the Department of Health and Human Services Office for Civil Rights at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Geriatric Solutions's website: geriatricsolutions.org

GERIATRIC SOLUTIONS

1510 E. Flower St. Phoenix, AZ 85014 (602) 954-0444 FAX (602) 952-7146 **geriatricsolutions.org**

A program of Hospice of the Valley

QC 6556 | 08.24

AVAILABILITY OF LANGUAGE ASSISTANCE, AUXILIARY AIDS AND SERVICES

0. English	ATTENTION: If you speak [insert language], free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-602-287-7077 or speak to your provider.
1. Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-602-287-7077 o hable con su proveedor.
2. Navajo Diné	SHOOH: Diné bee y1ni[ti'gogo, saad bee an1'awo' bee 1ka'an7da'awo'7t'11 jiik'eh n1 h0l=. Bee ahi[hane'go bee nida'anish7 t'11 1kodaat'4h7g77 d00 bee 1ka'an7da'wo'7 1ko bee baa hane'7 bee hadadilyaa bich'8' ahoot'i'7g77 47 t'11 jiik'eh h0l=. Kohj8' 1-602-287-7077 hod7ilnih doodago nika'an1lwo'7 bich'8' hanidziih.
3. Chinese 中文	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提 供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-602-287-7077 或咨询您的服务提供商。
4. Vietnamese Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-602-287-7077 hoặc trao đổi với người cung cấp dịch vụ của bạn.
5. Arabic العربية	انتبه: إذا كنت تتحدث اللغة العربية، فستكون هناك خدمات مساعدة لغوية مجانية متاحة لك. كما تتوفر أيضًا مساعدات وخدمات مساعدة مناسبة لتقديم المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل على الرقم 1-602-287-7077 أو تحدث إلى مقدم الخدمة الخاص بك.
6. Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-602-287-7077 o makipag-usap sa iyong provider.
7. Korean 한국어	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-602-287-7077 번으로 전화하거나 서비스 제공업체에 문의하십시오.
8. French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-602-287-7077 ou parlez à votre fournisseur.
9. German Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-602-287-7077 an oder sprechen Sie mit Ihrem Provider.
10. Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-602-287-7077 или обратитесь к своему поставщику услуг
11. Japanese 日本語	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための 適切な補助支援やサービスも無料でご利用いただけます。1-602-287-7077 までお電話ください。または、ご利用の事業者にご相談ください
12. Persian (Farsi) فارس	توجه: اگر فارسی صحبت می کنید، خدمات کمک زبان رایگان در اختیار شما قرار می گیرد. خدمات کمکی و کمکی مناسب برای ارائه اطلاعات در قالب های قابل دسترس نیز به صورت رایگان در دسترس هستند. با شماره 1-602-287-7077 تماس بگیرید یا با ارائه دهنده خود صحبت کنید.
13. Syriac (Assyria) ܣܘܪܝܐ (ܐܬܘܪܝܐ)	[illegible] 1-602-287-7077 [illegible].
14. Serbo-Croatian српско-хрватски	ПАЖЊА: Ако говорите српскохрватски, на располагању су вам бесплатне језичке услуге. Бесплатна су и одговарајућа помоћна помагала и услуге за пружање информација у приступачним форматима. Позовите 1-602-287-7077 или разговарајте са својим провајдером.
15. Thai ไทย	หมายเหตุ: หากคุณใช ◌้ภาษา ไทย เรามีบริการความช ◌่วยเหลือด ◌้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและ ◌ บริการช ◌่วยเหลือเพื่อให ◌้ข ◌้อมูลในรูปแบบที ◌่ ◌ เข ◌้าถึงได ◌้โดยไม่เสียค่าใช ◌้จ่าย โปรดโทรติดต่อ 1-602-287-7077 หรือปรึกษาผู ◌้ให ◌้บริการของคุณ

healthcurrent

Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

How does Health Current help you to get better care?
In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

What health information is available through Health Current?
The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at healthcurrent.org/permitted-use.

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

Does Health Current receive behavioral health information and if so, who can access it?
Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

How is your health information protected?
Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

Your Rights Regarding Secure Electronic Information Sharing

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.

2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.

3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:

1. Except as otherwise provided by state or federal law, you may "opt out" of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.

2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.

3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.