PHOENIX CHILDREN'S Hospital®

Medical and Financial Treatment Agreement (Conditions of Admission)

Apply Patient Label

This Medical and Financial Treatment Agreement (Conditions of Admission) is an important document. This Agreement is a contract between Phoenix Children's Hospital ("PCH") and the person signing below ("Undersigned"). This Agreement covers any services provided at any PCH inpatient or outpatient facility.

Patient named above is admitted to PCH for treatment. Here are the terms and conditions:

1) **MEDICAL TREATMENT:** Patient consents to the treatment and procedures performed during this hospitalization or on an outpatient basis, which may include, but are not limited to, physician and other licensed practitioners' services, nursing services, laboratory procedures and tests, medical and surgical treatments or procedures, anesthesia, radiologic and diagnostic examinations, emergency treatment, state-mandated screenings, and other hospital services provided under the general or specific instructions of Patient's physician and other licensed practitioners or as required by PCH policy. Specific consent forms such as surgical and anesthesia consent may also be needed. In certain situations, some tests may be performed without a separate consent. All female patients age 11 or older, and younger female patients who could become pregnant will get a pregnancy test at the time of inpatient admission and before potentially harmful outpatient procedures or tests. For outpatient visits, follow-ups, or ongoing treatment of the same type, this agreement is effective for one (1) year from the date signed below. For inpatient, observation, procedures or hospital testing, this agreement is effective for this visit.

2) **RELATIONSHIP BETWEEN PCH AND PHYSICIANS/OTHER LICENSED PRACTITIONERS:** Patient will be treated under the care and supervision of Patient's attending physician and other licensed practitioners. Some of the physicians, other licensed practitioners and other health care providers who give services to Patient are not employees or agents of PCH, but are independent contractors or independent providers who have privileges to use PCH facilities to care for and treat patients. Independent contractors and independent providers are responsible for their own treatment activities and PCH is not liable for their acts or omissions.

3) **PHYSICIAN AND OTHER LICENSED PRACTITIONERS' BILLS:** Patient's physicians and other licensed practitioners may bill separately from PCH. Physicians and other licensed practitioners may or may not participate in the same insurance plans as PCH. This could affect the payment made by Patient's insurance to physicians/licensed practitioners who do not participate in Patient's insurance plan. By signing this Agreement, Undersigned is responsible for all physicians/licensed practitioners' bills, separate from what is owed to PCH.

4) **HOSPITAL-BASED OUTPATIENT FACILITIES:** Services provided in PCH's outpatient facilities may be billed as hospital-based services and billed separately or jointly by the hospital, physician and/or other providers. Undersigned must pay for billed services as determined by Patient's insurance or other benefit plan.

5) **GENERAL DUTY NURSING:** PCH provides general duty nursing care. If Patient needs special or private duty nursing care, it must be arranged by Patient and the treating physician. PCH is not responsible for the lack of special or private duty nursing beyond the care that PCH and the treating physician determine is medically necessary.

6) **MONEY, VALUABLES AND PERSONAL ITEMS:** Money, valuables and personal items should be sent home when possible. PCH has a safe in which Patient may store money or small valuables upon request. PCH's maximum liability in case of loss or damage for items placed in PCH's safe is $500.00. PCH is not responsible for any loss or damage to items not deposited in the safe, including, but not limited to, money, glasses, wallets, purses, watches, jewelry, electronic devices, keys, clothing, toys, stuffed animals, and other personal items.

7) **WEAPONS/EXPLOSIVES/DRUGS:** Weapons of any kind, explosive devices, illegal substances or drugs, alcohol and other contraband may not be brought onto PCH property. If the presence of such items is suspected, PCH may search Patient's room and belongings. These items will be taken and disposed of as appropriate, including delivery to law enforcement.

8) **TEACHING PROGRAMS:** PCH participates in programs for training of health care providers. Services may be observed and/or provided to Patient by persons in training under the supervision and instruction of physicians or other health care providers.

9) **RELEASE OF INFORMATION:** PCH may disclose all or any part of Patient's medical and/or financial records necessary, as allowed by law and/or PCH's Notice of Privacy Practices.

10) **RIGHTS AND RESPONSIBILITIES:** PCH's Patient and Family Rights pamphlet explains Patient and his/her family's rights and responsibilities, including who to contact if there is a concern. Please read the pamphlet for more information.

11) **RECORDINGS:** PCH may record still images, photos, video and audio of Patient for the following purposes: diagnostic and surgical procedures for treatment, patient identification, patient safety, documenting Patient's condition, quality improvement and risk management activities, education, training and certain scientific and research activities. Such photos and recordings will be used or disclosed only as allowed by law and/or PCH's Notice of Privacy Practices. Digital video recording (DVR) of trauma/medical resuscitations may be performed for quality improvement or educational purposes, and will be used only for those purposes.

12) **ASSIGNMENT OF BENEFITS**: If Patient is entitled to receive benefits from insurance, Medicare or Medicaid plans, including AHCCCS plans, and/or a third party, Patient assigns any and all benefits to PCH and all other providers of services to Patient. This assignment of benefits allows PCH, physicians/licensed practitioners and any other health care provider to be paid directly by Patient's benefit plan to be applied to Patient's bill(s). Undersigned, or the insured party, if applicable, is responsible for paying Patient's bill and any insurance deductibles and copayments regardless of this assignment.

13) **LIEN RIGHTS:** If services are provided as a result of an accident or the negligent or wrongful acts of a third party, PCH, physicians/licensed practitioners and any other health care provider providing services to Patient has the right to assert a lien against any judgment, damages or settlement that Patient receives from liable third parties or their insurers as allowed by law.

14) **FINANCIAL AGREEMENT:** In return for the services provided to Patient, Undersigned, or the insured party, if applicable, is responsible for paying Patient's bills and/or making payment arrangements prior to discharge satisfactory to PCH and all other providers of services to Patient. Prior authorization does *not* guarantee payment and there may be items or services that are not covered by Patient's insurance or other benefit plan. Undersigned is responsible for paying PCH's usual and customary charges, as filed annually with the Arizona Department of Health Services and available for inspection upon request. Each patient may be required to pay a different amount for services rendered based upon the terms of the patient's insurance or other benefit plan, or lack of coverage. Undersigned agrees to cooperate with PCH to obtain necessary insurance or other benefit plan authorizations. If the bill is not timely paid, Undersigned is responsible for paying reasonable attorney fees and collection expenses, and may be charged interest at the legal rate from the date of Patient's discharge until payment in full. This provision and the bold, capitalized language below will not apply in the event patient is in state custody or foster care.

15) **CONTACT:** PCH and its authorized agents have permission to contact the Undersigned at any telephone number associated with the account, including cellular telephone numbers, which could result in charges, for the purpose of appointment reminders, scheduling and collection of payment for services. Methods of contact may include text messages, use of pre-recorded or artificial voice messages, and use of an automatic dialing system.

IT IS UNDERSTOOD THAT THE UNDERSIGNED AND PATIENT ARE PRIMARILY RESPONSIBLE FOR PAYMENT OF PATIENT'S BILL. IN GRANTING THE ADMISSION OR RENDERING TREATMENT, PCH IS RELYING ON THIS AGREEMENT TO PAY THE ACCOUNT. EMERGENCY CARE WILL BE PROVIDED WITHOUT REGARD TO THE ABILITY TO PAY.

(Please Initial) _____ I have received a copy of the "Patient and Family Rights" pamphlet.

(Please Initial) _____ I have received a copy of the "Notice of Privacy Practices".

(Please Initial) _____ I have received a copy of the "Notice of Health Information Practices".

Undersigned certifies that:
(1) I have read and understand both sides of this Medical and Financial Treatment Agreement (Conditions of Admission);
(2) I am the patient or I am a legally authorized representative of Patient and authorized to sign this Agreement on behalf of Patient;
(3) I have had an opportunity to have any of my questions about this Agreement answered; and
(4) I agree to all terms in this Agreement.
(5) I have read and understand the Notice of Health Information Practices regarding my provider's participation in The Network, the statewide Health Information Exchange (HIE), or previously received the information and decline another copy.

_____ _____

Signature of Patient / Legally Authorized Representative of Patient | Witness

* Please check the box indicating this person's authority to act as the patient's Legally Authorized Representative:
[ ] Biological or adoptive parent
[ ] Legal Guardian*
[ ] Delegation of Authority*
[ ] Foster Parent*
[ ] Health Care Power of Attorney*
[ ] Mental Health Care Power of Attorney*
[ ] The patient is age 18 or older and does not have the capacity to make health care decisions or is being admitted in an emergency, and I have the following relationship with patient: _____
[ ] Other (explain): _____

***Valid documentation must be provided**

_____ _____ _____

Signature of Person Completing This Form | Printed Name | Date/Time

_____ _____ _____

Witness' Signature | Witness' Printed Name | Date/Time

PHOENIX CHILDREN'S *Medical Group*®

IMMUNIZATION SCREENING AND CONSENT

Apply Patient Label

A) Does not have health insurance_____ B) Enrolled in AHCCCS _____ C) An American Indian or Alaskan Native _____ D) Patient does NOT qualify for VFC because he/she has health insurance that covers vaccines____

***Please inform us if your health insurance does not cover vaccines, we will direct you to the appropriate deputized facility.**

Patient or Legally Authorized Representative Signature_____

Printed Name: _____ Date & Time: _____

IMMUNIZATION SCREENING INFORMATION

Is the PATIENT being immunized:	**YES**	**NO**
a. Sick with something more serious than a minor illness?	_____	_____
b. Have a history of recent or recurrent wheezing?	_____	_____
c. Ever had a reaction after an immunization that required a doctor's visit or hospitalization?	_____	_____
d. Allergic to neomycin or streptomycin?	_____	_____
e. Ever had an allergic reaction to eggs or gelatin?	_____	_____
f. Ever had an allergic reaction after receiving the flu vaccine?	_____	_____
g. Received Gamma Globulin or V-ZIG in the past 6 months?	_____	_____
h. Pregnant or planning to become pregnant in the next 3 months?	_____	_____
i. Received any Blood products in the past 6 months?	_____	_____
j. Have any of the following conditions:		
- Chronic problems with the heart or lungs, including asthma?	_____	_____
- Chronic problem such as diabetes, kidney disease, blood disorder (such as sickle cell anemia), or a low immune system	_____	_____
- Unable to handle his/her secretions (such as cerebral palsy, seizures or intellectual disability)	_____	_____
- Long-term aspirin therapy	_____	_____
k. Lives in a HOUSEHOLD, that has any of the following conditions:		
- HIV positive or AIDS	_____	_____
- Infections due to Immunity problems	_____	_____
- Treatment for Cancer	_____	_____
- Leukemia	_____	_____
- Taking Steroid or Cortisone medication	_____	_____
- Had an Organ Transplant	_____	_____

Patient or Legally Authorized Representative Signature: _____

Printed Name: _____ Date & Time: _____

IMMUNIZATION CONSENT FORM

_____I have been provided a copy of the appropriate Center for Disease Control and Prevention Vaccine Information Sheet(s) and have read, or have had explained to me, information about the diseases and vaccines listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) cited, and ask that the vaccine(s) listed below (including appropriate combination vaccines) be given to the patient named above, for whom I am authorized to make this request.

_____I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me or to the person for whom I am authorized to consent to the Arizona State Immunization Information System (ASIIS), other health care providers, and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunization have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

DT/Td/TdaP _____ DtaP_____ HIB _____ IPV_____ PCV-13_____ PPV23_____

ROTAVIRUS _____ HEP B _____ HEP A _____ VARICELLA_____ MMR_____

HPV _____ MENACTRA _____ FLU 6 – 35MO _____ FLU 36MO+ _____

FLUMIST _____ OTHER (COMBINATION VACCINES)_____

Patient or Legally Authorized Representative Signature: _____

Printed Name: _____ Date & Time: _____

PHOENIX CHILDREN'S *Medical Group*®

SCREENING QUESTIONS FOR FLU VACCINE ADMINISTRATION

Apply Patient Label

Has your child received his/her flu shot this season? Yes ☐ When? _____ No ☐

If interested in receiving a flu shot today, please answer the questions below.

1. Has your child ever had a serious reaction to eating eggs or after receiving a previous dose of flu vaccine? Yes ☐ No ☐
2. Does your child have a history of recent or recurrent wheezing? Yes ☐ No ☐
3. Does your child have any of the following conditions?
   - Chronic problems with the heart or lungs, including asthma Yes ☐ No ☐
   - A chronic problem such as diabetes, kidney disease, blood disorder (such as sickle cell anemia), or a low immune system Yes ☐ No ☐
   - A condition that causes the child to be unable to handle her/her secretions (such as cerebral palsy, seizures or intellectual disablitiy Yes ☐ No ☐
   - Long-term aspirin therapy Yes ☐ No ☐
   - Pregnancy Yes ☐ No ☐
4. Is your child sick today? Yes ☐ No ☐
5. Has your child ever received flu vaccine before? Yes ☐ No ☐

I acknowledge that the administration of flu vaccine today is dependent upon my accurate answer(s) to the above questions.

_____ _____

Signature of Patient/Legally Authorized Representative Date

_____ _____

Printed Name of Patient/Legally Authorized Representative Relationship to Patient

*** * * FOR OFFICE USE ONLY * * ***

Physician Order

☐ Give 0.25 ml of trivalent inactivated flu vaccine IM (≤ 36 months)

2nd dose in 1 month ☐

OR

☐ Give 0.5 ml of trivalent inactivated flu vaccine IM (> 36 months)

2nd dose in 1 month ☐

_____ _____ _____

Practitioner Signature Date Time

_____

Practitioner Printed Name

PCH10509 (Rev. 2 (10/2017))

PHOENIX CHILDREN'S Hospital

Notice of Health Information Practices

healthcurrent

You are receiving this notice because your health care 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 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 and population health services.

You 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. 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.

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 federally-assisted 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 the 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.

PHOENIX CHILDREN'S Hospital®

Notice of Health Information Practices

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. Contact your health care provider and you can get a copy within 30 days.

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. Contact your healthcare provider and you can get a copy within 30 days. 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 3, section 3802 to keep your health information from being shared electronically through Health Current:

1. You may "opt-out" of having your information available for sharing through Health Current. To opt-out, ask your healthcare provider for the Opt Out Form. After you submit the form, your information will not be available for sharing through Health Current.
   Caution: If you opt out, your health information will NOT be available to your healthcare providers even in an emergency.

2. You may exclude some information from being shared. For example, if you see a doctor and you do not want that information shared with others, you can prevent it. On the Opt Out Form, fill in the name of the healthcare provider for the information that you do not want shared with others.
   Caution: If that provider works for an organization (like a hospital or a group of physicians), all your information from that hospital or group of physicians may be blocked from view.

3. If you opt out today, you can change your mind at any time by completing an Opt Back In Form that you can obtain from your healthcare provider.

4. 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 INFORMATIONMAY BE SECURELY SHARED THROUGH HEALTH CURRENT

Not Part of the Medical Record

PHOENIX CHILDREN'S Hospital

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 INFORMATON. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your medicalinformation, and are required by law to do so. This Notice describes how we may use your medical information within Phoenix Children's Hospital and its Outpatient Clinics, Ambulatory Surgery Centers, Outpatient Treatment Centers, and Urgent Care Centers ("PCH"), and how we may disclose it to others. This Notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

HOW WILL WE USE AND DISCLOSE YOUR MEDICAL INFORMATION?

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurse practitioners, nurses, medical and nursing students, technicians, technologists, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care. For example, we will allow your physician to have access to your PCHmedical record to assist in your treatment at PCH and for follow-up care.

We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Patient Directory: In order to assist family members and other visitors in locating you while you are in the Hospital, the Hospital maintains a patient directory. This directory includes your name, room number, your general condition (such as fair, stable, or critical), and your religious affiliation (if any). We will disclose this information to someone who asks for you by name, although we will disclose your religious affiliation only to clergy members. If you do not want to be included in the Hospital's patient directory, please speak with the Hospital Admitting Department.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. If you do not wantPCH to disclose your medical information to family members or others, please speak with the PCH Department Manager at the time of your visit.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or Health Insurance Company may ask to see parts of your medical record before they will pay us for your treatment.

Health Care Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run health care operations. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate whether PCH personnel, your doctors, or other health care professionals did a good job.

Fundraising: Many of our patients like to make contributions to support the care provided by PCH. PCH may use and disclose medical information to contact you in the future to raise money for this purpose. If you do not want PCHor its Foundation to contact you for fundraising, please notify the PCH Foundation in writing at 2929 East Camelback Road, Phoenix, Arizona 85016.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information.

Required by Law: Federal, state, or local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases. We also are required to give information to the Arizona Workers' Compensation Program for work-related injuries.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State of Arizona. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at PCH. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include governmentregulatory agencies that oversee PCH or its personnel, such as the Arizona Department of Health Services, the federal agencies that oversee Medicare,or licensing agencies who govern physicians and other health care professionals. These agencies need medical information to monitor PCH's compliance with state and federal laws.

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

PHOENIX CHILDREN'S Hospital

NOTICE OF PRIVACY PRACTICES

Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. PCH may also disclose medical information to federal officials for intelligence and national security purposes or for presidential Protective Services.

Judicial Proceedings: PCH may disclose medical information if PCH is ordered to do so by a court or if PCH receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, PCH is required to get your permission before disclosing that information to others in many circumstances.

Other Uses and Disclosures: Unless permitted by law, we will not sell your information to a third party, use your medical information for marketing purposes, or use and disclose most psychotherapy notes without your permission. If you give your permission, you may take back that permission any time, unless we have already relied on your permission to use or disclose the information. If you want to revoke your permission, please notify the Health Information Management Department.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information whether in paper or electronic format. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, please contact the Health Information Management Department. If requested, and the medical information is maintained electronically, PCH will provide the information if readily producible or in a readable electronic format mutually agreed upon. If you request a copy of your information, we may charge you for our costs to copy the information. We will tell you in advance what this copying will cost. You can look at your record at no cost.

Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, please contact the Health Information Management Department.

Right to Get a List of Certain Disclosures of Your Medical Information: You have the right to request a list of many of the disclosures we make of your medical information. If you would like to receive such a list, please contact the Health Information Management Department. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How PCH Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to ask us not to make uses or disclosures of your medical information to treat you, to seek payment for care, or to operate PCH. We are not required to agree to your request, but if we do agree, we will comply with that agreement. If you want to request a restriction, please contact the Health Information Management Department.

Right to Receive Confidential Communications: You have the right to ask us to communicate with you by an alternate method or at an alternate location if you tell us that our usual methods of communicating with you might place you in danger. For example, you can ask us not to call your home, but to communicate only by mail or to call you only on your mobile phone or send mail to your work address instead of your home address. If you want to request a restriction, please contact the PCH Privacy Officer.

Right to Receive a Notification of a Breach: You have the right to be notified if your unsecured medical information is inappropriately accessed or disclosed by PCH, except when there is a low probability that the information has been compromised.

Right to Restrict Disclosures of Your Medical Information to Health Plans: If you paid out of pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. If you want to request this restriction, please contact the Health Information Management Department.

Right to a Paper Copy: If you have received this Notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the Notice from our web site, at www.phoenixchildrens.com <http://www.phoenixchildrens.com>, or you may obtain a paper copy of this Notice at any PC the PCH Admitting Office, or the Health Information Management Department.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current Notice of Privacy Practices at any time by visiting the Phoenix Children's Hospital's web site at www.phoenixchildrens.com <http://www.phoenixchildrens.com> or by stopping by any PCH facility.

PHOENIX CHILDREN'S Hospital®

NOTICE OF PRIVACY PRACTICES

WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE?
This Notice of Privacy Practices applies to Phoenix Children's Hospital and its Outpatient Clinics, ambulatory Surgery Center, Outpatient Treatment Centers, and Urgent Care Centers and their personnel, volunteers, students, and trainees. The Notice also applies to the Medical Staff of Phoenix Children's Hospital, which is composed of physicians, nurse practitioners, physician assistants, therapists, other health care providers who may not be employees of PCH but who come to PCH to provide care to PCH patients. The notice also applies to emergency service personnel, medical transportation personnel, and medical equipment suppliers and others involved in your care at PCH. PCH may share your medical information with these providers for their treatment purposes, to get paid for treatment, or to conduct health care operations. These health care providers will follow this Notice for information they receive about you from PCH. These other health care providers may follow different practices at their own offices or facilities.

DO YOU HAVE CONCERNS OR COMPLAINTS?

Please tell us about any problems or concerns you have with your privacy rights or how PCH uses or discloses your medical information. If you have a concern, please contact the PCH Privacy Officer in writing at 1919 East Thomas Road, Phoenix, Arizona 85016 or by telephone at (602) 933-1964.

If for some reason PCH cannot resolve your concern, you may also file a complaint with the Secretary of Health and Human Services. We will not penalize you or retaliate against you in any way for filing a complaint with PCH or the Secretary of Health and Human Services.

DO YOU HAVE QUESTIONS?

PCH is required by law to give you this Notice and to follow the terms of the Notice that is currently in effect. If you have any questions about this Notice, or have further questions about how PCH may use and disclose your medical information, please contact the PCH Privacy Officer in writing at 1919 East Thomas Road, Phoenix, Arizona 85016 or by telephone at 602-933-1964.

Effective date: September 20, 2013