PATIENT REGISTRATION

Patient Name: ______________________________ Birth Date: __________ Age: _____ Gender: M F

Permanent Address: ______________________________ City: ______________ State: ________ Zip: _________

Secondary Address: ______________________________ City: ______________ State: ________ Zip: _________

Primary Phone: ______________________________ Secondary Phone: ______________________________

Email: ______________________________ Marital Status: Single Married Divorced Widow/Widower

Patient SSN: ____________________ Employment Status: Full time Part time Unemployed Retired Disabled

Race: ____________________ Ethnicity: ____________________ Preferred Language: ____________________

Patient Employer: ______________________________ Business Phone: ______________________________

Business Address: ______________________________ City: ______________ State: ________ Zip: _________

Resident of Care Facility? No Yes Name: ______________________________ Phone: ____________________

Referring Doctor (Name & Phone#): ____

INSURANCE INFORMATION

Primary Insurance Co: ______________________________

Insurance Co. Address: ______________________________

Policy Holder Name: ______________________________

Policy Holder Sex: M F Policy Holder DOB: __________

ID# / SSN#: ______________________________

Relationship to Patient: ______________________________

Group / Policy#: ______________________________

Employer: ______________________________

Secondary Insurance Co: ______________________________

Insurance Co. Address: ______________________________

Policy Holder Name: ______________________________

Policy Holder Sex: M F Policy Holder DOB: __________

ID# / SSN#: ______________________________

Relationship to Patient: ______________________________

Group / Policy#: ______________________________

Employer: ______________________________

AUTHORIZATION, ASSIGNMENT AND RELEASE

I authorize ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY to perform evaluation and treatment, as they deem necessary. I further authorize my insurance company ______________________________ to pay ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY all medical benefits. I understand that ultimately I am responsible for all charges not covered by my insurance as well as all deductibles, co-insurance and co-pay amounts as determined by my insurance company. I, also, understand I will be responsible for all collection fees and all legal fees, if my account is placed with an outside collection agency.

I hereby authorize this office to release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

______________________________ ______________________________

SIGNATURE OF INSURED **DATE**

Patient Physician List

Patient Name:____

Date of Birth:____

Radiation Oncologist:____

Today's Date: ____

Referring Physician: ____

Specialty: ____

Phone/Fax: ____

Address: ____

City/State/Zip: ____

Primary Care Physician: ____

Specialty: ____

Phone/Fax: ____

Address: ____

City/State/Zip: ____

Other Physician: ____

Specialty: ____

Phone/Fax: ____

Address: ____

City/State/Zip: ____

Other Physician: ____

Specialty: ____

Phone/Fax: ____

Address: ____

City/State/Zip: ____

Patient Signature: ______________________________ **Date:** __________________

Virginia G. Piper Cancer Center
10460 N 92nd St, Ste 101
Scottsdale, AZ 85258
480-278-8300
F 480-922-5231

West Valley Office
14155 N 83rd Ave, Ste 127
Peoria, AZ 85381
623-773-2873
F 623-414-4922

Patient Health History

Full Name:____________________________ **Age:**_____ **Birth Date:**__________ **Today's Date:**____________

Who are you seeing for this appointment (circle one)? ***Dr. Ivor Benjamin*** ***Dr. Dennis R. Scribner, Jr.***

Marital Status:
☐ Single ☐ Married ☐ Significant Other ☐ Widowed ☐ Divorced

Employment Status:
☐ Currently Working (Occupation): ____________________ ☐ Retired ☐ Extended Leave of Absence

Do you have a living will? __________ Do you have a Medical Power of Attorney? _________
Please list the name of your Medical Power of Attorney_________________

Please check which following health issues are applicable to you:

☐ Diabetes (1, 2)
☐ High Cholesterol
☐ Heart Pacemaker
☐ Hepatitis
☐ Thyroid Problems
☐ Arthritis
☐ Glaucoma
☐ High Blood Pressure
☐ Asthma
☐ Emphysema
☐ Kidney Disease
☐ Depression
☐ Stroke
☐ Other Chronic Conditions (please list below):

____
____

Please indicate if you have any of the following skin conditions:
☐ Shingles ☐ Chicken Pox ☐ MRSA ☐ Other (specify): ________________________________

Which of the following describes you TODAY?

☐ Fatigue
☐ Headache
☐ Ringing in Ears
☐ Mouth Sores
☐ Sore Throat
☐ Wheeze
☐ Heart Palpitations
☐ Heartburn
☐ Diarrhea
☐ Trouble Walking
☐ Skin Sores
☐ Other __________________________
☐ Other __________________________
☐ Pain
☐ Dizziness
☐ Spots Before Your Eyes
☐ Bloody Nose
☐ Pain w/Swallowing
☐ Shortness of Breath
☐ Pacemaker
☐ Abnormal Bleeding
☐ Blood in Stool
☐ Poor Coordination
☐ Fever
☐ Hearing Loss
☐ Double Vision
☐ Runny Nose
☐ Sore Tongue
☐ Chest Pain
☐ Nausea
☐ Yellow Skin
☐ Numbness
☐ Difficulty Sleeping
☐ Other _________________________
☐ Other _________________________
☐ Sweats
☐ Wear Glasses
☐ Dentures
☐ Nasal Blockage
☐ Cough
☐ Oxygen Use
☐ Vomiting
☐ Constipation
☐ Weakness
☐ Rash/Itch

Please list all surgeries you have had:

Surgery	Age	Surgery	Age

Virginia G. Piper Cancer Center
10460 N 92nd St, Ste 101
Scottsdale, AZ 85258
480-278-8300
F 480-922-5231

West Valley Office
14155 N 83rd Ave, Ste 127
Peoria, AZ 85381
623-773-2873
F 623-414-4922

Your Name & Date of Birth ____

Please list all medication allergies (or write "none") ____

Please list **<u>all</u>** **medications you currently take or regularly take** (you may attach your medication record):

	Name of Medication	Reason for Taking
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________
4.	______________________	______________________
5.	______________________	______________________
6.	______________________	______________________
7.	______________________	______________________
8.	______________________	______________________
9.	______________________	______________________

☐ Never Smoked ☐ Currently Smoke (# Packs/day):____ How Many Yrs: ____ ☐ Quit Smoking (mo/yr)______

☐ Never Drank Alcohol ☐ Occasionally Drink ☐ Drink Daily

Do you feel safe at home? ______________ Do you feel threatened at home?_______________

Family History of Cancer:

Who	Type of Cancer	Age at Diagnosis
______________________	____________	____________
______________________	____________	____________
______________________	____________	____________

<u>The rest of this form pertains to WOMEN ONLY</u>

Number of Pregnancies: _____ Number of Children Born: _____ How old were you gave birth to your 1st child? _____

Age at first period: _____ Date of your last menstrual period: ________

Is There Any Chance You Could Be Pregnant? _________

Are You Sexually Active? ______

Hormone History:

Do you currently take hormones? ________ How many years?____

Have you taken hormones in the past? _______ How many years?____

Menstrual/Period Flow:

☐ Light Flow ☐ Medium Flow ☐ Heavy Flow ☐ Cramping

Do you have any of the following symptoms or conditions?

☐ Vaginal Swelling ☐ Vaginal Itching ☐ Vaginal Discharge ☐ Blood in Urine

☐ HIV ☐ AIDS ☐ Sexually Transmitted Disease(s): _________________

ARIZONA CENTER FOR HEMATOLOGY AND ONCOLOGY, PLC
ARIZONA CENTER FOR CANCER CARE

Devinder Singh MD • Christopher Verdi MD • Joan Dahmer MD • Parmjeet Banghar MD •
Clarence Sarkodee-Adoo MD • James Choi MD • Anjali Iyengar MD
Terry Lee MD • Christopher Biggs MD • Daniel Reed DO • Marianne Mildenberger MD • Ivor Benjamin MD
Carol Fillian NP • Eileen Gebhart NP • Hetal Trivedi ANP • Cheryl Wolfe-Ruiz PA • Deborah Chapman PA • Candice George PA

FINANCIAL POLICY

Thank you for choosing Arizona Center for Hematology and Oncology, P.L.C. to meet your specialized medical needs. We are committed to providing you with the best treatment available. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, of which we require that you read and sign.

All new patients must complete our Patient Registration form as well as our Financial Policy before seeing the physician.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS.

PAYMENT PLANS ARE ACCEPTED UPON APPROVAL.

REGARDING INSURANCE*:* Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We will bill your insurance plan for you, as long as you provide us with correct information. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered medically necessary under your health insurance plan. You, as the patient, ultimately are responsible for payment of all services provided by Arizona Center for Hematology and Oncology, P.L.C. While payment is your responsibility, we will assist you in negotiating settlement with your insurance company for any disputed claim. Our billing department is available to discuss any questions you may have regarding your insurance or your account at 602-368-3045.

Regarding insurance plans where we are a participating or preferred provider. All co pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating or preferred providers, refer to the above paragraph. If you have a secondary insurance, we will bill it for you, as a courtesy, as long as you have provided us with the appropriate information.

USUAL AND CUSTOMARY: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
MEDICAL NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you, is unnecessary, you will be responsible for the bill.
CREDIT POLICY: Accounts are due and payable as of the date billed. Unpaid balances will be considered delinquent after 60 days.

We realize it may be necessary on occasion to arrange installment or other payment programs. If financial problems arise, please contact our billing department as soon as possible by calling 602-368-3045.

If an account becomes past due with no valid reason, necessary action will be taken to recover the account balance due. If your account is placed with an outside collection agency, you will be responsible for all collection fees and all legal fees.
Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

X____Date:_________________________
Signature of Patient or Responsible Party

Glendale Office
5750 W Thunderbird Rd.
Suite C300
Glendale, AZ 85306
602-938-2848 F- 602-938-4401

Surprise Office
14674 W Mountain View Blvd.
Suite 105
Surprise, AZ 85374
623-975-2323 F-623-975-3902

Avondale Office
10320 W McDowell Rd.
Suite 9030
Avondale, AZ 85392
623-536-2580 F-623-536-2868

Peoria Radiation Office
14155 N. 83rd Ave
Suite 127
Peoria, AZ 85381
623-733-2873 F-623-414-4922

ARIZONA CENTER FOR CANCER CARE

Medical Records Release

Devinder Singh MD • Christopher Verdi MD • Joan Dahmer MD • Parmjeet Banghar MD
Clarence Sarkodee-Adoo MD • James Choi MD • Anjali Iyengar MD
Terry Lee MD • Christopher Biggs MD • Daniel Reed DO • Marianne Mildenberger MD • Ivor Benjamin MD
Carol Fillian NP • Eileen Gebhart NP • Hetal Trivedi ANP • Cheryl Wolfe-Ruiz PA • Deborah Chapman PA • Candice George PA

Patient Name: ______________________________ DOB:____________ SS#:______________________

Address: __________________________________ Phone #:__________________________________

City/State/Zip:____

I hereby authorize use or disclosure of the above named individual's health information.

INFORMATION REQUESTED OR TO BE DISCLOSED:

Physician Notes Lab Reports Pathology Reports
X-ray, Imaging Reports Operative Reports Other __________

PURPOSE OF REQUEST:

Self Continued Medical Care Moving
Other (Specify Reason) ____

REQUESTING RECORDS FROM: ____
(Organization/Contact Information)
____

RECORDS TO BE SENT TO: ____
(Organization/Contact Information)
____

I understand that the 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. It may also include information about behavioral or mental health services and treatment of alcohol and /or drug abuse; my signature authorizes of any such information.

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

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that revocation will not apply to the information already abased on this authorization.

Unless otherwise revoked, this authorization will **EXPIRE 12 MONTHS FROM THE DATE SIGNED.**

____ Date: ___________________
Signature of patient or legal representative

____
If signed by Patient or legal representative, relationship to patient

FOR INTERNAL OFFICE USE ONLY:

DATE RECEIVED: _______________ DATE SENT: ________________ BY: ________________

Glendale Office	Surprise Office	Avondale Office	Peoria- Radiation Office
5750 W Thunderbird Rd.	14674 W Mountain View Blvd.	10320 W McDowell Rd.	14155 N. 83rd Ave
Suite C300	Suite 105	Suite 9030	Suite 127
Glendale, AZ 85306	Surprise, AZ 85374	Avondale, AZ 85392	Peoria, AZ 85381
602-938-2848	623-975-2323	623-536-2580	623-733-2873
F 602-938-4401	F 623-975-3902	F 623-536-2868	F 623-414-4922

ARIZONA CENTER FOR CANCER CARE AND/OR
ARIZONA CENTER FOR HEMATOLOGY & ONCOLOGY

5750 W Thunderbird Rd, Suite C300, Glendale, AZ 85306 •(602) 938-2848
14674 W Mt. View Blvd, Suite 105, Surprise, AZ 85374 • (623)975-2323
10320 W McDowell Rd, Suite 9030, Avondale, AZ 85323 • (623)536-2580
14155 N. 83'° Ave, Suite 127, Peoria, AZ 85381 • (623)773-2873

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.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with ARIZONA CENTER FOR CANCER CARE. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.
ARIZONA CENTER FOR CANCER CARE is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice please contact our Privacy Manager at 602-938-2848.

YOUR RIGHTS UNDER THE PRIVACY RULE

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information Please feel free to discuss any questions with our staff.

You have the right to receive and we are required to provide you with a copy of this Notice Privacy Practices- We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected. health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure- This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative- This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of protected health

information.

You have the right to inspect and copy your protected health information- This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.

You have the right to request a restriction of your protected health information- This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.

You may have the right to have us amend your protected health information- This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

You have the right to request a disclosure accountability- This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment- We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. For example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment.

We may also call you by, name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment- Your protected health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake

before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations- We may use or disclose, as-needed, your protected health information in order to support the business activities of our practices, This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identify information.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To Others Involved in Your Healthcare- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, you identify, your protected health information that directly relates to that person's involvement in your health care. If you are to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law- We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health- We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases- We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In

this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings- We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement- We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation- We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity- Consistent with applicable federal and state laws, we may disclose protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security- When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

For Worker's Compensation- Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

When an Inmate- We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures- Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

ARIZONA CENTER FOR HEMATOLOGY & ONCOLOGY
AND / OR
ARIZONA CENTER FOR CANCER CARE

A. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _________________________ _____________acknowledge that I have received
(Name of Patient)
a copy of ARIZONA CENTER FOR CANCER CARE '**Notice of Privacy Practices**'. This Notice describes how the ARIZONA CENTER CANCER CARE may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

B. AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

TO AUTHORIZE ANOTHER PERSON/ORGANIZATION TO PICK UP AND/OR DISCUSS YOUR RECORDS, PLEASE PROVIDE THE NAME, RELATIONSHIP TO YOU AND PHONE NUMBER BELOW:

1.____

2.____

3.____

C. AUTHORIZATION TO LEAVE MESSAGES

TO AUTHORIZE OUR DOCTORS/STAFF/FACILITY TO LEAVE DETAILED HEALTH INFORMATION MESSAGE ON VOICE MAIL/ANSWERING MACHINE, PLEASE PROVIDE A SECURE PHONE NUMBER

____

_________________________________ ______________________
(Signature of Patient or Personal Representative) (Date)

H1PAA-ACK2

Patient Rights & Responsibilities

The following list of patient rights is not intended to be all inclusive. Every patient has the right to:

- Be treated with dignity and respect
- Privacy and confidentiality concerning their medical care - the patient has the right to be advised as to the reason for the presence of any individual directly involved or observing their care
- Have their questions, concerns or complaints addressed in good faith
- Be provided with complete information about their diagnosis, indications for tests and procedures, treatment and alternatives, prognosis, and both normal and abnormal test results. Such communication will be in a timely manner.
- Make choices and decisions regarding their medical care to the extent permitted by law - this includes the right to refuse treatment
- Change physicians if other qualified physicians are available
- Receive, on request, information about fees and charges, and receive an explanation of their bill, regardless of source of payment
- Have an advance directive concerning treatment or designation of a surrogate decision maker
- Exercise these rights without regard to gender, cultural, economic, educational or religious background
- Have access to interpreter services, free of charge

The care a patient receives depends partially on the patient himself. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities shall be presented to the patient in the spirit of mutual trust and respect.

The patient has the responsibility to:

- Provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health
- Make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her
- Follow the treatment plan established by his/her physician, including the instructions of nurses and other health professionals, as they carry out the physician's orders
- Keep appointments and notify AZCCC or physician when unable to do so
- Accept responsibility for his/her actions should he/she refuse treatment or not follow his/her physician's orders
- Assure that financial obligations of his/her care are fulfilled as promptly as possible
- Follow our facility's policies and procedures
- Be considerate of the rights and property of other patients and facility personnel
- Notify AZCCC staff of request for interpreter services

If you have any comments or concerns regarding services provided at AZCCC, please contact Practice Administrator at (623) 773-2873, or write Practice Administrator, AZCCC, 14155 N. 83rd Ave. Suite 127, Peoria, AZ 85383.

Derechos y Responsabilidades del Paciente

Estos son los principales derechos del paciente; todos los pacientes tienen derecho a:

- Ser tratado con dignidad y respeto
- Privacidad y confidencialidad en cuanto a su cuidado medico
- Respuestas a sus preguntas, preocupaciones, y quejas de buena fe
- Ser informado completamente acerca de sus diagnósticos, indicaciones para ordenar estudios, tratamientos y alternativas, al igual que pronostico, y ambos resultados de estudios, normales y anormales. dicha notificación se hará en tiempo oportuno.
- Escoger y tomar decisiones sobre su cuidado medico
- Cambiar de medico si lo desea y otro medico esta disponible
- Recibir y solicitar información sobre honorarios, costos y orientación acerca de su factura, independientemente de quien efectué el pago
- Tener una directriz pre-dirigida concerniente a tratamiento o designar una persona que pueda tomar decisiones por usted de presentarse tal situación
- Participe de estos derechos sin distinción de sexo, cultura, estado económico, educación o religión
- Los pacientes tienen acceso de interprete a través de AZCCC

Un paciente tiene la responsabilidad de:

- Proveer información completa y precisa concerniente a su queja o problema actual, historial medico pasado, o cualquier otra información pertinente relacionado a su salud
- Comunicar el nivel de comprensión acerca del tratamiento medico recomendado y lo que se espera de si como paciente
- Seguir las recomendaciones de tratamiento dadas por su medico, incluyendo las instrucciones dada por otros profesionales aliados a la medicina como enfermeras que siguen instrucciones de su medico
- Acudir a sus citas y notificar a AZCCC cuando no sea posible
- Aceptar la responsabilidad de sus actos si rehúsa tratamiento o no sigue las recomendaciones de su medico
- Garantizar que las obligaciones financieras sean atendidas tan pronto sea posible
- Seguir las normas y procedimientos de nuestra institución
- Ser considerado respecto a los derechos de otros pacientes y nuestros empleados
- Favor de notificar al personal de AZCCC si solicita los servicios de un interprete

Si tiene cualquier comentario o preocupación acerca de los servicios provistos en AZCCC o cualquiera de nuestros centros regionales por favor llame a (623) 773-2873 con el administrador general, o escriba AZCCC, 14155 N. 83rd Ave. Suite 127, Peoria, AZ 85383.