Patient Label

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

FACE SHEET

DATE_____ TIME _____

Purpose of disclosure: To identify persons supporting and using services; notification of admission, discharge, and aftercare plans.

All requested information must be completed for insurance claims to be correctly processed. Exclusion of insurance policy information may result in an insurance denial in which you will be totally responsible for your bill. The person who signs consent is the Guarantor/responsible party for this bill.

Please Complete ALL information

1. Patient Demographics

Who referred you to come into Valley Hospital/How did you hear about Valley hospital?

Patient Last Name:			**First:**		Middle:	
Sex: ☐M ☐F	DOB:	Age:	Marital Status: ☐S ☐W ☐M ☐Divorced ☐Separated	Ethnic Origin: ☐Caucasian ☐African-American ☐American Indian ☐Hispanic ☐Asian ☐Other		Religion:
Address:			Apt#:	City:	State/Zip:	
Home Phone:	**Cell Phone:**		Social Security #:		Driver's License and State:	
Vehicle Make/Model:			Year:	Color:	License Plate#:	
Employer Name:	Occupation:		Length of Employment:		Employer Phone:	
Employer Address:	Suite#:		City:		State/Zip:	
Have you had recent change in coverage? ☐ Yes ☐ No			Term date:		Do you have Cobra? ☐ Yes ☐ No Date:	
Was premium Paid? ☐ Yes ☐ No			Amount of Premium?		Date of premium payment	

Have you been incarcerated in the last 30 days? ☐ Yes ☐ No

2. Guarantor/Legal Guardian of Minor

Last Name:	First:		Sex: ☐M ☐F	DOB:	Relation:
Cell Phone:	Social Security#:		M. Initial:	Occupation:	
Address:	Apt #:	City:		State/Zip:	
Employer Name:	Length of Employment:		Employer Phone:		

3. Primary Insurance Information

Name of Insurance:			Insurance Phone:		
Policy/Hic#:	Social Security #:		Group Name:		Group#:
Insured's Last Name:	First:	Middle Initial:	Sex: ☐M ☐F	Relation:	DOB:
Employer Name:	Occupation:	Length of Employment:		Employer Phone:	
Employer Address:	Suite#:	City:	State/Zip:		

Name of Insurance:			Insurance Phone:		
Policy/Hic#:	Social Security #:		Group Name:		Group #:
Insured's Last Name:	First:	Middle Initial:	Sex: ☐M ☐F	Relation:	DOB:
Employer Name:	Occupation:	Length of Employment:		Employer Phone:	
Employer Address:	Suite#:	City:	State/Zip:		

5. Emergency Contact:

Emergency Contact #1:		Relationship:	
Address:	Apt#:	City:	State/Zip:
Home Phone:	**Cell Phone:**	Work Phone:	
Emergency Contact #2:		Relationship:	
Address:	Apt#:	City:	State/Zip:
Home Phone:	**Cell Phone:**	Work Phone:	

6. Previous Hospitalizations:

Last 12 months: ☐ Yes ☐ No	Last 6 months: ☐ Yes ☐ No
Where:	Where:
When:	When:
Why:	Why:
How long:	How long:

7. Primary Care Doctor:

Name: _____

Address: _____

Phone number: _____

Date of last appointment: _____

Are you willing to sign a Release of Information for this Provider?

☐ YES ☐ NO

8. Therapist/Psychologist

Name: _____

Address: _____

Phone number: _____

Date of last appointment: _____

Are you willing to sign a Release of Information for this Provider?

☐ YES ☐ NO

9. Psychiatrist

Name: _____

Address: _____

Phone number: _____

Date of last appointment: _____

Are you willing to sign a Release of Information for this Provider?

☐ YES ☐ NO

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

Patient Label

Consent to Release Protected Health Information (PHI)
3550 E. Pinchot Ave, Phoenix, AZ 85018

Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors and others who may be taking care of you your PHI unless you provide your written consent. By signing this form, you give us your written consent. We will only give out the PHI that you authorize us to share and we will only give it to the people or agencies that you list.

Part 1 Who is the patient?

Last Name	First Name	Middle Initial
ID Number (SSN)	Date of Birth (MM/DD/YYYY)	Phone Number (with area code)
Address	City	State / Zip Code

Check One

☐ I am the patient OR

☐ I have the legal right to act for this person. (Check one below; if "other" fill in blank)
I'm his/her: ☐ Parent or ☐ Guardian, or ☐ Other _____

Part 2 Who may give out the PHI?

Valley Hospital manages your mental health and/or drug and alcohol treatment. Valley Hospital may give out your PHI. If you want someone else to give out your PHI, name them here:

_____

Part 3 Who can get the PHI I give out?

Name (a person, like family members who live with me, or a place of business)	Relationship	Phone Number (with area code)
Address	City, State, and Zip Code	

Part 4 What can be shared?

We will only share the PHI that you authorize. Tell us the type of PHI by checking the box. Give the date if you can.
(Note: Government rules (HIPAA) require a separate form to share psychotherapy notes. If you want us to share psychotherapy notes, please complete a second form.)

☐ HIV/AIDS/Other Communicable Diseases ☐ Alcohol/Substance Abuse Records ☐ Treatment Plans
☐ History & Physical ☐ Billing Records ☐ Medications ☐ Radiology/Lab Results
☐ Assessments ☐ Medications ☐ Discharge Summary ☐ Consultation ☐ Other _____

Part 5 Why can you get the PHI?

☐ Follow-up Care ☐ Patient is requesting disclosure ☐ Disability Benefits ☐ Attorney
☐ Insurance Coverage/Payment of Care ☐ Other _____

Part 6 When does my written consent end?

Your written consent will expire in six (6) months from the date it is signed by you unless you specify a date.

☐ **My consent ends on this date** ---- OR

☐ **My consent ends when this happens:** _____

(It can be something like "you can share my medical records this one time.") If you do not tell us when your consent ends then we will end your consent in six (6) months from the date when you sign. After six months, we will need a new written consent form.

Turn this page over.

- Giving your consent is up to you. You do not have to share your information.
- You can take back your consent to share your PHI with some exceptions. You must tell us in writing.
- What if you take back your consent? This will not take back the PHI that we have already shared. But, we will not share any more of your PHI.
- If we share your PHI with the people or agencies that you named, they may share it with others if allowed under the law.
- HIV/AIDS and other communicable disease information cannot be shared with others unless you specifically give written consent to share it or as permitted by law.
- You have a right to get a copy of this signed consent form. If you need another copy, notify the staff at Valley Hospital.
- If you do not understand, or have questions, we can help. Notify a staff member for assistance.
- I understand the information discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Part [illegible] Signature of Patient

I give my written consent to share the information listed on this form.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

Part [illegible] Signature of Authorized Representative (if any)

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the patient is less than 18 years old, a parent or guardian should sign for the minor.

_____ _____

Signature of Person signing on behalf of patient Date

Printed Name: _____

Address: _____

Witness: _____

You should get a copy of this signed form. Remember, Protected Health Information (PHI) means any information about your health in the past, present, or future. It includes facts like your address and date of birth. A full definition of PHI is at 45 CFR §160.103.

NOTICE TO ANYONE OTHER THAN THE PATIENT

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), or under state statute on confidentiality of HIV/AIDS and other communicable disease information (A.R.S. 36-664(H) you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2 and A.R.S 36-664(H). A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ At this time I decline to give my written consent to share the information listed on this form.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

Patient Label

VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

COORDINATION OF BENEFIT FORM
MENTAL HEALTH / SUBSTANCE ABUSE TREATMENT

Primary Coverage — **Insured Date of Birth** ___ / ___ / ___

Insured: (Last) (First) (Middle Initial)

Insured Address: (Street) (Apt #) City/State/Zip

Insured Social Security Number: Insured Phone Number:

Patient Information

Patient's Name: (Last) (First) (Middle Initial)

Patient's DOB: Gender: ❑ Male ❑ Female Patient's Relationship to Subscriber: ❑ Self ❑ Child ❑ Spouse

Other Coverage – Secondary

Is The Patient Covered By Any Other Group Insurance Plan? ❑ Yes ❑ No

If Yes

Insured: (Last) (First) (Middle Initial)

Insured Address: (Street) (Apt #) City/State/Zip

Insured Social Security Number: Insured Phone Number:

Name of Insurance Company: Policy # : Phone #:

Address of Insurance Company:

Is The Patient Eligible For Medicare? ❑ Yes ❑ No

If Yes

Medicare Effective Date: Part A	Day	Year
Medicare Effective Date: Part B	Day	Year

If Claim Is For Dependent Child Age 19 or Over, Is Child A Full-Time Student? ❑ Yes ❑ No

If Yes

School Name: Phone #:

School Address: (Street) City/State/Zip

Last Date Attended

Assignment of Benefits

Authorization to pay provider. For service described, I hereby authorize payment of benefits, if any, to the named provider. I understand I am financially responsible for the charges not covered by this authorization:

Signature: Date:

I certify that the information provided on this coordination of benefit form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named, and hereby authorize any insurance company, organization, employer or provider of service to release any information with respect to this coordination of benefit form.

Signature: Date:

Rev: 10/1/19

REQUEST FOR A REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

Today's Date: Month: Day: Year:

Name of Party Requesting the Independent Review:	**Relationship to the Patient:**
Print (Last Name) (First Name) (Middle Initial)	(i.e. self, person acting on behalf of the patient, healthcare provider):

Reason for Request For Review By An Independent Review Organization (Check only one)

1) ___ The Utilization Review Agent's adverse determination has been upheld on appeal. I request this determination to be reviewed by Independent Review Organization.
2) ___ I request the adverse determination of the Utilization Review Agent to an Independent Review Organization because the patient has a Life-Threatening Condition on this date and care has not been rendered.
3) ___ As ordered by the court, I am requesting review by an Independent Review Organization.

Provider of Record:

Name _____
Street _____
City _____ **State** _____ **Zip code** _____
Phone Number _____-_____ **Fax Number** _____-_____ (if applicable)

PROVIDER OF RECORD - The physician or other health care provider that has primary responsibility for the care, treatment, and services rendered to the patient and includes any health care facility when treatment is rendered on an inpatient or outpatient basis.

Patient Name:

Health Plan Identification Number _____ **Identification Number** _____
(The unique number which identifies the patient's Health Plan – usually found on the Patient ID card)

Patient's Date of Birth: **Sex: M F** **Social Security Number:**

Name _____
Street _____
City _____ **State** _____ **Zip code** _____
Phone Number _____-_____ **Fax Number** _____-_____ (if applicable)

Person or Provider Acting On Patient's Behalf (if applicable)

Name _____ If a provider, Federal Tax Identification Number _____
Street _____
City _____ **State** _____ **Zip code** _____
Phone Number _____-_____ **Fax Number** _____-_____ (if applicable)

(THE RELEASE MUST BE SIGNED BY THE PATIENT, or his or her LEGAL GUARDIAN)
I, _____, the patient, or his/her legal guardian, do hereby authorize the **(Print)(last name)(first name) (middle initial)**

Release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signature **Date**

Return this form to:

If you have questions concerning the independent review process, please feel free to call the Texas Department of Insurance 1-888-TDI-2IRO (1-888-834-2476) for information.